HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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COVID-19 Increases Need for Case Managers

By Jeanie Davis

COVID-19 has spurred myriad changes in hospitals as providers scrambled to adapt to the new normal. That includes new and creative ways to connect and support patients, says **Bonnie Geld**, MSW, president and chief executive officer of the Center for Case Management.

Virtual patient care and digital outreach, now more readily available to patients, are among the new models that quickly emerged, says Geld. She also sees renewed emphasis on case managers, social workers, and utilization review in patient care — in coordinating care, supporting patients in the management of chronic illness and post-hospital care, and advocacy and interventions in social determinants of health.

Geld indicates these essential roles can be handled remotely. "We learned a lot during COVID-19 about the critical importance of case management," Geld explains. "We learned how flexible the role has to be to meet the needs of our patients. But at a time when only the provider can be in the hospital room in some hospitals, the case manager has not been at the bedside."

> "WE LEARNED A LOT DURING COVID-19 ABOUT THE CRITICAL IMPORTANCE OF CASE MANAGEMENT."

Many case managers have been working remotely, especially those in outpatient and ambulatory care centers, Geld adds. "Case managers in hospitals have had limited time at bedside with the patient, and only phone calls with family members. Utilization review has also been handled remotely."

Yet those roles have been performed effectively, she adds. Teamwork was essential in this paradigm shift. "The

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need for collaboration has been at an all-time high."

Adapting the Case Manager's Skill Set

Case managers have become savvy using software to connect hospital care with post-acute care, Geld points out.

"There have been a lot of challenges in discharge planning to post-acute care due to semiprivate rooms and concern about disease transmission," she explains. "With the high volume in these facilities, it's been especially challenging."

Working out the logistics, "case managers have used their ability to collaborate and predict which patients may need post-acute care so they can make plans very early for transition," Geld says.

Social workers also have proven effective in assisting patients with emotional and mental health issues. "We learned that patient isolation has significant emotional consequences for the patient's recovery and the family's coping," Geld explains. "The impact of a social worker shines in helping with emotional and mental health aspects of COVID, whether it's the patient or the family. Social workers were very effective in helping with patients' and families' anxieties."

Moving Forward with Medicaid

As patient volumes return to hospitals, they are challenged again with capacity, says Geld. "Now that hospitals have started doing elective surgeries, they will need a strong entry point case management resource. If hospitals haven't planned their emergency room case management, they will be overwhelmed with COVID-19 cases, flu, and kids' respiratory syncytial virus infections in the fall."

As hospitals prepare for the return of preauthorizations and three-day requirements, she notes "it all is going to come back. It's going to be interesting to see how many patients may not have met certain conditions for authorization pre-COVID. We're going to have to support these efforts. All these things make the case manager's mission critical."

Geld sees great need for case managers in helping uninsured patients find the help they need. "For those uninsured and on Medicaid, they're going to have a huge impact — especially on children's hospitals," she says.

A large percentage of pediatric hospital patients are on Medicaid, and that likely will increase. With people out of work, getting their kids on Medicaid will be essential, Geld says. "The need for case managers will be essential in helping them. It takes a lot of advocacy with Medicaid or MediCal [California's Medicaid program] to get access to resources they need. The time and attention of both the social worker and case manager are very important."

Hospital emergency departments will see more adult Medicaid patients, and patients with no insurance at all, especially if COVID-19 is considered a pre-existing condition, says Geld.

"It's hard to know how insurance companies will handle it," she says. "This demonstrates a need for stronger utilization review to get on top of payer requirements, and for case managers and social workers to advocate for resources."

This role as advocate helps children and adults move through

the system in a timely manner, which will help control volume and length of stay in the hospital, Geld adds. "Some Medicaid patients come in sicker because they've avoided the medical system. We need to see what we can do collectively for these patients at our doorstep."

Social determinants of health are integral to this scenario, she adds. "COVID-19 has resulted in long food lines, and food insecurity is a major social determinant of health. People don't have appropriate nutrition, and that is critical for people with chronic illness — yet it's more expensive than snack food. We're seeing long lines at food banks and more on SNAP [Supplemental Nutrition Assistance Program]."

Education and teaching tools are important, Geld says. "Health literacy is critical. We come across patients who don't understand the impact of COVID-19, and some who remain skeptical about taking precautions. It takes a lot more education with these patients, as well as point-of-contact tracing."

Also, when working with a recovering COVID-19 patient, case managers should help them understand what their recovery will involve, whether their family was exposed or is at high risk, and help them understand safety issues, she adds.

"The case manager can connect all the dots; they've always been responsible for care coordination," says Geld. "We have to make sure all providers and the patient are on the same page. The fact that we have remote and bedside providers, remote families — communication is essential."

The Center for Case Management is designing remote case management partnerships involving telehealth. "That will be very significant in the future," Geld says. "Some patients are good with the phone; others like to see their electronic medical record online. We have to really understand how the patient and family access information best so we can best communicate with them."

Mentoring Future Case Managers

It is time to nurture and encourage young case managers early in their career paths, says **Audrey Sefakis**, BSN, RN, CCM, case manager with Tuft Health Plan. "My daughter graduated from nursing school this year, and case management was small blurb in one chapter," she says.

Sefakis believes nurses should learn about case management earlier in their training. "It's a career opportunity they should consider, in addition to getting their clinical background. With so many nurses retiring, we need new case managers coming into the field," she explains.

She advises academic nursing and social work programs to add case management as a topic in their care coordination and/or healthcare financing curricula. Sefakis also encourages professional organizations to create opportunities for proactive outreach. Conferences, educational institutions, and employer settings are perfect venues to connect with prospects. Sending enthusiastic speakers to schools, universities, and career fairs is possible with little planning.

Summer internships and mentoring should be possible in clinical settings, Sefakis adds. Shadowing a case manager, completing department research, participating in projects, conducting time studies, and performing administrative duties all present good assignments for an intern.

"Offering these experiences also allows organizations to network and recruit new talent," she says. "An internship presents the opportunity to establish a one-on-one relationship between an experienced case manager and someone considering such a career path. The intern-preceptor relationship is extremely important, and warrants careful planning and execution to ensure success." ■

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Practice the Five Disciplines in Case Management

By Jeanie Davis

Hospital case managers, just as case managers in all work settings, have faced unbelievable challenges this year. Many were pushed back into clinical nursing practice because they were needed as frontline workers.

Hospitals are slowly transitioning back to more of a "normal" environment. With the new year approaching, it is a good time to revisit the Five Disciplines that help case management teams refocus on the business side of client care, says **Teresa M. Treiger**, RN-BC, MA, CCM, FABQAURP, current commissioner for the Commission for Case Manager Certification and past national president of the Case Management Society of America (CMSA).

"In the pre-COVID-19 environment, case managers ensured each client got the right care, at the right time, in the right place," Treiger says. "We can all benefit from a recharge for the new year."

InterQual and Milliman are two healthcare technology platforms that align payers and providers with actionable, evidence-based clinical intelligence, all to support appropriate care and foster optimal resource use, she explains. "If client care does not meet both the guidelines, there are consequences of payment denial."

It is essential case managers work smarter, both as individuals and on a team. Treiger refers to "The Five Disciplines" described by Peter Senge, a systems scientist, as one way to optimize efforts as professional case managers and as case management team members.

To maintain a high-functioning team, all members must provide consistent, high-quality case management support, Treiger says. It is in that environment the five disciplines of success can be applied:

- shared vision;
- mental models;
- team learning;
- personal mastery;
- systems thinking.

Shared Vision

A shared vision is the result of a common spirit, Treiger says. "The hospital's mission statement is intended to inspire that vision, but often it doesn't always connect with day-to-day work life in a client unit. In some hospitals, there may never be an effort to help case managers connect with the mission or vision."

More importantly, Treiger espouses the personal mission statement that comes from thinking deeply about one's work and employer's mission and vision statements. "If you really take case management to heart, and seriously consider it your professional life's work, you have to find a construct to make your employer's mission statement meaningful to you," says Treiger.

She also advises looking to professional organizations like CMSA for support. "They will share your values," she explains. "You might not have an employer who supports your professional perspective, but you can find it in professional and credentialing organizations that seek to advance case manager skills and knowledge. You will learn about standards of practice, codes of conduct, and adopt those as your own personal work ethos. Take the time to make those connections yourself."

Mental Models

"Mental models are the bumper pads in our minds," says Treiger. "They frame the way we think and act upon that thinking."

These may be negative stereotypes or biases of any type. For example, in the 1980s, "more than one of my co-workers refused to care for an AIDS client," she says. More recently, Treiger witnessed a case manager who neglected to work with an individual with a substance use disorder on post-hospital care coordination. "The person was recovering from a systemic infection, and spent six weeks in the hospital," she says. "During that time, no attempt was made to develop a discharge plan. He simply walked out of the facility."

How will you react? "If someone comes from a different culture, ask yourself if you can put aside your mental constructs, and provide the care the person needs on their terms," Treiger suggests. "It's a problem if you cannot."

Mental constructs "were not meant to be rigid, steel-enforced beams," she explains. "They were meant to be flexible, expandable so you can apply empathy in all situations. Professional case managers should embody impartiality and keep our personal mental models in check, because we have a code of ethics."

Empathy is the key to adapting in these situations, she says. "Maybe I don't understand what this client is going through. I can't always be sympathetic, but this is a human being and I can be empathetic

because the person is under stress and needs support. I can certainly broaden my perspective and do my best for them. Mental models help guide how I act and react in different situations."

That is especially important today, when the country is so divided, says Treiger. "People should strive to understand each other. It's the saying, walk a mile in someone's shoes. That may be a cliché, but it rings true."

Team Learning

Team learning is about aligning individual efforts toward achieving a greater purpose. What pulls your team together? Do you recognize each other's strengths and weaknesses, and focus on working in harmony?

If your day is fairly light but your colleague is slammed with admissions, what would you do? Would you head home on time or offer to help your colleague?

Care coordination is a team effort and should be embraced beyond an "assignment" perspective, says Treiger. "Some may say the physician is the care team leader, but the case manager is also a team leader where care coordination is concerned. You can set an example by helping your team members. After all, any failure reflects on all team members."

The team's culture is how people on the team behave toward each other, she explains. "One person might not be able to make a huge difference. This where really good case management leadership comes in. If you have bad leadership, it's going to be a tough work environment. But if you can find colleagues who hold similar values, you have the beginnings of a great team."

If one team member is bent on being disagreeable, "take the high road," says Treiger. "Or maybe there's one co-worker who always seems positive and does a really good job with clients. That's the person you want to get with."

She adds: "Maybe others will see you and that other person doing great things. It is the start of your own 'revolution,' so to speak. In my career, there was always at least one naysayer or Debbie Downer. I could not change that person, and that's fine. But I did not let it determine who I was or how I worked."

When coaching other case managers, Treiger often finds this problem: "Don't let them dictate your frame of mind. Get your head out of the sand, start noticing. Change your frame of reference. If things are not working out no matter what you have tried, then it may be time to move on. Teams learn together."

Personal Mastery

Ongoing and disciplined personal growth and learning are imperative, says Treiger. "Beyond the pursuit of knowledge, skills, and competencies, personal mastery transcends through all layers of life. Inquiry is a companion of personal mastery."[1]

Professional organizations have helped many case managers gain personal mastery, she explains. "Look for those points under your control. Where can you improve your knowledge of case management? Your ability to make assessments? Your interview skills? Computer skills?"

These are necessary skills to perform well in case management, she says. "Personal mastery is knowing where you need to improve, then pursue improving it. Make a conscious effort every day to work toward that goal."

With today's technology, continued learning has become easier, she adds. "Online courses abound. Even if a course is not a perfect match for your needs, you'll gain from the expanded perspective."

She also advocates personal activities that stretch your experience: "Do something you've wanted, like kayaking that local river; just do it. Seize opportunities to improve your all-around self."

Treiger adds: "If the pandemic has taught us anything, it should be 'don't wait.' Do things while you can. Make yourself a more well-rounded person. Reflect on your life, what you're doing, what your goals are, what makes you happy. At the end of your life, will you have achieved your goals?"

Systems Thinking

In case management, systems thinking is imperative, says Treiger. "We should be looking at the big picture in our day-to-day lives and thinking about the whole of each client, each work setting, and each colleague."

What is systems thinking? The weather provides a good analogy: "How many variables create rain showers in a particular place and time? Case management is much the same. Our clients arrive and with them come untold variables ,which resulted in the circumstance that requires our intervention."[1]

When a case manager intervenes, they add even more variation to the equation, Treiger says.

"Consider the factors that affect how we perform our responsibilities every day," she explains. "A new case manager may have had a

really bad commute to work, or another is just one week away from retirement after 25 years." However, while the circumstances in their lives are different, that should not affect how they perform their case management responsibilities, she says. "Instead, these circumstances should challenge us all to push for greater professionalism, for a mental model and personal mastery that brings our best talents to our work setting."

Treiger adds: "The more we practice this, the better we get at seeing the big picture and thinking about the whole of each client, each work setting, each colleague, and the kind of team which we aspire to create." ■

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CHECK Program Addresses Chronic Illnesses with a Holistic Approach

By Melinda Young

A program created to help children and young people, from birth to age 25 years, with chronic illnesses has evolved into a way to prevent emergency department (ED) visits and rehospitalizations for any population, including at-risk, older adults.

The CHECK program was designed to address social determinants of health, including cost, school attendance, and patient engagement, among a Medicaid population in Cook County, IL, says **Michael Gerges**, LCPC, executive director of the CHECK program at the University of Illinois at Chicago and UI Health.

CHECK, initially called the Coordinated Healthcare for Complex Kids, began as a four-year grant to help Medicaid families with children with one of four conditions/criteria: asthma, sickle cell anemia, diabetes, or premature birth. *(See story about CHECK and prevention focus in this issue.)*

"Originally, it was a three-year grant, but we got an extension to run it for four years," Gerges says.

It is a relatively low-cost care management model, composed of community health workers supervised by licensed providers. The ration is one community health worker per 200 patients and one licensed provider per 1,000 patients. They are supported by care management software, texting outreach programs, a community-based medical neighborhood of organizations, online health education, and a robust early intervention model for mental disorders, says **Benjamin W. Van Voorhees**, MD, MPH, head of the department of pediatrics at the University of Illinois Chicago and CHECK project director. The goal was to reduce ED visits and medical costs.

Investigators found the program's healthcare usage and costs declined over the first year, but the control group's healthcare utilization and costs also fell in the same period. "However, during the same time CHECK was implemented, Illinois transitioned its Medicaid program to managed Medicaid private sector companies," Van Voorhees says. "These companies also implemented cost control models at the same time. Consequently, even though healthcare utilization and costs fell in the CHECK intervention group, they also fell to a comparable extent in the control group."

Researchers are analyzing data from the second and third years of CHECK implementation. This information might help clarify group differences, if they exist, he adds.

"Generally, we saw a reduction in hospital days, so patients who were going to the hospital were not staying as long as they had before," Gerges says. "We saw some reduction in ED costs and an overall reduction in

EXECUTIVE SUMMARY

The CHECK program teams community health workers with licensed behavioral health staff to address patients' social determinants of health and improve health outcomes.

- The program uses resources efficiently, with one licensed professional per 1,000 patients.
- Community health workers represented the neighborhoods they served.
- The CHECK team helped patients with transportation, home environmental issues, and other obstacles to health management.

patient costs. We saw some reduction in school absenteeism, where patients were better able to remain in school."

For example, CHECK community health workers created care plans for families, including ways to help them establish 504 plans or individualized education programs. They also linked parents, schools, and medical teams to improve communication.[1]

CHECK also facilitated asthma support to children at Chicago Public Schools using in-service training and support of school nurses. From 2016-17, the CHECK asthma medical director gave an introductory course to all the school nurses in the district. The program formed a work group of school nursing coordinators and CHECK physician leadership to meet monthly to determine ways to improve asthma management in schools.[2]

The CHECK program was implemented concurrently with the value-based, population health benefits of the Affordable Care Act, Gerges notes.

"The readmission numbers went down across the board, and that made it tricky to know whether our numbers were going down because of what we were doing, or whether they would be going down if we hadn't done anything," he adds.

Increased Efficiency, Lower Costs

CHECK used a tiered screening model focused on mental health and social determinants of health — a somewhat unique aspect of the project, Van Voorhees says. The project was efficient, using nonlicensed community health workers to assist with care plans that were reviewed, approved, and monitored by licensed supervisors. "In this manner, one licensed professional can supervise 1,000 patients rather than 100 or less," Van Voorhees says.

"We had a team of 30 community health workers," Gerges adds.

CHECK also created a behavioral health team of licensed professionals who could perform a biopsychosocial assessment of patients. "We addressed the needs of patients and their family members together," Gerges says.

Referrals of study participants, including those in the control group, came through the Centers for Medicare & Medicaid Services and insurance plans.

"Perhaps the most important aspect was the use of middle-skill workers like community health workers — combined with technology and automation — to create a potentially lower cost and, thus, a more feasible method to implement the chronic care model," Gerges explains. "Future studies may further examine the potential cost-effectiveness of the CHECK model."

The community health workers were hired to represent the neighborhoods they would be serving. "We had some folks who had more like nursing home experience, but not hospital or clinic-based experience," Gerges says. "This proved to be really helpful."

For example, the CHECK team met weekly for clinical rounds to discuss challenging cases. One community health worker had visited a patient's home and found the family did not have adequate bedding, Gerges recalls. The worker wanted to help the family find an affordable mattress. Another person on the team, who lived in the area, mentioned a nearby store that did not advertise online, but offered mattresses at affordable prices.

"It was amazing to watch when someone actually knows the neighborhood and knows how to find resources that the rest of us wouldn't know was there," Gerges notes.

Community health workers also provided coaching to families to encourage adaptive behavior in managing the patient's disease. For instance, they worked with sickle cell disease patients to help them overcome barriers, such as provider access issues, patient frustration, disorganized medications, inadequate hydration or nutrition, family stress, and household chaos.[3]

Behavioral health staff address the needs of patients who have not been diagnosed with a behavioral or mental health condition, but might be experiencing anxiety or some other issue. "They could use quick skills with patients and families. Our hope was it would prevent them from having a situation that worsens," Gerges says.

Alternative Approach for Chronic Care

CHECK should be considered an alternative and lower-cost approach to delivering a chronic care model for children and young adults, Van Voorhees notes.

"While the development of databases, care management software, texting outreach, and online health education technology was complex and proved difficult to operate in tandem, it did enable the reasonably efficient delivery of more than 120,000 services to more than 6,000 patients," he says. "Further studies are being proposed to examine the health impacts of different components of the CHECK model."

Once the grant ended, the CHECK program evolved to

work with at-risk adults. Initially, an insurance company agreed to continue the program for its clients. Later, it evolved into a program for a specific health plan's Medicare population, Gerges says.

"We're looking out for new opportunities to utilize this model to provide services," he adds. "We really want care coordination in the system to be a flow-through process. As time goes on and more research is done, we hope we can demonstrate long-term outcomes." ■

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CHECK Program Works to Solve Problems Brewing Beneath Surface

By Melinda Young

The CHECK program prevents rehospitalizations by employing a team of community health workers and licensed behavioral health professionals to help people with chronic diseases deal with the social determinants of health that hinder their disease management.

"Some people have high levels of social disarray, like housing, social, transportation issues, as well as behavioral health needs," says **Michael Gerges**, LCPC, executive director of the CHECK program at the University of Illinois at Chicago and UI Health.

"What we do with CHECK is say, 'Why does one person have to address all of these things?'" he says. "Community health workers can have expertise in addressing social determinants, and behavioral health workers can address behavioral health needs, and patients get support from all the experts, working in a coordinated way."

Address, Treat the Whole Person

The goal of the CHECK team is to address all the obstacles and issues that surround a patient.

"If we start looking at individuals and say, 'As a whole person, you have all these needs,' and then we split them up to have different people address them, then we can move people through the healthcare process in a better way," Gerges says.

The needs the team addresses can be problems that have not yet resulted in a diagnosis, including mild depression or anxiety. For instance, a patient might have some health issues that are not yet a medical or behavioral health diagnosis. In traditional, fee-for-service health care, these patients and those types of issues are not addressed until the problems are exacerbated and reach a crisis level.

"We wait for people to get bad enough to diagnose them, and then we wrap services around them," Gerges says. "If we focus our efforts on those who haven't crossed that line yet, then there's a chance we can prevent [the crisis]."

Gerges uses the analogy of water with ice on the surface. Patients with diagnosable conditions are those who have reached the ice level and can be seen and treated. But right below that sheet of ice are a bunch of patients who will reach that top crisis level soon, but are not yet there.

"We provide direct interventions to the folks below that line," Gerges

EXECUTIVE SUMMARY

The goal of the CHECK team is to address patients' obstacles and issues that affect their health.

- These include problems that have not yet yielded a diagnosis, such as mild depression or anxiety.
- The team used grant funds to provide rideshare transportation to take patients to medical appointments.
- Also, the team helped people access legal resources to address their housing challenges.

says. "These can range to up to six skills-building sessions with a licensed clinician."

The goal of the CHECK team is to focus on the patient's existing resources and put the patient on a different, healthier path.

When CHECK, through a grant, focused on young people from birth to age 25, the team saw considerable depression among parents of the children, who had chronic conditions, and were enrolled in the program.

The parents' behavioral health issues could affect the children and entire family. The team helped them through addressing their social determinants of health, including transportation to behavioral health and medical appointments, Gerges says.

"Medicaid had a specific transportation service available to patients, but it was very challenging to use," he explains. "You would call for a referral and they would give you a company to call, and we'd set up the medical and behavioral health appointment."

Then, the patient would wait an hour or longer for the ride. By the time the driver arrived, it would be too late to make the appointment.

"We found ways around that," Gerges says. "Because we had a grant, we would use a rideshare service to pick up the patient and take them to the appointment, and that made for better engagement."

The CHECK team also worked with medical-legal advocates to help families with applying for educational services that would accommodate the patient's medical and behavioral health conditions.

"We helped families recognize what legal resources were available to them to address challenges in their housing," Gerges says. "We found that a lot of our behavioral health interventions were going to the parents."

The goal was for the team to use its knowledge of the patient's health issues to help them approve their surroundings and to intervene as a way to prevent worse health problems, he adds.

"We would send out reminders of a national crisis hotline for anyone needing support," Gerges says. "We'd offer people information or links to websites and resources." ■

Nurse Navigator Role Helps Reduce 30-Day Readmissions

By Melinda Young

By using nurse navigators, a hospital cut in half its 30-day readmission rate for heart failure patients.[1]

"Readmissions for heart failure patients were an issue at our local community hospital, and actually nationwide," says **Karen Weeks**, DNP, RN, CCRN-K, instructor at James Madison University in Harrisonburg, VA. Weeks worked as a heart failure nurse navigator for the pilot study.

Follow-up care can make a big difference in transitioning patients to their homes and keeping them healthy and out of the hospital. For a pilot study, nurse navigators targeted both heart failure and sepsis patients, she adds. Investigators found when the program started in January 2019, the readmission rate was 24.05%. In February 2019, the readmission rate dropped to 20%. In March, it was 19.75%, and in April, the readmission rate had dropped to 11.11%.[1]

"It cut the readmission rate in more than half," Weeks says. "I presented the findings to a senior leadership resource team, showing them the results of having a navigator and what costs were avoided. In October 2019, they created two full-time navigator roles. The cost avoided from readmissions [and Centers for Medicare & Medicaid Services penalties] paid for both nurse navigator salaries, and that's how we justified it to the facility."

Initially, nurse navigators targeted both heart failure patients and sepsis patients, but the person hired for the sepsis portion left the job. Then, the COVID-19 pandemic hit, and the sepsis navigator has not been replaced, Weeks says.

One reason the nurse navigator helps reduce readmission rates is because follow-up is important to keeping newly discharged patients healthy. "Follow-up is key, particularly in this area, which is more rural and providers are not available on the weekend," Weeks says. "When I called on Fridays, especially in the morning, patients were gaining weight and were more short of breath. Getting them to call their physician about their weight gain and having them get into a physician office before the weekend, so they would not have to go to the emergency department (ED), was their only resource."

The nurse navigator helps patients get into the doctor's office before the weekend and makes sure patients receive an extra diuretic or whatever else they need to reduce their symptoms before the weekend. "Once they have a weight gain and are symptomatic, they were encouraged to call their provider before noon, and the provider could then see the patient before the weekend," Weeks adds.

Navigators help fill the gap between when patients might be discharged with a home health order and the 72 hours or so when home health can visit the patient.

"There's always this window when a patient is discharged that they start to gain weight or go back to old habits of salt intake and drinking a lot of fluids, and they come back to the hospital in heart failure and are readmitted," Weeks explains. "We're trying to catch them earlier to see and minimize their coming back to the ED."

The navigator program included patients filling out a discharge ticket in which they noted who would be taking them home and how they would cook, clean, wash laundry, and whether they had necessary tools like a walker and shower chair, she says. Patients also explain how they will travel to their provider appointments, and show they know how to take their medication correctly.

"Heart failure patients often get confused on what medication they should take, so the discharge navigator goes into detail with them over multiple visits to help them understand what to take," Weeks says. "The navigator collaborates with pharmacy to make sure patients can afford their medications."

The navigator ensures patients have functional scales at home. Nurse navigators do not order medication, so this role does not have to be filled by nurse practitioners, she notes.

"The heart failure navigator is a nurse with solid expertise in cardiac care, and she does what I did for this research project," Weeks says. "The sepsis navigator talks with patients about ways to prevent urinary tract infections, getting their flu shots, good handwashing, and those kinds of things."

The sepsis navigator played an important role in connecting patients with community resources at or after discharge. For example, one sepsis patient had pneumonia and was a veteran. He told the navigator he could not afford the antibiotic prescribed for him to take at home post-discharge. He was going to wait to fill the prescription at a veterans hospital that was in another state — 90 minutes from his home, Weeks recalls.

"The navigator had to call the pharmacy and make sure he had medication before he left," she says. "Then, the navigator followed up to make sure he was doing OK and would get his pneumococcal vaccine, flu vaccine, and was taking his antibiotics and probiotics." The navigator collaborated with the pharmacy to find the man appropriate, equivalent, and affordable medication.

Patients with serious illnesses like sepsis and heart failure often are overwhelmed with their illness and need additional support and education.

"Navigators make sure they understand their medication," Weeks says. "It mimics the breast cancer navigator for breast cancer patients, but it's for heart failure and sepsis patients."

Nurse navigators also spend more time with patients in education than do hospital case managers, she says. "It's about coming into the patient's room and diving down deep into what the patient requires. A lot of times, I would sit with patients for an average of 60 minutes."

Spending that much time with patients builds trust and allows the navigator to learn things the patient would not share with hospital nurses and case managers.

For instance, when a navigator talked with a patient about her primary care provider visit after discharge, she learned the patient did not like her doctor. "I said, 'Why don't you find somebody else? Where do you live?'" Weeks says. "We connected her with another provider, when before her only option was to come to the hospital because she didn't realize she could find another doctor."

In another case, a nurse navigator learned a heart failure patient lived by himself and had limited access

EXECUTIVE SUMMARY

A program that used nurse navigators with heart failure patients cut its 30-day readmission rate in half and provided more thorough follow-up care in transitioning patients home.

- The program also was used for sepsis patients, with the sepsis navigator connecting patients with community resources after discharge.
- One basic idea was to help patients meet with their primary care providers before the following weekend after they were discharged from the hospital.
- Nurse navigators worked with pharmacies to ensure patients received their medications after discharge.

to healthy foods. He ate mostly processed and microwave meals.

"We found a heart-healthy market on the internet with low-sodium options that all he had to do was heat up in the microwave," Weeks says. "He was internet-savvy, and he ordered them online at the equivalent of Walmart prices, but the sodium was low."

Helping patients solve these types of obstacles requires a thorough research and attention to detail, she adds. ■

IHI Issues Action Plan on Patient Safety

The Institute for Healthcare Improvement's (IHI) National Steering Committee for Patient Safety (NSC) recently released its national action plan, aimed at helping healthcare organizations reduce preventable medical harm.[1]

Safer Together: A National Action Plan to Advance Patient Safety includes evidence-based practices, case studies, and recommended interventions. The report was the result of work by federal agencies, safety organizations and experts, and patient and family advocates. It includes four areas: culture, leadership and governance, workforce safety, and learning systems. There are implementation tactics, case examples, tools, and resources. This action plan is intended to return focus to patient safety and medical errors, says **Patrick Horine**, MHA, who served on the IHI NSC that wrote this report. The Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System*, brought attention to patient safety.[2]

Patient safety is more of a constant focus that it was before the IOM report, Horine says, but it has plateaued as a priority for healthcare organizations.

"We've done more on the preventable issues, but eradicating patient harm has not happened. Keeping this to the forefront of the mindset of leadership was a key issue for us," says Horine, chief executive officer at DNV GL Healthcare in Milford, OH, which offers hospital accreditation. "We brought together so many different parties because we wanted to look at this from all perspectives, which includes patient safety and healthcare worker safety."

The protection of healthcare workers was a key component of the plan, even though most of it was developed before the COVID-19 pandemic.

"This is something that DNV GL is going to be asking hospitals about more in the future. It goes well beyond patient/staff ratios. This is really about the psychological and physical impacts, what it is doing to contribute to patient outcomes as well as the well-being of staff," Horine says. "I never would have foreseen the psychological impact that COVID has had on healthcare workers. Patients are dying, and [clinicians are] doing everything they can for them, to no avail. That has a real impact."

The IHI report also focuses on the involvement of the hospital or health system board. "What level of involvement do we have at the board level? They might get summaries and highlights at the board level, but how aware are they of safety and quality issues? What do they need to be committing more resources to?" Horine asks. "That level of understanding and participation from the board level is a primary concern." ■

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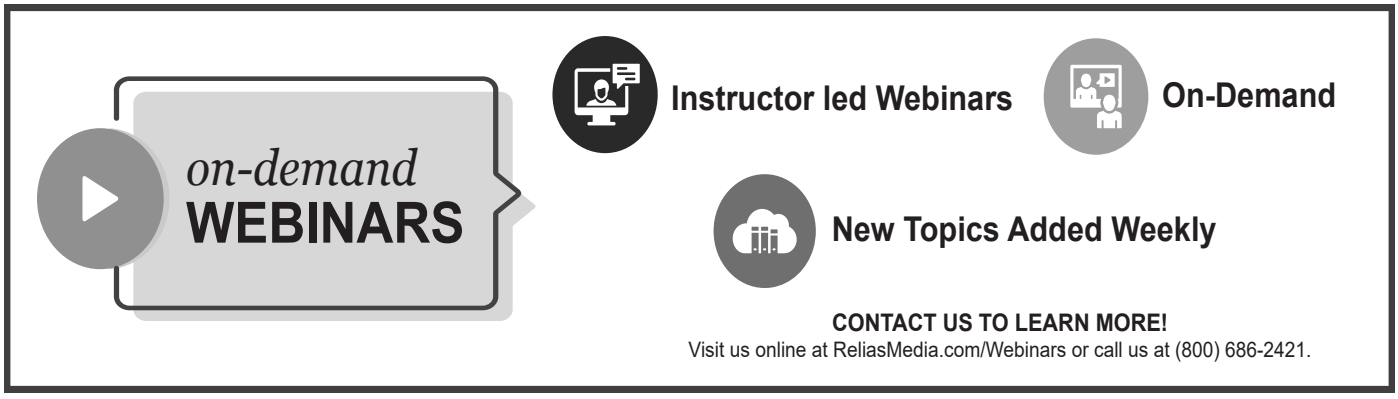

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CE QUESTIONS

1. **When should new nurses receive case management education, according to Audrey Sefakis, BSN, RN, CCM?**

   a. During their first nursing job
   b. Five years into their careers
   c. Early in nursing training
   d. Ten years into their careers

2. **Which is one of the Five Disciplines in case management?**

   a. Personal mastery
   b. Collaboration
   c. Education
   d. Mindfulness

3. **CHECK, a program that teams community health workers with licensed behavioral health professionals to keep at-risk patients healthy and out of the hospital, focuses on a Medicare population of at-risk adults. Initially, CHECK focused on a Medicaid population of children and young adults with:**

   a. kidney disease, cystic fibrosis, and sickle cell anemia.
   b. asthma, sickle cell anemia, diabetes, and premature birth.
   c. congenital heart issues, paralysis, and asthma.
   d. cancer, traumatic brain injury, asthma, and lead paint exposure.

4. **A recent study of a hospital's nurse navigator program for heart failure patients revealed this education and attention on patients reduced 30-day readmissions by:**

   a. 25%.
   b. 41%.
   c. 50%.
   d. 80%.

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 Basic Elements of Healthcare Reimbursement — Part 1

By Toni Cesta, PhD, RN, FAAN

Changes in healthcare reimbursement have occurred with lightning speed over the last two decades. Earlier, reimbursement had been stagnant for many years and functioned on a "no questions asked" basis. Providers billed for services rendered and were reimbursed — with no checks, balances, or control over costs of care. Case management, as a care delivery model, followed a similar course. It was a community-based model dating to the 1920s. But as reimbursement changed, so did case management. This month we will begin our discussion of reimbursement, including the changes to case management as it evolved with reimbursement.

Reimbursement Inspired Change in Healthcare

Evolution in reimbursement motivated change in healthcare delivery, moving case management into the limelight in the mid-1980s. Before the 1980s, most reimbursement schemes were fee-for-service (FFS), with little concern for length of stay or cost of care. Overuse was common — the more that was spent, the greater the reimbursement. This could be viewed as an overuse reward system. With no checks and balances on the system, costs continued to increase. At the same time, the costs of pharmaceuticals, radiology, and supplies escalated with minimal management. It became apparent to hospitals and healthcare systems that greater accountability was needed.

Forces driving the move toward case management:

- 1970s: Escalating healthcare costs;
- 1980s: Prospective payment system in acute care settings;
- 1990s: Managed care infiltration;
- 2000s: Prospectivfve payment in home care, outpatient care, rehabilitation services, and long-term care;
- 2010: Healthcare reform.

Eventually, these spiraling and unchecked costs brought pushback from patients and third-party payers. No longer were they willing to pay these high costs. It also was becoming apparent that healthcare quality was not keeping pace with the increased expenditures. Were these higher costs necessary or were they simply a result of an unchecked healthcare system? Some patients were concerned they were paying more and getting less. This concern was not unfounded. Care quality did not improve simply by throwing more resources into the process. In fact, in some instances, resource misuse and overtreatment exacerbated the problem.

EVOLUTION IN REIMBURSEMENT MOTIVATED CHANGE IN HEALTHCARE DELIVERY, MOVING CASE MANAGEMENT INTO THE LIMELIGHT IN THE MID-1980S.

By the mid-1980s, many pilot projects were underway to develop changes in delivery that might reduce costs while improving care quality. Since value in healthcare is the equation that reduces costs and improves patient outcomes, these changes were a serious value proposition. The federal government under the Medicare and Medicaid programs introduced the prospective payment system (PPS) and the development of the diagnosis-related groups (DRGs). The idea was to move hospitals and healthcare systems to fixed-rate payments applied, regardless of the resources consumed.

Almost simultaneously, employers — the largest

purchasers of healthcare insurance — began looking for alternatives to indemnity plans as healthcare costs continued to rise.

Early efforts were focused on cost-cutting, particularly in many of the early managed care plans. The tighter the controls on the expenditures, the lower the cost of care. Lower costs meant premiums could be kept as low as possible, attracting more companies to these plans.

It was not long before hospitals and healthcare systems realized the best way to control costs was to understand care quality. A different approach to measuring outcomes was born. While financial indicators were obvious, there were bigger challenges in measuring quality within managed care as well as under the PPS. Many hospitals introduced and adopted quality tools that focused on continuous quality improvement (CQI). CQI was one of the first concepts to gain popularity. The other was case management. In time, these techniques provided the framework for future delivery models and outcomes management.

The PPS and DRGs were the major drivers that moved case management from a community-based model to one that would be used in hospitals and other acute care settings. Under the earlier FFS models, there were no financial incentives for hospitals to reduce cost or shorten length of stay.

In the 1980s, healthcare policy began to shift to quality and cost of care as well as fiscal responsibility. The PPS was intended to control hospital costs by providing a price-per-case reimbursement. The provider, including the physician, became responsible for controlling the direct costs of care associated with treating each patient. The DRGs would set the price for the care provided during a hospital stay. By controlling the reimbursement, physicians, nurses, ancillary departments, and administrators could work to provide more efficient and cost-effective care. Also, the PPS would facilitate a reduction in variation, lead to standardization of care, and improve the efficiency of the care process. Unfortunately, although the PPS controlled the payment rate the hospital was to receive, it did not control the cost of care. This required changes in behavior, particularly from physicians who ordered the healthcare resources. Therefore, hospital costs continued to rise. This led to the opportunity for managed care to provider a greater influence in healthcare reimbursement.

Under the PPS, appropriate reimbursement is directly linked to the documentation in the medical record. How well a hospital fares under PPS was dynamically linked to accurate, legible, and timely documentation coding accuracy. Some hospitals introduced a new position that used either medical coders or registered nurses to monitor and audit medical record documentation. The most commonly used title for these positions is documentation specialist, although other titles are used. This person ensures the documentation reflects the care delivered, increasing the likelihood the hospital will be paid under the most accurate DRG assignment.

DRGs were codified in 1982 under the Tax Equity and Fiscal Responsibility Act (TEFRA). This was initially created to set limits for Medicare reimbursement. Developing this methodology was complex and laborious. The first DRGs were based on ICD-8 and HICDA-2 diagnostic codes. The I-8 was a four-digit system that measured the incidence of disease, injury, or illness. The five-digit I-9 was more specific in terms of location and precision of reporting clinical conditions. Specific measures would require more specificity in physician documentation.

DRGs

DRG is a patient classification reimbursement system that groups similar patients. They are considered

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alike if they demonstrate similar cost and length of stay. Costs include services and resources used to directly care for a patient, including diagnostic and therapeutic interventions. Personnel costs include nursing hours per patient, among other criteria.

DRGs are subdivided into major diagnostic categories (MDCs). Examples of MDCs include diseases of the central nervous system, bone and cartilage, and diseases and disorders of the kidneys and urinary tract. MDCs are medical or surgical. The amount of DRGs in each MDC can vary from 1 to 20 or more.

Relative Weights and Case Mix Index

Each DRG is assigned a relative weight. These weights are relative to the number 1 and are based on average lengths of stay and costs of care. DRGs assigned 1 use an average amount of resources. DRGs weighted above 1 include greater case mix complexity and use more resources. These types of patients are reimbursed at higher amounts. DRGs weighted under 1 require fewer resources, are less complex, and are paid at lower amounts.

DRG weights correlate to the case mix index (CMI) of the hospital. The CMI is the sum of all DRG weights divided by the number of patients cared for over time, usually one calendar year. The higher the CMI, the higher the assumed case mix complexity of the hospital. Case mix is affected by:

- severity;
- prognosis;
- treatment complexity;
- interventional needs;
- intensity of resource use;
- presence of complications and comorbidities.

The Centers for Medicare & Medicaid Services (CMS) assigns each hospital a base rate for reimbursement. The base rate is determined by the type of hospital (teaching, academic, community), location, patient population, local cost of living, and services provided.

THE TYPES OF PATIENTS AND THEIR USE OR RESOURCES, NOT THE NUMBER OF PATIENTS, AFFECTS HOSPITAL COSTS.

Reimbursement is calculated by multiplying the DRG's relative weight by the hospital's base rate. CMS reviews DRGs and base rates annually. Adjustments are made as needed based on the previous year's performance for all hospitals in the United States.

Measuring the Elements in Case Mix

Illness severity includes clinical indicators that reflect the need for hospitalization. Prognosis is the patient's likelihood of recovering. The case mix reflects hospital costs. The types of patients and their use or resources, not the number of patients, affects hospital costs. Assignment of a DRG is based on the documentation in the medical record.

The DRG is assigned after discharge based on medical record coding. Once it is assigned, the hospital receives a lump-sum payment based on the relative weight of the assigned DRG. Some DRGs are weighted higher based on the complications and comorbidities associated with that DRG.

Assigning the DRG

Severity of Illness Criteria

- Clinical findings: chief complaints and working diagnosis identified on physical examination, direct observation, and patient interview;
- Vital signs: temperature, pulse, respiratory rate, and blood pressure;
- Imaging: diagnostic radiology, ultrasound, MRI, and nuclear medicine results;
- ECG;
- Hematology, chemistry, and microbiology results;
- Other (clinical parameters not identified already).

Intensity of Service Criteria

- Physician evaluation;
- Monitoring;
- Treatments/medications;
- Scheduled procedures;
- Presence of comorbidities.

Outliers

Patients with atypical short or long lengths of stay are defined as outliers. All other patients are defined as inliers. Classifying a patient as an outlier depends on the trim points for the DRG. Each DRG has a high length-of-stay trim, while some also have a short length-of-stay trim. Trim points represent the lowest and highest average lengths of stay for the DRG.

Patients also can be categorized as cost outliers. These patients are in appropriate length of stay but have used a higher-than-normal amount of resources. This is determined by using a flat amount or if the charges exceed the rate by at least 50%.

In 1985, the PPS was advanced beyond Medicare to allow some states to designate reimbursement rates for Medicaid and third-party payers such as managed care plans. Strong incentives were in place aimed at controlling hospital resources. The hospital would still be reimbursed a fixed amount of money based on the coded DRG, regardless of the cost.

During the early years of DRGs, hospitals realized RNs could play a vital role in managing these dwindling healthcare dollars. These early roles mainy focused on utilization review and discharge planning:

- timely admissions;
- confirmation of physician orders;
- coordination of tests, treatments, and procedures;
- accurate documentation;
- patient and family education;
- timely discharges.

Before these changes, there were few financial incentives in place to control healthcare processes. In fact, there were many disincentives. The fee-for-service environment meant more revenue and financial success for hospitals when patients stayed longer and used more resources. The PPS changed that. It became important to maximize the patient's hospital stay by coordinating the flow of patient care activities, including tests, treatments, and procedures so delays could be avoided. Additional tactics included confirming physician orders and/or questioning of their appropriateness. These changes necessitated the movement of case management into the acute care setting and used RNs to drive the case management processes.

These are the steps of the DRG reimbursement process:

1. The DRG is assigned after discharge.
2. Once the DRG is assigned, the hospital is paid.
3. One lump-sum payment is made for:
   - DRGs with complications or comorbidities;
   - Cost outlier payments.

Summary

The payment system for the acute care setting is complicated, and we have only begun to review the CMS system. Next month, we will continue to discuss this system and how it applies to the roles of case management professionals. ■

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