



HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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ED Care Transition Teams Can Address Behavioral, Social Needs

Case management approach in ED saves money

By Melinda Young

Health systems that employ care coordination/case management teams in the ED can save hundreds of thousands of dollars, and improve the health of some of their most vulnerable patients.

The results of a recent study showed that frequent ED users experience higher death rates and greater health-related social needs. One solution is care coordination and communication.¹

"Right now, there is a large emphasis by policymakers and clinicians on patients who use emergency departments frequently," says **Hemal Kanzaria**, MD, MSc, associate professor in the department of

emergency medicine and an affiliated faculty member at the Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco.

Kanzaria is the lead author on a paper about frequent ED users.

"In our study, we found that frequent emergency department use had higher use of all nonemergency medical services," he says. These include increased use of primary care providers, urgent care, behavioral health

care, behavioral health services, and a sobering center.

The study revealed that 22% of people who did not use the ED frequently had logged mental health visits within

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the previous year. For frequent ED users, 46% recorded mental health visits, and for people who used the ED the most, two-thirds had used mental health services.¹

Substance use followed a similar pattern: About 8% of non-ED users had a substance use disorder visit, 28% of frequent ED users had a substance use disorder visit, and 54% of the super frequent ED users had a substance use disorder visit.¹

Frequent ED users also were more likely to be homeless, have been jailed, and have high social needs. The most frequent ED users experienced tri-morbidity, including mental health, substance use, and medical comorbidities.¹

"These patients are very sick and seeking care for medical needs. But they also are coming in to the ED for social and behavioral health needs, and they come to the emergency department a lot," Kanzaria says. "That should make us think about how we're organizing our system of care to meet their needs."

Traditionally, EDs are set up to take care of patients with medical emergencies, such as traumatic injuries, heart attacks, and strokes. The study's findings suggest that EDs

should be adapted to address the new realities of their most frequent patients.

"We have to think about how we can best address and partner to address their social needs and behavioral health needs," Kanzaria says.

One method involves a case management-style team approach to ED navigation. Nurses, social workers, case managers, and others can work together to address the social determinants of health and care transitions of ED patients who need sociobehavioral health services, says **Julie Nevers, MN, BSN, CCM**, director of care coordination at St. Tammany Health System in Covington, LA.

"We identified a need to have a team approach for emergency department navigation," Nevers says. "This is to involve the RN in case management, the social worker to focus on social determinants of health, and the psychosocial aspect of navigation."

The team also includes a utilization management person and an ED navigator. The team uses data and a dashboard to help identify at-risk patients. (*See story on team and identifying patients, page 28.*)

EXECUTIVE SUMMARY

A study showed frequent ED visitors experience higher death rates and more social determinants of health issues — problems that can be reduced through better care coordination and communication.

- People who often end up in the ED are more likely to be homeless and experience substance use disorders, mental health problems, and social issues, such as having been jailed.
- A case management-style team can work with ED patients to address their social determinants of health needs and ensure transition to community healthcare providers.
- An ED transition program also can include a pharmacist to help vulnerable ED patients fill prescriptions when they are discharged.

"Having the team in the emergency department has really proved to be beneficial to us," Nevers adds. "The ED team decides if we can avoid an admission and get patients the services they need within our market community, instead of putting them in a bed and potentially admitting them to the facility for low-level care."

Kanzaria works with a hospital that uses a social medicine ED program to meet patients' social and medical needs. The program consists of social workers, a care coordinator, a quality improvement specialist, and Kanzaria. The program also includes a pharmacist who ensures vulnerable ED patients, including patients with addiction or mental health problems, fill their prescriptions when they are discharged.

"This is so they don't have to take all of their life belongings on two buses and pay out of pocket to pick up their medication," Kanzaria says. "We give patients their medication free of charge."

One component of the program engages patients with medication-assisted therapy. Another includes case management that starts in the ED and follows patients for six months in the outpatient setting. "We partner with other groups of people who are experts on housing," he adds.

St. Tammany started the ED navigation program on a trial basis in March 2019. Since then, it has produced a significant return on investment with financial savings, along with ED avoidance, decreases in acute admissions, and referrals out of the community. The program has saved the hospital about \$850,000 over a year, Nevers says.

The hospital hired social workers to cover the ED 16 hours a day, seven days a week. It also is planning to add

an ED navigator seven days a week for 12-hour shifts. "The return on investment has been astronomical," Nevers says.

Overall satisfaction also has improved. "Patient, staff, and family satisfaction has increased dramatically," says **Bradley Leonhard**, BSN, RN, department head, emergency services at St. Tammany Health System. "Placing a

drive so many repeated visits to the ED, Hill explains.

"Over half of the emergency department visits are driven by social determinants of health, lack of medication, lack of linkage to medical resources, living in food deserts, and lack of social support at home," Hill says. "We help with these things, in addition to getting patients to the right care provider and getting them support."

For example, some patients use the ED because they do not have access to a PCP. This is due to lack of insurance, lack of transportation, or because they do not know how to find a doctor under Medicaid, says **Angela Gottschalk**, BSN, RN, CCM, department head of care coordination at St. Tammany Health System.

The ED transition team can help patients find a PCP and obtain transportation through Medicaid services or local service organizations. "The RN care coordinator plays a huge role in working with the social worker for these services," Gottschalk says.

Educating patients is a major role for the ED team, Hill notes. "Many of these patients are not literate in medications, or the medical disease process," he says. "We're simplifying it for the patient, and linking patients to appointments for the next day." This is an important part of closing the loop, Hill adds.

The ED navigation team is expanding its follow-up to a texting service, Nevers says. "An artificial intelligence program that we're using in the emergency room with patients will send them an email or use a text messaging service with questions they can answer to help alert the team of the need to step in, from a navigation perspective," she explains. "We learn whether they are able to fill their

THE ED TRANSITION TEAM CAN HELP PATIENTS FIND A PCP AND OBTAIN TRANSPORTATION THROUGH MEDICAID SERVICES OR LOCAL SERVICE ORGANIZATIONS.

team in the emergency room allows patients to get in and out quicker, and gets patients to the right setting. Having our navigator on hand to handle those [social determinants of health] problems allows us to care for patients, and not have to deal with the social aspect."

The ED had assessed patients for psychosocial issues prior to the implementation of the ED navigation team, but most of those patients were placed in observation, says **Michael Hill**, MD, vice president of quality and utilization management at St. Tammany Health System. "We've cut out that piece completely," Hill says.

Instead, the team works to find primary care providers (PCPs), specialists, and other services for patients. The team also addresses the social determinants of health that

medication or make a follow-up appointment — any issues that would prevent them from coming back to the emergency room.”

Patients receive a message, inviting them to join the platform and activate an account. Then, the team sends canned questions, such as:

- Did you fill your medication after discharge?
- Did you make your follow-up doctor’s appointment?
- Is your condition worsening or getting better?
- Do you need any help?

Depending the patient’s answers, the program might send another question. For example, if a patient has

not filled prescriptions four days after discharge because the cost was too high, he or she may receive a message, asking “What could we do to make your medication more affordable?” Nevers says.

The hospital is piloting the texting program, which began in January, to see how involved it is and if it will close the loop of care after patients are discharged, Nevers says.

“We’ve been working on this program for a while, and have done testing on it,” Hill says. “We’ve realized that healthcare is about people, and we have to reach beyond the four walls of the hospital, working with people once they

leave the hospital, making sure they have follow-up and get all the right medications and appointments.”

Using the texting program, the team can stay in touch with patients about various clinical conditions. The data it collects can be used in a dashboard and screening tool that helps the team focus on the most vulnerable patients, Hill adds. ■

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Use Data-Driven Dashboard, Other Tools to Assist ED Navigation Team

Data include sociobehavioral info

By Melinda Young

ED navigation teams can connect patients to primary care providers, psychosocial programs, and community-based organizations to help keep people out of hospital beds and the ED.

“There is value in integrated data,” says **Hemal Kanzaria**, MD, MSc, associate professor in the department

of emergency medicine and an affiliated faculty member at the Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco.

Health systems can pull data from community providers whenever this information is accessible. “As an emergency department doctor, I work

in a very busy system, and I don’t want to duplicate efforts,” Kanzaria says. “If I want to link a patient to social services, but the patient might already be linked, I don’t want to duplicate.”

Clinicians need to communicate and coordinate care between health-care settings to reduce interruptions of care, as well as duplication of care. “These types of data could be used to advocate for services in the ambulatory care setting, and for outpatient care management,” Kanzaria explains. “It speaks to the high social needs of these clients.”

Homelessness is one of the chief social needs among frequent ED users, Kanzaria says. ED case management can be an opportunity for the health system to engage with patients in need of housing. For

EXECUTIVE SUMMARY

Using a navigation team with access to integrated data, an ED can connect patients to primary care providers, local organizations, and psychosocial programs.

- The ED care management team can build bridges with local housing authorities and collect data on patients’ housing vulnerability.
- The ED team can use a dashboard to collect information about patients’ home situations, their sociobehavioral health issues, substance use issues, and medical conditions.
- The team can help patients set up appointments with community providers.

example, if a homeless patient seen in the ED has a skin infection on the leg, the treatment might be to elevate the leg and prescribe antibiotics, he says.

"We look for a service in the community where they can do that," he says. "We offer to help patients get into transitional housing."

The key is for the ED care management team to build bridges with local housing authorities, and to collect data on patients' housing vulnerability, including their length of time homeless, mental health status, and other vulnerabilities. This information helps housing departments assess and rank them according to a housing prioritization list, Kanzaria adds.

One of the keys to the team's success involves data-driven screening and decision-making. "We have different analytic platforms that we look at every day," says **Julie Nevers**, MN, BSN, CCM, director of care coordination at St. Tammany Health System in Covington, LA. The dashboard provides information about patients who frequently return to the ED. It includes information about patients' home situations, their sociobehavioral health issues, substance use issues, and chronic diseases and medical conditions.

With dashboard data on patients, an ED navigation team communicates with ED staff and others about the patients. ED staff might make a referral based more on

their observation and experience than what is in the medical chart, Nevers notes.

"The ED staff will say, 'I have a feeling something is not right with this patient. Do you mind looking into it?'" she says. "A lot of it is open communication and everyone believing in everyone's discipline and believing in what value they bring to the team."

St. Tammany Health System started its ED navigation team as a pilot project a year ago. The team includes an ED navigator, RN case manager, social worker, and utilization review professional.

"When we put our ED navigator in this role, she was actively having to seek out consults and things to do. Physicians weren't quite sure of what her role was, and how they could utilize her," says **Angela Gottschalk**, BSN, RN, CCM, department head of care coordination at St. Tammany Health System. "Today, they are actively seeking her out. The staff has come to realize how valuable she is in the emergency department, and how she could help them move their patients along the continuum." The ED is proactive in seeking out the navigator, asking for help in moving patients along the care continuum, she adds.

It also is important that ED navigation teams know about community resources that can help patients with their social determinants

of health and other problems. "It's important that those who start the navigation program are aware of what resources are available in their market," Nevers says. "They should have relationships with community providers."

For instance, if an ED patient needs an immediate appointment with a primary care provider, the ED navigation team should be able to call a particular provider and ask for a next-day appointment. The provider, who has a relationship with the ED navigator, would know that this is an important case, and that the navigator would not ask for this favor lightly, she explains.

"You have to go out and meet community providers, and work together with them on projects," Nevers says. "We're fortunate here to have a robust community network that works well. Although there always is room to grow, we're fortunate to have that teamwork approach that extends outside the hospital."

St. Tammany's ED navigation team has access to patients' schedules in some physician offices. Sometimes, the team can schedule an appointment for a patient without having to speak with anyone in the office, Gottschalk says.

"Sometimes, we don't have to call anyone, and we can schedule it right from the computer. That's where building relationships and having trust helps," she adds. ■

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Ensure Adherence by Addressing Patients' Social Needs

By Jeanie Davis

If a patient fears he or she will get robbed leaving the pharmacy, he or she is less likely to buy the medication. The patient may be homeless, or simply cannot afford the medication. He or she may struggle with literacy and reading the prescription information. The patient may be depressed, or may not believe the medication will help.

These all are realities for patients, especially those living in inner cities. The result is medication nonadherence, which can pose serious consequences for a patient's health — and lead to billions of dollars in excess healthcare costs in the U.S. annually.

"I worked as a home care nurse early in my career, and that's where you see it all," says **Lene' Hudson**, MSN, RN, CCM, CCDS, director of care management for Maricopa Integrated Health System in Phoenix. "In home care, you see their living conditions, their real problems," she explains. "You learn about their finances, access to care, lack of transportation. They either don't have a primary care provider, or the ability to pay, or they simply can't get to a doctor for follow-up."

Case managers and nurses have long known these factors to be barriers to healthcare, but public health researchers are digging deeper to understand these issues. Social determinants of health are the conditions in which people are born, grow, live, work, and age that shape health. Factors like socioeconomic status, education, neighborhood and physical environment, employment, social support networks, and access to healthcare all are important in this scenario.

Healthcare systems across the country are launching initiatives to help patients get past these social factors. At Valleywise Health System, case managers are guiding a broad program of efforts to address the multiple factors affecting a patients' treatment.

For example, many more questions are asked at intake to help determine a patient's needs. "You can never ask enough questions," says **Sondra King**, MSN, ACM-RN, care coordinator at Valleywise. "The goal is to determine if they have risk factors that will impact their health at any point in their care."

Social determinants are a little deeper than barriers to care, she explains. "They cover basics, but it also gets more personal — living arrangement, are you working, are you disabled, do you have a car? We ask about social support: Do you go to church? Attend social events regularly? Do you have family nearby, and do you talk to them regularly?"

The screening also addresses mental health by asking about how a patient has felt in the past two weeks to determine if there is hopelessness and depression.

"Medication adherence is directly related to social determinants of health because a patient's ability to purchase medications and adhere to a medication regimen can be affected by a variety of social and economic factors," explains King. "Education level affects the ability to understand difficult medication schedules while income and finances simply decide whether a patient will purchase medications or put food on the table."

Transportation is a big issue for many people who do not have a primary care doctor or pharmacy nearby, King says. Many patients do not know Medicare has a transportation benefit. For others, community services like bus passes and vouchers are available. Valleywise is seeking grants for transportation initiatives, including Uber-style rides for patients, so they can get to a pharmacy or doctor safely.

Valleywise also provides 13 federally funded primacy care centers across the county for patients receiving their care at home for chronic conditions. "This is a unique structure within Maricopa County," Hudson says. "We serve 68% Medicaid and 17-18% Medicare patients; the rest are uninsured or have commercial insurance."

Food insecurity also is a problem, Hudson adds. "If they have a chronic disease, they may need four or five medications. Anyone on a limited budget will have difficulty paying for it all. They eat anything from a can; they don't have money for better food."

Valleywise has partnered with a local pantry to bring food to the hospital. The volunteer-led initiative serves inner city residents of all ages and gets a good turnout every time, she says. That popular program is now being expanded to one of the inner city family clinics.

Through a partnership with a major insurance company, Valleywise also is providing housing for homeless patients. Valleywise Health has purchased 40 apartments, and identified high-risk patients with "homeless" as their primary diagnosis.

The first group of 20 patients was placed in an intensive rehabilitation program for a year, explains Hudson. "This program has cut our costs of care across the board tremendously," she reports. The second group of 20 patients is entering the program.

"Give people with chronic disease good food and housing, and their health will improve," says Hudson.

Overcoming Medication Non-Adherence

Studies have shown that patients with chronic conditions record adherence rates of 50-60%; typically, adherence declines after the first six months. Medication nonadherence is responsible for up to 70% of hospital admissions — costing up to \$100 billion annually. An estimated 125,000 deaths per year in the United States have been attributed to medication nonadherence.¹

To ensure patients take medications as prescribed, pharmacists advise healthcare providers to educate patients on three specific points: What is my main problem? What do I need to do? Why is it important for me to do this?

This simple dialogue helps ensure the patient's understanding and compliance. Patients also should learn the consequences of not taking medication, like potentially fatal events such as heart attack or stroke. Follow up with a phone call to confirm the patient's understanding.

Identifying community resources to help patients certainly is not new to hospital case managers, says Hudson. "People don't know about these benefits, so we educate them." But in setting up those benefits, it is important to dig deeper for all the problems a patient might be facing.

Depressed patients are at greater risk for medication nonadherence. Patients with diabetes may be overwhelmed by the cost of the medications. These patients benefit from open discussions of these issues so they can receive the help they need.

For those who lack prescription coverage, there are multiple plans, including Medicare Part D, Medicare Extra Help, Medicaid, the Together Rx Access Card, Partnership for Prescription Assistance, Coast2Coast Rx Card, and discount cards from some pharmacies and pharmaceutical companies. Generic programs offered by large chain pharmacies

also are helpful. Some independent pharmacies offer price matching programs.

Also, physicians should be aware of the patient's difficulties, as it will affect the patient's success, adds King. "They should know if the patient has no support at home, especially a newly diagnosed diabetic patient. They're going to enter this new diagnosis all alone, with no support, which can be very challenging. They may need to see the doctor in one month instead of three months to see how they're progressing."

She explains: "Navigating the healthcare system is a difficult task. When a person doesn't feel well, and also has other factors to consider, such as food and shelter, it further impacts their health. To help patients heal, we must consider what social determinants they are facing, and how those things are impacting an individual's life." ■

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Health System Makes Utilization Review Paperless, More Efficient

By Melinda Young

As health systems update and revamp their electronic health records, they might want to consider adding a case management module.

An electronic health record that includes an acute case management module with robotic process automation can create seamless efficiency, says **Patricia Resnik, MJ, FACHE**,

CPHQ, vice president, care management at ChristianaCare in Wilmington, DE.

"In the past, case managers would have to go into the record and review it themselves by reading the medical record to determine whether it was an observation or inpatient level of care," Resnik says. "Now, they

can validate through an automated review."

The health system's case management team is trained in utilization management, and most of the reviews are handled by the utilization management team. The electronic system runs a review and presents it to the nurse, who finalizes the report, she adds.

"The determination of inpatient status is always the physician's decision," Resnik says. "The auto-review runs [its process], and if documentation doesn't support that decision, then it brings this to the nurse's attention."

Nurses initiate a discussion with physicians about the appropriate level of care for the patient. "If the automated review comes back and says [conditions are not] met, nurses see that in their work list, and can go in and evaluate that review," Resnik says. "It gives them the opportunity to have a discussion with the physician, and tell them the documentation is not supporting an inpatient admission."

The physician can confirm that an inpatient admission is necessary, and the nurse can forward the doctor's information to a physician advisor at the hospital level. The physician and advisor can discuss the case and the appropriate level of care. "Ultimately, it's the physician's medical judgment," Resnik says.

If the physician believes the inpatient admission is needed, then the physician advisor can talk with the payer's medical director about the case. "They will have a discussion with the payer about how the physician advisor is supporting the attending physician's decision to admit," Resnik

says. "Our physician advisors have a very high overturn rate, meaning they get that denial overturned at first peer-to-peer discussion 65% to 70% [of the time]."

Robotic process automation brings information to staff earlier in the patient's admission. "When we see it is partly meeting or not meeting [conditions], then we know to expect the payer to deny the claim, and we can have a discussion with the attending physician sooner," Resnik says.

Another utilization review management efficiency is the health system's concurrent denial management process, led by the utilization management team with physician advisors.

"If we get notification from a payer that they are denying a claim, then our physician advisors do a level of review to get this resolved before the patient is discharged," Resnik explains. "If the denial remains, management of the denial will occur after discharge through the patient financial services team."

That team has access to all dates, documentation, and information about the case and denial, and will continue to manage the denial.

Utilization management has become so efficient that case managers

can take on additional work functions because of the time saved by the auto-review, Resnik says. For example, case managers now have more time to be proactive. They have more time to evaluate patients' medical records, and work with physicians to ensure the severity of patients' illnesses are well documented.

"When we gained efficiencies in the robotic process, we decided we didn't need two nurses looking at a particular case," Resnik says.

It also reduces the number of people who have to reach out to the physician, Resnick says. "We can expand the number of cases that we're able to see in the day because we don't have two nurses on the same case."

Utilization management with robotic process automation has made it possible for the health system to meet several overall goals. "We are always curious, and continuously look for ways to innovate our work well," Resnik notes. "When the opportunity came along to co-develop this automated system, we knew this would help us be more efficient and effective, and use our resources wisely."

The automation supports the health system's goals for continuous learning and change. ■

Getting Involved: Case Managers Go to Washington

By Jeanie Davis

Legislation and regulatory changes do not always seem in patients' best interests. Insurance coverage issues have made news headlines. In skilled nursing facilities, physical therapy time has been limited by the Centers for Medicare & Medicaid

Services (CMS), which has also triggered concerns.

What can a case manager do? When one sees changes of concern, what is one's recourse? How can one influence state legislators/regulators, and public policy?

Advocacy for patients is integral to the case manager's role, explains **MaryBeth Kurland**, CEO of the Commission for Case Manager Certification (CCMC). "Case managers are always looking at areas or protections related to how they

practice that impact how they serve clients. They inherently ask, ‘Is this change important? Will it affect the client?’”

As a credentialing body, CCMC works to ensure consumer protection and make sure the client is safe, she adds. The organization considers whether every new regulation or law will benefit the client. They also assess if the change will protect the role of the case manager in ensuring public protection. CCMC partners with Case Management Society of America (CMSA) and National Association of Social Workers (NASW) to support their advocacy efforts.

CCMC also has joined the Professional Certification Coalition, a group that monitors state legislation. That group has advocated for a bill that would allow individuals to use 529 plans (typically used for college education) to pay for certification. The House passed that bill; Kurland is hopeful the Senate will pass it as well.

What Case Managers Can Do

Kurland advises case managers to:

- Stay current and monitor legislation related to healthcare issues, on both the federal and state levels. “Very often, these issues are directly related to what case managers do,” she says.
- Discuss the issue with their professional association’s local chapter. If one person is concerned, his or her colleagues are, too.
- Be active in local chapters of professional organizations like NASW and CMSA that support the case manager community. “A lot of information about what is happening at the state level gets shared at the grassroots level,” says Kurland. “Involvement in these groups will

help keep you current on those state issues.”

CCMC’s executive team attends NASW and CMSA state and regional meetings, as well as regional meetings hosted by American Case Management Society (ACMA). “We also are an ANCC provider for accredited education,” says Kurland. “Nursing is our base, but we are diversifying as a community to include more social workers and other professionals doing case management.”

Advocacy efforts can bring results, as with the Nurse Licensure Compact, an agreement between states that allows nurses to have one license with the ability to practice in other states that are part of the agreement. “This offers nurses many more opportunities for employment, including telehealth,” Kurland says.

She also encourages case managers to look for mentoring opportunities, or to seek a mentor. “Having that relationship can help you stay current and better understand what’s going on in the legal or regulatory landscape,” she says.

Case managers also should share their stories, adds Kurland. “If you see something going on and you are concerned how it will impact you as a case manager or your clients, send a letter to lawmakers. Tell them what’s going on in the front lines.”

Be vocal, whether through social media, through letters, or contacting congressmen or senators. If a case manager sees a connection with another professional association, contact their home office.

“Provide feedback after a law or regulation gets passed,” Kurland adds. “You can still go back to your elected officials — whether it is helping, what can be improved. Your local groups are a good channel to communicate. The intent of the law may not be how it is actually being practiced.”

“Patient advocacy is an important component of the work of an RN or social work case manager,” says **Toni Cesta**, PhD, RN, FAAN, partner and consultant with Case Management Concepts, LLC. “It is included in the guiding principles for case management in the CMSA Standards of Practice. In fact, advocacy is one of the six key functions that case managers perform. These include assessment, planning, implementation, coordination, advocacy, and evaluation.”

Advocacy takes many forms for case management professionals, she explains. “As such, one of our responsibilities is to stay current with issues associated with the CMS Conditions of Participation and other regulatory requirements related to case management.”

The CMS Conditions of Participation for Discharge Planning and Utilization Review apply directly to case management work, and are sometimes changed by CMS, Cesta adds.

Check CMS’s blogs and updates regularly. “In this way, you can learn what is changing or being considered for change,” she says. “CMS generally provides a ‘comment period’ before anything becomes law. That’s another opportunity to voice your concerns.”

Maintain membership in your associations. “When you don’t agree with an actual or proposed change, you can make your voice heard through one of your national organizations,” says Cesta. Both CMSA and ACMA have working committees that focus on political issues of concern, and even attend meetings in Washington, DC.

“By bringing your issue to them, they can work on your behalf to address these issues directly with legislators and others,” she explains.

"This type of lobbying work can be very successful. Changes in legislation related to observation status came directly from this type of work."

Even lay organizations advocate for patients. AARP was actively involved in the issues associated with observation status. "Add your

voice to the mix when you feel that something isn't in the best interests of our patients, and make a difference," says Cesta. ■

How to Initiate Serious Illness Conversations With Patients

By Jeanie Davis

Patients with serious and life-threatening illnesses are faced with choices on the treatments they receive or elect not to receive. The treatment for a patient with advanced cancer is different than the treatment for a patient with advanced heart failure or chronic obstructive lung disease, says **Mary Beth Billie**, DNP, RN-BC, CCM, regional executive director of population health at Loyola University Health System. She speaks from family and professional experience.

However, the essence of a serious illness conversation is the same: What are the patient's goals, values, and preferences? How do those inform their plan of care?

Ideally, these decisions are reached after engaging in a serious illness conversation with clinicians, Billie says. Many clinicians, including case managers, find these conversations difficult, as do patients and families.

"I've been a nurse for many years, and have always felt very strongly that we often miss the patient and family's voice in their care," she explains. "The true definition of patient-centered care is providing care in accordance with the patient's goals, values, and preferences."

As medical technology has prolonged life, clinicians often focus on what they can do, rather than asking the patient what he or she wants to do. "It's very, very

important to have that voice," Billie adds.

In recent years, she has lost a sister to ovarian cancer, and a close family member to heart failure and kidney disease. She also completed her doctorate in nursing practice, creating a Capstone project on serious illness conversations.

What Patients Want

A report by the National Academy of Medicine (NAM), formerly the Institute of Medicine, about death and dying in America identified significant opportunities for improved communication with patients and families about their preferences for end-of-life care, says Billie. The reports suggested that clinician education and training did not provide them with the knowledge, skills, and attitudes to address the physical and emotional needs and concerns that dying patients and their families frequently experience, she explains. (*View the report at: <https://bit.ly/36nsbiK>.*)

When these conversations do not take place, the end-of-life experience often defaults to more care. Often, this is not what the patient and family would have preferred, Billie says. Most importantly, research shows that when these conversations take place earlier, it can decrease patient anxiety, improve their quality of life, reduce

suffering, and result in better coping, higher patient satisfaction, and less nonbeneficial care and costs.

"Nurses and social workers can play a critical role in initiating these conversations to help patients identify their values and preferences for medical care, and prepare patients for further conversations with their physicians," says Billie.

This applies to patients with serious illness with an expected life expectancy of 12-24 months, as with Billie's own sister, who was treated for ovarian cancer for six years.

"In her last two years, as her condition continued to deteriorate, the conversation shifted to what were her goals of care, was she willing to undergo more chemotherapy for more time, and what was the tradeoff in terms of quality of life," says Billie. Typically, this is not a single conversation; decisions evolve over time through thoughtful discussions.

That is a classic example of helping a patient understand their options, Billie explains. "Often, the patients don't understand that they have options, including saying 'I don't want to be in the hospital anymore or continue aggressive treatment.' For patients who select these choices, care coordinators and physicians can align the treatment plan to support their decisions. But without a serious illness conversation, the default is frequently more care. Patients

should have a voice in making these decisions. They should know all their options, especially if they choose to end treatment."

The NAM report shows that the vast majority of patients want to die at home, but often end up dying in a hospital or spending time in an ICU in the last months of their lives, Billie says. "Clearly, there's a disconnect here. We often don't start the discussion until the patient is quite far along that path."

For example, Billie's father completed a Physician Orders for Life-Sustaining Treatment (POLST) form stating he did not want artificial nutrition and other measures. When he was in the dying process, her brother was concerned that lack of feeding and fluids was hastening his death.

"Because we had this in writing, it was comforting to my brother," says Billie. "This can become a very emotional experience. But by having that conversation, and putting those wishes in writing, it documents the patient's wishes. This helps all family members get on the same page."

This same document should be in the patient's chart, she adds. "The document will guide the family and physician with the healthcare choices a patient wants in the last months and days of life."

A Loyola Case Study

Billie created a program for her nurse and social worker staff to learn how to initiate serious illness conversations. The educational program was based on programs developed by the Veterans Administration and Ariadne Labs Serious Illness Care Program, and included a structured communications guide developed specifically for nurses and social workers. Care coordinator nurses and social workers

first underwent a baseline education session, and received communications training. Weekly practice sessions with social workers helped nurses hone their skills and increase their confidence in initiating serious illness conversations.

"Key components of a serious illness conversation include eliciting what the patient understands about their condition, what are their worries if their health were to worsen, what trade-off they are willing to make for more time, and how much does their family and doctor know about their goals and preferences," Billie explains.

Once these questions are answered, patients are in a better position to make informed decisions about how much aggressive treatment they are willing to undergo, and how and where they want to spend the last months of their lives, she says.

Billie offers these tips for initiating serious illness conversations:

- **Engage the patient in these important questions:** What do they understand about their health condition? What do they expect for the future related to their health condition? What would be important to them if they were to become sicker? What are they willing to go through for the possibility of getting more time? As you think about the future with your health, what are you most worried about? How much does your physician and family know about your wishes?

- **Use reflective listening.** "This is what I hear you saying. Am I understanding you correctly? Tell me more about what you mean by that," Billie explains.

- **Show empathy.** Give the patient time to engage in the conversation. These are difficult and often emotional conversations.

"Nurses must learn to set their own beliefs aside," she adds. "We must

facilitate these conversations so we can understand the patient's own belief system. It may not be aligned with our own beliefs, but that's not our call."

Over the 12-week program, the nurses' knowledge and confidence increased significantly, Billie reports. Many patients opted for palliative care, and completed POLST forms documenting their wishes regarding life-sustaining care.

She views this as "a very positive experience," says Billie. "These conversations are not necessarily comfortable, so it takes practice. The communication guide provides structure to help staff as they gain more confidence having these conversations."

Nurses and social workers are perfectly poised to start these discussions, she adds. "The prognosis clearly falls in role of physician, but we're helping the patient understand about their health condition. We're helping them consider what's important to them in quality of life."

With a close family relative, she wishes that conversation would have taken place earlier. But as in many families, death was a taboo topic, seen as giving up. "My relative had very advanced heart disease and kidney disease, and he clearly didn't want to go back and forth to the hospital," Billie says. "He would do anything to stay at home. But that conversation never happened. In his last three months, he was either in the hospital or in a nursing home, and that's where he died."

There are ways to work with patients to improve that experience, she adds. Medicare continues to evaluate programs that can change that experience and support patients in achieving their goals of care. "It is essential because otherwise the default in the U.S. is hospital care, which often is not aligned with patients wishes, and very expensive," she says. ■



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CE QUESTIONS

- 1. The authors of a 2019 study found that ED frequent users were more likely than ED visitors who were not frequent users to experience:**
 - a. diabetes, COPD, and asthma.
 - b. homelessness, HIV infection, hepatitis C.
 - c. substance use disorder, mental health problems, and medical comorbidities.
 - d. medical comorbidities, tuberculosis, transportation challenges.
- 2. When a health system uses a robotic, automatic case management system to assist with utilization reviews, who makes the determination of a patient's inpatient status?**
 - a. The automated case management system
 - b. The utilization review nurse
 - c. The payer's case manager
 - d. The physician
- 3. Which is one of the six key functions of case managers?**
 - a. Communication
 - b. Advocacy
 - c. Writing
 - d. Filing
- 4. Which is an important question to ask a patient when engaging in serious illness conversations?**
 - a. How much longer do you expect to live?
 - b. Have you filled out any paperwork?
 - c. What do you expect from the future related to your condition?
 - d. Have you created a will?

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

The Conditions of Participation for Discharge Planning: Current Rules and 2020 Updates

By Toni Cesta, PhD, RN, FAAN

Introduction

In 2015, the Centers for Medicare & Medicaid Services (CMS) introduced proposed rules for discharge planning. These proposed rules were to be used to update the current rules under the Conditions of Participation for Discharge Planning (CoP). In 2019, CMS provided the elements of the proposed rules that would be adopted in November 2019. While the selected rules may not be as dramatic as the entire set of proposed rules, some of the new rules will require changes in how case management departments perform some components of discharge planning. This month, we will discuss the current rules, the proposed rules, and the final rules published in 2019.

Federal Guidelines for Discharge Planning

CMS describes discharge planning as a process, not an outcome.¹ Because it is a process, case management professionals should always follow the CoP for discharge planning, as well as their department's policies and procedures. In this way, one can ensure one's practice and department are compliant.

The process begins at the point of admission, and continues until the patient is safely in the community. It should be noted that discharge planning also occurs in skilled nursing facilities, acute care, and home care. In other words, discharge planning allows for a smooth move for the patient across the continuum, and at all transition points. As discharge planners, case management professionals are responsible for

ensuring that the patient's discharge is timely, safe, and appropriate.

Current Rules and Regulations for Discharge Planning

SOME OF THE NEW RULES WILL REQUIRE CHANGES IN HOW CASE MANAGEMENT DEPARTMENTS PERFORM SOME COMPONENTS OF DISCHARGE PLANNING.

CMS requires the Health and Human Services Secretary to develop discharge planning guidelines to ensure a timely and smooth transition to the most appropriate post-hospital care. It is important to understand these federal regulations only apply to the following entities. Please note these entities are all acute care:

- Medicare and Medicaid participating hospitals;
- Short-term psychiatric;
- Rehabilitation;
- Long-term, children's, and alcohol/drug facilities.

The process standards go on to say that hospitals must:

- **Identify patients in need of discharge planning early in their hospitalization.** While CMS does not specify when to perform the initial discharge planning evaluation, best practice calls for it to be completed on the day of admission whenever possible.
- **Provide a discharge planning evaluation for those identified patients, or at the request of the patient, representative, or physician.** CMS only requires evaluation of patients who are identified for a discharge plan, or when someone requests one. Best practice tells us that all patients should receive a discharge planning evaluation.

- Complete the evaluation early to ensure appropriate arrangements are in place before discharge to avoid unnecessary delays. This reinforces the best practice of assessing the patient on the day of admission.

- **Include in the evaluation the patient's need for appropriate post-hospital services, and the availability of such services.**

This is the foundation of the case management admission assessment.

- **Include the evaluation in the patient's medical record.** The results must be discussed with the patient or representative.

- **Arrange for the development and initial implementation of a discharge plan.**

- **Develop the plan under the supervision of a registered nurse, social worker, or other qualified personnel.** Typically, registered nurse or social work case managers complete the discharge planning assessment. CMS says other personnel can complete the assessment under the supervision of the nurse or social worker. It is critical to educate these other professionals in the discharge assessment and planning process.

- **Be consistent with Section 1802 (Freedom of Choice) by not specifying or limiting qualified providers. Identify any provider in which the hospital has a financial interest.** This can be achieved by placing an asterisk in front of any

of these providers with a footnote explaining their financial interest.

Exceptions for Medicare Advantage Plans

Understand these two elements of Medicare Advantage plans:

- The discharge planning evaluation is not required to include information on the availability of home health services through individuals and entities that do not have a contract with the organization.
- The plan may specify or limit the provider (or providers) of post-hospital home health services or other post-hospital services under the plan. This means that a Medicare Advantage patient's choice list should be limited to those providers that are contracted with the patient's managed care plan.

The Conditions of Participation

The current federal standards for hospitals participating in the Medicare and Medicaid programs are presented in the Code of Federal Regulations (CFR) as 13 Conditions of Participation (CoPs). The original CoPs were written in 1983, and were developed to ensure quality standards in hospitals and other provider settings. They became the foundation for improving quality and protecting the health and

safety of Medicare and Medicaid beneficiaries. Today, the CoPs are managed under the Department of Health and Human Services. While all the CoPs are important, the two that apply most closely to case management include Section 482.30 (Utilization Review) and 482.43 (Discharge Planning). Each of these represents core roles that case management professionals perform, and will be our focus this month. To find information on the entire Conditions of Participation, visit: <https://bit.ly/2N4xn3V>.

The 13 Conditions of Participation include these categories:

- Quality assessment and performance improvement program;
- Medical staff;
- Nursing services;
- Medical record services;
- Pharmaceutical services;
- Radiologic services;
- Laboratory services;
- Food and dietetic services;
- Utilization review;
- Physical environment;
- Infection control;
- Discharge planning;
- Organ, tissue, and eye procurement.

CMS CoP for Discharge Planning

The following requirements outline the rules as they relate to discharge planning:

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- The hospital must establish a discharge planning process for all patients. The hospital's policies and procedures must be specified in writing.

- Patients who require discharge planning evaluation must be identified early in the hospital stay. Evaluations also should be provided to other patients at the request of the patient, the person acting on the patient's behalf, or the physician.

- The evaluation should determine the likelihood of the patient needing post-hospital services, and availability of the services.

- Case managers must determine the patient's capacity for self-care, or the likelihood of needing home care services.

- Include evaluation in the medical record, and discuss the results with the patient or his or her representative.

The Discharge Plan

- A patient's physician can request a discharge plan. The hospital must develop discharge plan for patient.

- The discharge planner must arrange for plan implementation.

- Reassess discharge plan if care needs change.

- The patient and family members or interested persons must be counseled to prepare them for post-hospital care.

- The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

- The hospital must continually reassess its discharge planning process. This should include a review of discharge plans to ensure they are appropriate for patient needs.

Conditions of Participation for Patient Choice

- In the discharge plan, include a list of HHAs or SNFs available to the patient that participate in Medicare, and serve the geographic area in which patient resides. SNFs must

be given for patients transferring to home health or to a SNF. While you can provide choices for other discharge destinations, you have no regulatory requirement to do so.

CMS Conditions of Participation Final Discharge Planning Rules: 2020

The new rules for discharge planning went into effect on Nov. 29, 2019, which represents federal fiscal year 2020. New CoP rules apply to hospitals and home health agencies. Facilities that must adhere to the new rules include:

- Acute care hospitals;
- Long-term care hospitals;
- Inpatient rehab facilities;
- Inpatient psychiatric facilities;
- Children's hospitals;
- Cancer hospitals;
- Critical access hospitals.

CMS estimates that hospitals and home health agencies will spend \$215 million per year to comply with the discharge planning changes, and will incur an additional \$46.5 million in one-time costs. CMS is hoping the new rules will allow patients to make healthcare decisions that are right for them, and gives them transparency into what can be a confusing process.

CMS ESTIMATES THAT HOSPITALS AND HOME HEALTH AGENCIES WILL SPEND \$215 MILLION PER YEAR TO COMPLY WITH THE DISCHARGE PLANNING CHANGES, AND WILL INCUR AN ADDITIONAL \$46.5 MILLION IN ONE-TIME COSTS.

serve the geographic area requested by patient; HHAs must request to be listed by the hospital.

- The list should only be present to patients for whom home healthcare or post-hospital extended care services are indicated and appropriate.

- For patients enrolled in managed care organizations, the hospital must indicate availability of home health and post-hospital extended care services through individuals and entities that have contracted with the managed care organizations.

- Document that the list was given to the patient and/or the patient's representative.

At this time, choice lists need only

The New Rules for Discharge Planning

- Focus on patients' goals of care and treatment preferences. Providers are required to consider the patient's health objectives and care preferences during the discharge planning process to ensure that patients receive the desired care.

- Assist patients, families, or representatives in selecting post-acute care service providers or suppliers by sharing data on quality and resource use measures that are relevant to patients' goals of care and treatment preferences.

- Hospitals and home health agencies are required to transfer and refer patients along with necessary medical information — including course of illness and treatment — to post-acute services, providers, facilities, agencies, and other patient service providers and practitioners responsible for patient's follow-up care to ensure a safe transition.

- Provide additional clinical information for patients if requested by receiving facilities.

- Ensure patients can access their medical records when requested.

- Use quality and resource measures relevant to patients' goals of care and treatment preferences in the discharge planning process. This is aimed to increase the use of quality data as a decision-maker in selecting post-acute providers.

Implementing the New Rules

The first thing to consider is focusing on including the patient's goals and preferences in the planning process. This means a case manager

must consider alternatives when the patient's goals diverge from the initial discharge plan. This can be difficult as issues such as availability and insurance coverage will have to be considered.

CMS REQUIRES THAT A STANDARD DATA SET OF THE PATIENT'S MEDICAL INFORMATION IS SENT TO THE POST-ACUTE PROVIDER AT THE TIME OF TRANSFER. THE CHANGE HERE IS THAT IT MUST BE IN EITHER ELECTRONIC OR WRITTEN FORMAT.

Next, discharge planners must share data from post-acute care providers with patients. These include quality data such as star ratings and outcomes data, where appropriate.

The third issue is the need to include the caregiver or support person along with the patient to develop the discharge plan. This means the case manager must discuss the plan and preferences with the patient's family or other supports along with the patient, when appropriate, and ensure they agree with the plan. This applies to anyone who will be caring for the patient after discharge.

Finally, CMS requires sending a standard data set of the patient's medical information to the post-acute provider at the time of transfer. The change here is that it must be in either electronic or written format.

Summary

As case managers implement new rules, be sure to include parameters for correct documentation. This should include the original and the new rules. Without documentation of these tasks in the medical record, case managers will not receive credit for completing them. This can result in a negative audit outcome, so be diligent in understanding as well as implementing the rules. ■

REFERENCE

1. Centers for Medicare & Medicaid Services. Glossary: Discharge Planning. Available at: <https://go.cms.gov/35u2WdR>.

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