HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Leading the Charge in 2021: Managing Capacity

By Jeni Miller

Approaching one year after COVID-19 began spreading in the United States, case managers are considering how to make the most of their new perspective in 2021 and beyond. The pandemic has shone a light on case management program and healthcare facility weaknesses, but also has brought new opportunities for leadership and advocacy. What can case managers do to maximize these opportunities and avoid pitfalls?

> "WHEN SO MANY HOSPITALS ARE HAVING CAPACITY ISSUES, YOU HAVE TO CONSTANTLY REPRIORITIZE HOW YOU MIGHT WANT TO DO THINGS DIFFERENTLY."

Keep Reassessing

"I know I learned a lot about this at ground zero on 9/11," says **Toni Cesta**, PhD, RN, FAAN, partner and consultant at Case Management Concepts in North Bellmore, NY.

"When so many hospitals are having capacity issues, you have to constantly reprioritize how you might want to do things differently."

It takes the whole team to make it happen, Cesta says. "I think you have to look at your staffing every single morning and up-staff or down-staff as you need to, depending on where you've got overcapacity issues or bottlenecks."

This reassessment can make a difference when there are many discharges planned in a day, or to ensure there is enough case management staff in the emergency department (ED). "You need

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regular, comprehensive assessments to deploy staff to where they're most needed," Cesta explains. This is the biggest challenge right now, but once the leader has deployed staff in the morning, don't stop there. Keep assessing throughout the day."

As uncomfortable as it can be, reprioritizing day by day and, as Cesta calls it, "turning things on their heads to really focus on today's issue," can help the staff become more proactive.

"We should all expect that between COVID, hurricanes, floods, and everything else, any hospital in any part of the country can be impacted by capacity issues," Cesta shares. "You never know what kind of emergency might happen, so being proactive and always being prepared, the whole hospital, that's key."

Maintain the Flow

When those capacity issues hit, like they did in many places throughout 2020, it is important to know when to reorganize the four main case management roles to concentrate on patient flow and capacity management.

During a pandemic, be sure to "prioritize the work in this way: patient flow, capacity management, discharge planning, utilization management," says **Beverly Cunningham**, RN, MS, partner and consultant at Case Management Concepts. To make this happen, says Cunningham, consider these tactics:

- Keep the patients moving;
- Conduct quick, daily rounds;
- Know the day's discharges;
- Order transportation the day before so there are no delays;
- Make sure families know when the patient will be ready to go at least a day ahead if you can.

"Usually, patient flow would not be No. 1, but during a critical time, things like reimbursement are less of a priority while the biggest thing is opening beds for sick patients," Cesta explains. "Expediting the process should be at the front and center of the day as a case manager, making sure that discharges are happening in a timely manner, that treatments and procedures are timely, and that people are not staying in the ED longer than they need to if they're known to be moving to an inpatient bed."

During a high-capacity period, Cesta and Cunningham recommend that staff abbreviate patient rounds. "But don't eliminate them — these rounds are necessary also for knowing when beds will free up," Cesta adds.

Utilization review and discharge planning should be closely aligned and especially aggressive during times of high capacity, or generally during a pandemic or disaster.

"It's all about movement of the patient," Cesta explains. "The minute a patient can be discharged from an ICU, make that happen. Focus on really aggressive utilization reviews so a patient can move to a lower level of care as early as possible. We do this every day anyway, but make this a very aggressive process throughout the whole day. During a critical period, work closely together and prioritize the work unit by unit, and even hour by hour."

She also recommends case managers look closely at any potential delays. Many of these can be avoided by keeping an eye on the following, which account for the corresponding percentage of unnecessary extra days:

- Unnecessary admissions: 15-20%;
- Test/treatment delays: 20%;
- Lack of home care arrangements, nursing home beds, and more: 10-15%;

• Physician practice/custom: 50%.

There are several ways to plan and prepare for an influx of patients. It is important to consider how to optimize each facility's space.

"Some hospitals have found success in creating a 'discharge lounge' when at capacity," Cesta says. "This frees up a room by providing a lounge area where the discharged patient can go while they wait for their family."

Others make use of swing beds, using existing beds in a different way by repurposing recovery rooms or rehab rooms as COVID-19 units. Another option is to temporarily halt elective surgeries.

"Using a grid of some sort can help case managers be proactive and have a plan identifying potential problem areas and managing high-capacity situations," Cesta says. Leadership and staff should consider following this pattern:

• Each morning, review how many patients are in the ED.

• Review ED volume against expected discharges to determine capacity issues.

• Understand where bottlenecks may happen based on bed needs.

• Use a grid to help identify potential problem areas.

• Build these into your patient flow software, if possible.

Use Waivers

During critical times like the COVID-19 pandemic, emergency declaration blanket waivers can help enhance patient flow and ease the decision-making process for leadership and staff.

"Case managers should be acutely aware of these waivers because they're designed to help them move patients more quickly," Cesta explains. "For example, discharge planning waivers allow for high COVID capacity hospitals to avoid using a choice list. The three-day skilled nursing facility rule is also waived, as well as EMTALA [Emergency Medical Treatment and Labor Act], among others."

> "WE SHOULD ALL EXPECT THAT BETWEEN COVID, HURRICANES, FLOODS, AND EVERYTHING ELSE, ANY HOSPITAL IN ANY PART OF THE COUNTRY CAN BE IMPACTED BY CAPACITY ISSUES."

If case managers can use these waivers, they can move patients through the care continuum more quickly and help more people as needed.

Build New Bridges

Developing new and better relationships with other healthcare partners also has proven critical in 2020. This can make the difference between hospitals that thrive and those that barely survive. For instance, building partnerships with home care agencies can help case managers and leadership prepare for times of high capacity.

"I think home care has really stepped up and realized how significant the capacity issues have been this year," Cesta says. "If you have those dynamic relationships with home care or sub-acute facilities, that will really help everyone. During a time like this, if you're regularly conversing with them and explaining current issues, these agencies may even be able to help the same day."

Hospitals that are "newly COVID-intense," according to Cesta, "may not have been thinking about those providers." She recommends any hospitals that are not at capacity should be "thinking about and developing relationships right away" so they are prepared if COVID-19 intensifies in their area.

"To avoid an unnecessary hospital admission, try to work closely with home care agencies," she adds. During high-capacity periods, one trick of the trade is to ask a home care agency representative to sit in the ED alongside patient intake, as their joint assessment might shorten turnaround time by four to six hours.

Working closely with post-acute, home care, and skilled nursing facilities can be critical to capacity management, and can even result in a positive working relationship to carry into the future.

Silver Linings

"In 2021 and beyond — regarding capacity issues, for one — people will be rethinking what they can do with overflow," Cesta notes. "Having considered where they might get beds and equipment, where they could put an overflow of patients, and even how they'll access staff, if needed, knowing their options and having processes in place will benefit them in the future. That's another positive that has come out of this." ■

Case Management Leaders Can Help Staff Weather Ongoing Crisis

By Melinda Young

Research on the effects of the COVID-19 pandemic on nurses, physicians, and other healthcare workers across the world shows disturbing levels of anxiety, depression, stress, burnout, and suicide.[1-3]

The authors of one study estimate the prevalence of burnout among registered nurses in the United States to range from 35% to 45%. The authors concluded that nursing burnout due to COVID-19 threatens the stability of the healthcare workforce.[1]

Results of another U.S. study revealed nurses have experienced isolation, anger, betrayal, grief, exhaustion, loss, denial, and feelings of helplessness as the pandemic surges and strains on personal protective equipment (PPE) supplies forced them to work under risk of infection.[2]

Nurses from a hospital in Wuhan, China, reported high levels of depression, anxiety, and insomnia during the pandemic. They also noted higher levels of post-traumatic stress disorder (PTSD) symptoms when compared with a stable period.[3]

As the pandemic continues to push hospitals and healthcare workers to the limit, case management leaders need to help their employees improve resilience and engage in self-care.

"The pandemic is not letting up," says **Ellen Fink-Samnick**, LCSW, CCM, CRP, principal of EFS Supervision Strategies in Burke, VA. "Some states have no hospital beds, and rural communities are drowning from decreased availability of hospitals from hospital closures over the last decade."

Hospital case managers are exhausted and working at maximum levels of stress. "They have been watching colleagues get sick and die, and they have been dealing with what I term 'collective trauma,'" Fink-Samnick says. "There are many people who have seen more deaths in a day than they should have to see in an entire career."

OSHA Complaints

Case managers' roles changed fundamentally during pandemic surges in 2020. Those who continued case management and care transition work had to adjust to meeting patients through telehealth because they were not allowed into COVID-19 patients' rooms. Others were furloughed or laid off because of pandemic-related cutbacks. There also were RN case managers who were told they could keep a job, but they would need to switch from case management to bedside nursing for COVID-19 patients, Fink-Samnick explains.

"Some nurses were petrified and filed actions with their union or refused to come into work," Fink-Samnick says. "They were filing complaints with OSHA [Occupational Safety and Health Administration], and this was occurring all over the country. People were petrified they were going to bring this virus home to loved ones."

COVID-19-related complaints made to OSHA grew from 25 on April 20, 2020, to 10,350 on Nov. 15, 2020. *(More information is available at: https://bit.ly/38QGiC2.)*

OSHA complaints often focused on the lack of PPE and adequate cleaning. For example, a complaint filed in May 2020 stated a hospital did not provide N95 or equivalent respiratory protection to staff working with COVID-19 patients. Another complaint said the hospital ran out of gowns and asked staff to wear patient fabric gowns and separate fabric sleeves for direct patient care. *(A copy of the complaint is available at this link: https://bit.ly/3kAqmpt.)*

"People felt very threatened, and a lot of people made the decision to leave their job," Fink-Samnick says.

For case managers still on the job, the question on their mind is what the new norm will be like, she notes. "Just as people get used to having the new norm, it shifts again."

EXECUTIVE SUMMARY

Emerging research about the pandemic's toll on healthcare workers shows it is leading to disturbing levels of stress, burnout, anxiety, and other problems.

- Hospital case managers had to become frontline nurses to care for COVID-19 patients, adding to their stress and the possibility of post-traumatic stress disorder.
- Case managers need help building their resiliency as the crisis continues.
- Doctors and nurses who performed at a high level felt more supported by the hospital administration. Their perceived organizational support was higher.

Healthcare professionals can suffer from PTSD, but they are not prepared for this, even though they are exposed to trauma — particularly when a crisis occurs.

"In the military, they prepare for PTSD because they know people will be on the frontlines, and they prepare the whole family," says **Keith Doram**, MD, MBA, FACP, adjunct associate professor of medicine at Loma Linda (CA) University School of Medicine. "They don't do that in healthcare."

Build Resiliency

People reach their breaking point when confronted with stressors they cannot predict and stressors they cannot control. "The typical healthcare worker is constantly interrupted in clinical work and has competing demands with no off times," Doram explains. "In healthcare, we're trying to create a healing experience at the same time our workers themselves need healing."

A case manager's resiliency depends partly on the person's workplace environment and work support network, he notes. One goal is to create an environment in which staff can maintain resiliency despite the crisis and other conditions of their work. But this requires both attention to self-care and actions that enhance resiliency, as well as the right ingredients in the workplace environment, Doram says. *(See story on how case managers can build resilience in this issue.)*

Case management leaders need to build resilience in themselves and in their staff. Crises, such as the pandemic, often are times when new leaders arise. Case management supervisors can look for employees who are more proactive, resilient, and willing to find creative solutions to emerging problems.

"Think about who the more proactive people are, and put them in leadership positions," suggests **Mike Crant**, PhD, MBA, professor of management and organization at the University of Notre Dame. "Acknowledge that a crisis by definition has high levels of uncertainty; it's the wild West. Tell people, 'We can't give you guidance on everything. You have to figure things out for yourself.' Say, 'That's OK — we want you to do that. Don't wait for us to tell you what to do.'"

Doctors and nurses who performed at a high level felt more supported by the hospital administration, and their perceived organizational support was higher, Crant says, based on his research in Wuhan, China, about how healthcare professionals handled the emerging pandemic.[4]

"They felt the hospital had their backs and felt deeply about them," he adds. "Those who struggled felt less supported."

When proactive and resilient employees face a crisis, such as the pandemic, they thrive, Crant says. "The crisis did not totally destroy their sense of well-being."

Encourage Self-Care

Case management leaders can demonstrate support for their staff by encouraging self-care. For example, case managers should incorporate a 15-minute walk into even their busiest of days. They need to stay engaged in exercise, including tai chi and yoga, and eat nutritious foods when possible. "Don't grab those fast-food meals," Fink-Samnick says. "Try to socialize, even if it's a virtual happy hour. I have one friend who reaches out to me every two weeks just so we can see each other."

Even if case managers are exhausted by the end of the day and want to be alone, they should try to engage in at least one social interaction. "People who isolate are going to be more prone to health issues, substance use, and suicidal ideation, so they need to push themselves," Fink-Samnick explains. "Do one five-minute chat by picking up the phone, or maybe chat with colleagues about something that is not work-related."

Pet adoptions have increased during the pandemic. This is another way for people to receive nurturing and support. "Some people have gone in another direction and taken certifications and tried new things to engage their brains," Fink-Samnick says. "Everyone needs to cope in their own way." Other self-care activities include relaxing pastimes, such as coloring on paper or electronically. Case management leaders can recommend staff use their hospitals' employee assistance programs when they need short-term counseling.

Case managers should focus on sleep hygiene to ensure a better night's rest, including moving electronic devices out of the bedroom, or at least not on the bedside table. It also helps to avoid social media sites before bed, or to avoid spicy and caffeinated foods and beverages, Fink-Samnick says. "Don't get into a toxic conversation with a partner or girlfriend, or into a social media rant before you go to sleep," she adds. "There needs to be some sort of relaxing routine."

There are additional sleep tips available online at the National Sleep Foundation's website: https://bit.ly/2UGGQBT. For example, they recommend setting a regular

sleeping schedule, listening to music or reading a book before bed, and making sure the bedroom is cool and quiet. It also recommends turning off electronics and dimming lights on digital clocks. ■

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Methods for Case Managers to Build and Enhance Resilience

By Melinda Young

Hospital case management departments can anticipate increased levels of stress among their staff as the COVID-19 pandemic continues. This could cause employees to burn out and leave their jobs.

But before things reach a crisis point, there are practical and evidence-based steps leaders can take to help their employees shore up their resiliency to deal with pandemic-related stressors.

"There are things you can do at an individual level and at a system and unit level," says **Keith Doram**, MD, MBA, FACP, adjunct associate professor of medicine at Loma Linda (CA) University School of Medicine. "Changes at the unit level and system level are the most challenging because now you have to get everybody on board. The easiest things to do are at the individual level."

Doram describes these methods for building resilience at the individual level:

• Think of Three Good Things before sleeping. The Three Good Things intervention was tested among healthcare professionals and found to promote well-being and alleviate burnout.[1,2]

"Before going to bed at night, think of three things you did that day that you had responsibility for," Doram says. "This could be making your favorite salad, taking a five-minute walk, or calling a friend."

It does not matter what the three things are; just that the person thinks about them before going to sleep. "Do that for seven consecutive nights," he says. "Researchers found that if you did that, then your happiness factor, well-being, and ability to sleep and rest were all more impacted than they were for people who were taking an antidepressant." Practicing the Three Good Things intervention for a week positively affected people's resiliency for six months, Doram adds.

The authors of a study about Three Good Things used popular social software as part of the intervention. The researchers concluded nurse managers should include Three Good Things into their management systems to improve nurses' physical and mental health and long-term work performance.[1]

• Take a break. "Another thing in healthcare is doctors and nurses are running here and there with case after case," Doram says. "They're not taking in enough fluid and are not eating properly."

Their overall health suffers, and they are not taking time for a quick daily recharge moment at work. "We recommend hitting the pause button during the day," he says. "They need a state of mindfulness, just five or 10 minutes, to take a pause."

They can take a short walk, look at a tree, or whatever they choose. This needs to be uninterrupted time, Doram adds. "It's less important how much time it is than that you do it and you're in control of doing it."

Case management leaders can help their team members build resilience. Here are a few suggestions:

• Measure burnout. Survey staff to gauge their levels of burnout, Doram suggests. One reliable survey instrument to measure burnout is the Maslach Burnout Inventory — Human Services Survey for Medical Personnel, available at: https://bit.ly/32OCiOz.

If the results show three out of five people on a unit are burned out, the unit will not be effective until this problem is addressed. "If you have a burned-out unit, they cannot take on

more initiatives because they don't have the capacity," he adds.

• **Empowerment.** Employees experience more burnout when they feel as though they have no control over their working conditions.

For example, Toyota Production System discovered their factory workers were making too many mistakes, suggesting they had reached high levels of stress and burnout. The company put in a simple and effective solution: a big red button, Doram explains. Any worker could push that button and stop the entire assembly line if they noticed a quality problem. Assembly line workers were held responsible for pushing the button when they felt it was necessary. *(More information is available at: https://bit.ly/32UZNp3.)*

"What was amazing about that was the number of mistakes went down dramatically," Doram notes. "Even more striking, hardly anyone pushed the button; it was just the fact that they had control if they needed to."

• **Reward.** Leaders should commend their employees' achievements and be specific in their praise.

"Don't say, 'Keep on doing a good job,'" Doram suggests. "Say, 'I really like the way you talked with that family.'"

It is important to employees to be recognized for what they are doing. It matters to them, he adds.

• **Support.** Employees become more resilient when they have a supportive relationship at work.

For example, if a case manager comes into work after a stressful morning with a sick child or some other issue, a colleague might offer to let the case manager take the easier cases that day.

"It helps to have a sense of community and to know someone has your back," Doram says. "It's tremendously impactful."

• **Fairness.** Employees are more content at their jobs when management gives everyone equal and fair consideration, Doram says.

"A lot of this has to do with perceptions, not the reality," he notes. "Deal with things that are transparent and do not leave a person out."

• **Values.** Employees experience stress and burnout when the organization outwardly expresses values with which they agree, but behaves differently in the day-to-day work environment.

For example, hospitals often express the value of caring for their patients and employees. But, during the pandemic, many hospitals did not provide their staff with as much personal protective equipment as was needed. This disconnect contributed to some staff burnout, Doram says.

"If a manager isn't telling staff the exact truth about things, and employees discover that what they were told is not true, then they can't count on what their [leaders] are saying," he explains. "That's what erodes the confidence in the worker that the value of the organization is not matching what they perceived it to be." ■

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New Research Suggests More Data on Readmissions Can Help

By Melinda Young

A recent study of Medicare data revealed facilities have many opportunities to improve readmissions — to either a medical or psychiatric hospital — after psychiatric hospitalization.[1]

The mean 30-day, all cause, unplanned readmission following psychiatric hospitalization rate of 1,343 inpatient psychiatric facilities was 20%, with a mean range of 11% to 36%.

"I am a psychiatric nurse by background, and have worked for many years in hospital quality, looking to improve the quality of inpatient psychiatric units," says **Ivy Benjenk**, RN, MPH, a PhD student in health policy and management at the University of Maryland.

The Centers for Medicare & Medicaid Services (CMS) collects and publishes information on 30-day readmission rates for psychiatric hospitals. But, unlike medical hospitals, there are no penalties for poor outcomes at psychiatric hospitals.

"In psychiatry, they put a lot of focus on the public reporting program on hospital compliance, strategies to reduce 30-day readmissions, and what these strategies utilize," Benjenk explains.

IPFQR Program

Psychiatric hospitals have been collecting data from the Medicare Inpatient Psychiatric Facility Quality Reporting (IPFQR) program since late 2012. It collects 14 data elements, available at this link: https://bit.ly/3m2kg2Q.

The IPFQR program measures include:

- Hours of physical restraint use;
- Hours of seclusion;
- Appropriate justification for patients discharged on multiple antipsychotic medications;
- Screening for metabolic disorders;
- Brief intervention provided or offered for alcohol use;
- Treatment for alcohol and drug use disorder provided or offered at discharge;
- Assistance for smoking cessation offered or provided;
- Smoking cessation treatment provided or offered at discharge;
- Transition record received by discharged patients;
- Timely transmission of transition record;
- Flu shots;
- Follow-up after hospitalization;
- 30-day, all-cause, unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility;
- Continuing medication after discharge.

CMS publishes benchmarking data from IPFQR online so individual psychiatric hospitals can compare their own performance with other hospitals. *(The data are available at: https://bit.ly/2SOzzPD.)*

Benjenk's study highlights wide variation in psychiatric readmission rates, with freestanding psychiatric hospitals performing better than health systems. "That kind of makes sense because that's [freestanding hospitals'] bread and butter," Benjenk says. "Hospitals that are more focused on medicine also are focused on creating strategies for reducing readmissions for medical patients. They may use the same strategies on psychiatric units, expecting the same results. Psychiatric hospitals don't have competing responsibilities."

But the CMS data are limited in helping hospitals determine which other factors could affect 30-day readmission rates.

Public vs. Nonprofit, For-Profit

Benjenk and colleagues also found nonprofit and for-profit hospitals perform about the same on readmission rates, but public hospitals, such as state-run psychiatric facilities, perform the best. One reason why public hospital readmission rates are lower is their patients stay in those facilities longer than patients at nonprofit and for-profit facilities, Benjenk says.

"They have good, comprehensive services," she adds. "Most chronically ill patients would stay there for multiple months, which is what these patients need." By contrast, patients might stay at the typical nonprofit or for-profit psychiatric hospital for a week.

Benjenk's research showed that while some hospitals are performing well with extremely low readmission rates, others have high readmission rates and are performing poorly.

"You can see unbelievable amounts of variation across the country on psychiatric readmission rates," she says. "The readmission rates are risk-adjusted."

The findings were adjusted for demographics, severity of psychiatric illness, and medical illness. There was no perfect way to adjust for social determinants of health, Benjenk says.

The study also revealed the 30-day, all cause, unplanned readmission following psychiatric hospitalization rate was different depending on the state. For instance, the lowest, mean 30-day readmission rate was 16% in Washington, followed by Minnesota and New Hampshire, each with 18%. The highest mean 30-day readmission rate was 24% in Rhode Island and Florida.[1]

One question was if hospitals that performed well on care coordination measures, including completing the discharge plan, also did better on readmissions. "Not really," Benjenk says. "Hospitals can be good at doing processes that lead to lower readmissions, but it doesn't make much of a difference. Our general finding is these measures are probably too broad to make any sort of change in readmission rates."

The takeaway from the study is that quality measurement is a lot of work for hospitals. It can take a nurse or other staff member looking at 100 or more charts each month, she notes.

"If we make available all of these resources to publicly report it with the idea that what we collect is something we can improve on, then what if it does not lead to improvement?" Benjenk asks. "Is it worth the time? What can we do to get hospitals to reduce readmissions?" ■

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The Four C's of Patient Care

By Jeanie Davis

Is your patient living in a tent city? Refusing surgery? Requesting alternative cancer treatments only?

Every day, case managers face pressure to achieve optimal outcomes in a multitude of scenarios. At the core of each case is the patient's understanding of medical care, their ability to think critically, make decisions about their care, and use good judgment.

Case managers must help their patients in their medical "journey," says **Ellen Fink-Samnick**, MSW, ACSW, LCSW, CCM, CRP, owner of EFS Supervision Strategies. "The case manager's primary function is to advocate for their patients. A big component of advocacy is walking through the journey with them."

Capacity, competency, coping, and choice are the core considerations every case manager should examine with each patient, she explains. The patient's judgment, she adds, will influence their decisions — and the case manager will have little influence on this.

Capacity to Understand

Capacity is the first factor the case manager must ascertain, says Fink-Samnick. "Is the patient capable of understanding and engaging in informed consent about their own care and treatment? This capacity will determine decision-making and discharge planning."

Does the patient understand the purpose, consequences, and benefits of proposed interventions? What about treatment and medications? Can the patient participate in a discharge planning process, or develop an appropriate plan to ensure positive health outcomes?

Capacity is a consideration, for example, when a homeless patient presents at the emergency department (ED). That patient may be oriented to place and time. He or she chooses to live in the woods and does not consider himself or herself homeless, says Fink-Samnick.

"The patient understands that they have a condition caused by unclean living conditions; they don't wash their hands often," she says. "They understand that clean water and antibiotics will help their condition and overall health. While their camp doesn't have clean, running water, a discussion of options reveals that a recreational center up the road has clean water they can use. This patient has the capacity to understand, and can make decisions about their care. They can provide informed consent, which is a big factor in terms of the hospital and liability."

Competency to Make Decisions

That patient's lifestyle may not reflect sound judgment, but that is

a subjective observation, says Fink-Samnick. "He has shown he has capacity, and he has shown he has competency — the ability to make decisions."

When capacity is under question, competency also is questioned, she explains. A person who is disoriented may not have the capacity to understand his or her condition or treatment options. If that is the case, they likely will not be competent to make decisions about treatment.

While a case manager, social worker and/or physician may question the patient's capacity and competency, a judge must decide on competency. "This is a legal rendering on the patient's ability to make their own decisions," says Fink-Samnick.

This decision affects all communication with the patient and family. Is the patient mentally sound to make decisions about medical issues? Does a patient with congestive heart failure or another chronic condition understand the need to make behavioral changes to prevent complications? Does the patient have the capacity to understand the diagnosis, consequences if they undergo treatment, and if they do not? "The case manager must be able to make that assessment," she says.

In today's world, every patient is complicated, Fink-Samnick adds. "Social workers, case managers, and nurses must know how to conduct a basic mini-mental status assessment. At the least, most healthcare professionals can determine if a patient has capacity. Only a court of law can determine competency."

Commonly, older adults may appear very confused and incompetent, she explains. "Yet they may simply have a urinary tract infection, and an antibiotic changes their picture completely. Or, they may have a medical reaction that is affecting their clarity."

Incompetent is a different picture entirely: The patient is extremely disoriented and cannot fully understand risks or implications of avoiding treatment. "This person's financial affairs and home environment may be in complete disarray, and the situation unsafe," says Fink-Samnick.

Incompetence can be difficult to prove, as people may fluctuate in their lucidity, she adds. They may provide inconsistent information at admission, but answer behavioral health questions very well. There may not be sufficient need to hospitalize that patient, but medication may be necessary to stabilize them.

Competency is based on a series of mental status exams. A psychiatrist (and possibly a physician) will perform a full psychiatric evaluation. A judge will review the reports and make the determination. Patients are deemed incompetent when they consistently demonstrate they cannot think or act in their own best interests and are truly unsafe.

Coping Behaviors

A medical condition can stir many emotions, including anger and fear. The patient's coping process can affect his or her acceptance of or resistance to decisions. The patient's coping ability can determine whether he or she is ready to choose a treatment.

The case manager must show empathy for the patient's coping process — not anger, says Fink-Samnick. "How would you feel in their situation?"

Case managers must remember the coping process takes time. Unfortunately, time is a valuable commodity not often available in today's fast-paced healthcare setting. While you may feel impatient at times, it is important to develop the skills and patience required. Communication is at the heart of this process.

"We have to be attentive to all the patient and family's emotions — what's very evident, and what's beneath the surface," says Fink-Samnick. "Not everyone adjusts quickly to a life change. Imagine how you would feel with an unexpected diagnosis or prognosis — uncontrolled diabetes, congestive

heart failure, stage four cancer. Dealing with that change is different for everyone. It takes a while to process the emotions."

Can the person cope with his or her current life situation? What are the patient's emotions? Is the patient angry, resistant? Can they think about death and dying? Defense mechanisms can be positive or negative; the patient may be in denial, rationalizing their circumstances, or avoiding social interactions.

"If the patient can't cope, the discharge planner must show empathy — not anger or frustration," says Fink-Samnick.

Ask the patient and the family how they are feeling. "Let them tell you how they're doing, how upset and frustrated they are," she explains. "Don't just rush in with their discharge plan. Sit in silence with them a little bit. Don't devalue how they're feeling."

She encourages case managers to learn a basic understanding of human behavior and communication with patients and their families. Not every environment will include a social worker trained in family therapy to guide the process.

"Case management is about looking at the very big picture of assessment: medical, physiological, cognitive, behavioral health, social," she says. "It's wholistic with a 'w'— physical health, wellness, psychological, and the social determinants of health."

Choice in Care Planning

When the case manager has helped patients and families through this process, it is time to prepare them to make choices, says Fink-Samnick. "You have to have a relationship with them to ask about preferences, cultural diversity, treatment choices, timing, and when to stop treatment."

When case managers and patients develop trust, it can make all the difference in facilitating even the most challenging discharge planning processes. "All these factors lead to the patient's decision-making ability. They can rationally choose their own medical treatment, or choose to refuse treatment. A competent patient can make their own end-of-life decisions," she says.

For example, if a patient with end-stage ovarian cancer refuses further treatment, her choice is the final word. Even if her family vehemently disagrees, her decision stands, she explains. "If they're alert, oriented, and able to make their needs known, they are competent."

Another patient is advised to change eating habits to improve his medical condition, another common example. "But if they love fried chicken and insist on eating that way, it's their choice. They may be showing awful judgment, but they are competent to make the decision."

The Power of Communication

Communication is the fifth "C" in patient care. Communication that shows respect for the patient must be at the heart of every process, says Fink-Samnick. "We take the patient seriously. We don't interrupt the patient when they're talking. We take into account the patient's language and literacy levels, to ensure they understand."

The case manager will ask questions guiding the patient toward treatment choices, discharge choices, and end-of-life choices based on their preferences, including cultural rituals.

In these discussions, the case manager must understand the factors involved in these choices, respect them, and continue to act as advocates for these patients, she says. "That's the power of establishing a relationship with the patient and helping them through the journey. You've engaged them, you've come to understand them, and you can help them make choices that are aligned with their values." ■

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. **Which are tactics case managers can use to manage high capacity, according to Toni Cesta, PhD, FAAN?**

   a. Create a discharge lounge and use swing beds.
   b. Transfer some patients to other units, if possible.
   c. Ask if there is overflow room in the ED.
   d. Ask a nearby hospital if they can take some patients.

2. **What role do values play in staff resiliency and burnout, according to Keith Doram, MD, MBA, FACP?**

   a. Employees who pray and value faith are more resilient.
   b. Employees experience stress and burnout when the organization outwardly expresses values, but behaves differently in the day-to-day work environment.
   c. Employees with high values related to empathy and sacrifice fare better on burnout measurements.
   d. Leaders who repeatedly demonstrate their personal faith and values can instill these in staff.

2. **Recent research suggests the prevalence of burnout among registered nurses in the United States is at:**

   a. 29%
   b. 49% to 55%
   c. 35% to 45%
   d. 66%

4. **Who ultimately determines whether a patient is competent, according to Ellen Fink-Samnick, MSW, ACSW, LCSW, CCM, CRP?**

   a. The treating physician
   b. The case manager
   c. The patient's psychologist
   d. A judge in court

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 2

By Toni Cesta, PhD, RN, FAAN

Introduction

This month, we will continue the discussion of healthcare reimbursement by third-party payers. We began last month with a review of the diagnosis-related groups (DRGs) and associated terminology. We will continue by reviewing how medical records are coded followed by the new MS-DRGs implemented in 2007.

DRG Assignment

Once a patient is discharged from the hospital, the medical records department picks up the process. Specially trained coders review the record and look for the following elements in the documentation. Coders must identify these elements to determine the DRG assigned to that record:

• The principal diagnosis (or primary diagnosis) is what the physician determined to be the chief reason the patient was admitted. Coders also look for the major diagnosis, which is the diagnosis that consumed the most hospital resources. The principal diagnosis and the major diagnosis cannot be the same.

• Coders identify the secondary diagnosis, which also relates to resource consumption.

• Coders note the principal procedures used to treat the chief complaint or complication rather than those performed for diagnostic purposes. In the case of multiple procedures, the one most closely related to the principal is the principal procedure. All other procedures are considered secondary.

• Non-diagnostic operating room procedures also are considered principal procedures.

• Comorbidities and complications also are considered.

• One-fifth of DRGs are determined by age. Age 65 years is a demarcation line for some.

• Discharge status also is considered. This refers to the patient's final destination after discharge, such as a nursing home, home, or home with other services.

CASE MANAGERS HAVE A RESPONSIBILITY TO ENSURE THE DOCUMENTATION IN THE MEDICAL RECORD REFLECTS THE CARE ACTUALLY RENDERED TO THE PATIENT, AS WELL AS THE ACUITY LEVEL.

As a case manager or utilization review nurse, this information is not necessary to perform the job. However, you should understand how these are determined as you sometimes might be required to prospectively identify the expected length of stay. Case managers also are obligated to ensure the documentation in the medical record reflects the care actually rendered to the patient, as well as the acuity level. Documentation improvement specialists also are responsible for ensuring the documentation reflects the care provided, the patient's acuity, and the resources used. Case managers and clinical documentation specialists should establish a good working relationship as each role complements the other.

Complex patients, either due to acuity or resource consumption, are coded into a higher-weighted DRG, but not without the complete documentation needed to support the code. Coders cannot work based on assumptions. They are completely reliant on the documentation alone and cannot draw their own conclusions.

Other Uses of DRGs

Some states use DRGs to set per diem rates. States with these rate-setting programs use the DRGs and adjust their per diem rates accordingly. Some states are DRG-exempt for identified categories such as:

- Psychiatry;
- Pediatrics;
- HIV/AIDS;
- Specialty hospitals (e.g., cancer hospitals).

Calculating Payments

Payments are calculated by multiplying the relative weight by the reimbursement rate, which is determined annually. As each DRG carries a relative weight, the weight is used for the multiplier.

Example 1: Average Relative Weight

- Payment = Relative weight × current base rate;
- Payment = 1.0 × $1,000;
- Payment = $1,000.00.

Example 2: Light Relative Weight

- Payment = Relative weight × current base rate;
- Payment = 0.5 × $1,000;
- Payment = $500.00.

Example 3: Heavy Relative Weight

- Payment = Relative weight × current base rate;
- Payment = 22 × $1,000;
- Payment = $22,000.00.

Dollar figures are for example only and illustrate how the calculations are made. They do not reflect actual hospital reimbursements.

How DRGs Affect the Healthcare Industry

The advent of the prospective payment system and the DRGs started the shift of case management into the acute care setting. Other changes occurred in response to this reimbursement system, including shifting many procedures to the outpatient setting. For some low relative weight DRGs, there are more financial benefits for the hospital to perform procedures in outpatient and ambulatory settings. In general, the per diem rate will reimburse less than the DRG payment. Because of this, many hospitals opened same-day surgery programs, ambulatory or day surgery facilities, and outpatient dialysis.

Reducing Length of Stay

To optimize the DRG case rate payments, healthcare institutions changed their practices on the preadmission and post-discharge sides of an inpatient admission. Managing length of stay required handling these other processes as well. Preoperative or preadmission testing departments were created to address the patient's preadmission needs. The expense to the hospital was less on the inpatient side, and presurgical tests also could be billed. Similarly, the better the discharge planning process, as well as the availability of community-based programs, the sooner the patient could be discharged home or to a lower level of care.

DRGs Today

The latest DRG version (version 25) was created in 2007, called the Medicare Severity DRGs (MS-DRGs). Three tiers were created for some DRGs, including no CC (complication or comorbidity), the presence of a CC, or the presence of a major CC. The historical list of diagnoses that qualified for inclusion on the CC list was replaced with a new, standard CC list and a new major CC list.

Another change is the elimination of the strict numerical sequencing of prior versions. Before, newly created DRG classifications were added to

the end of the list. In version 25, gaps within the numbering system allow for modifications over time. They also placed new MS-DRGs in the same body system closer together in the numerical sequence.

The sequencing looks like this:

- major complication/comorbidity (MCC);
- complication/comorbidity (CC);
- noncomplication/comorbidity (non-CC).

These levels are calculated based on clinical factors that aligned the new DRG system with the clinical status of the patient. They include the patient's secondary diagnosis codes (such as pneumonia or sepsis) along with the primary diagnosis (hip fracture). The prospective payment before the MS-DRGs was driven by the resources and length of stay of the DRG rather than on the diseases or specifics associated with the patient. CMS noted this DRG system would provide more clinical relevance by aligning the diagnoses and patients with the DRG rather than resource consumption or length of stay.

There is a relationship between the relative weights and the patient's complexity as it relates to complications and comorbidities. As these are added in, the relative weight increases, which also increases reimbursement. The expected lengths of stay also rise or fall. These tiers demonstrate the clinical severity associated with the care of these patients and allows for differences in complexity of care in the amount of reimbursement.

Observation Status

Medicare has used a reimbursement structure for observation status for decades. Some states chose to use this level of payment while others did not. The notion of observation always has been to allow providers additional time to decide whether to admit a patient. This was to be decided based on the patient's condition and the provider's clinical judgment as to the patient's further needs. CMS defines observation status in this way:

WHILE CMS STATES THIS STILL IS A 24-HOUR BENCHMARK, IT ADDS: "THE RELEVANT 24 HOURS ARE THOSE ENCOMPASSED BY TWO MIDNIGHTS."

"A well-defined set of specific, clinically appropriate services, which include treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. In the majority of cases, the decision can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do outpatient observation services span more than 48 hours." *(More information is available at this link: https://go.cms.gov/397k9zg.)*

Observation is considered outpatient care and is billed as such under Medicare Part B. If patients are billed as observation patients, they might have to pay a deductible (if not already met) as well as a 20% copay. If many medications are administered during the period of observation, the copay can be highly variable and place a great financial burden on the patient.

The Two-Midnight Rule

The Two-Midnight Rule took effect Oct. 1, 2013. Despite backlash from the healthcare industry and efforts to stop the rule, CMS enacted it with the 2014 Hospital Inpatient Prospective Payment System (IPPS) Final Rules. CMS scrutinized one- and two-day hospital stays for years, but few in the industry saw this rule coming. It was a game-changer for case management and all hospitals reimbursed under the IPPS. The rule affects the use of observation status, the definition of medical necessity and inpatient status, length of stay, and physician documentaion. It requires case managers to conduct due diligence at the hospital's points of entry, particularly the emergency department (ED).

Defining 24 Hours

In the past, CMS defined 24 hours as the amount of time the patient might have needed hospital care. The Two-Midnight Rule uses different logic. Known as the Medicare Utilization Day (MUD), CMS redefined the 24-hour benchmark process. It is defined as the 24 hours starting at midnight of the first calendar day a patient is in a bed, and continues until the following midnight. While CMS states this still is a 24-hour benchmark, it adds: "the relevant 24 hours are those encompassed by two midnights." *(More information is available at: https://bit.ly/3lXoFnP.)* This MUD could last up to 48 hours when patients are admitted just after the first midnight benchmark.

The rule requires a patient to be admitted as an inpatient when a physician expects a patient's hospital stay will span at least two midnights. The time the patient spends receiving treatment in the ED and/or the time that patient spends in surgery is counted as part of this period. The patient's time of presentation can affect whether he or she is admitted. The physician must admit the patient based on a reasonable expectation that the patient's stay will span two midnights.

Outpatient and Observation Status

The Two-Midnight Rule also clarifies what does not constitute an inpatient stay. It stipulates that diagnostic tests, surgical procedures that require a limited stay and do not span two midnights are not appropriate for inpatient admission.

Providers' notion of observation status changes with this new rule. Physicians used observation as additional time to follow a patient's care in the ED to determine if the patient needed to be admitted to the hospital. The rule now instructs hospitals to place any patient whose stay will not span two midnights into observation status. Once the physician gathers more information, the patient may be admitted or discharged.

This distinction between the previous use of observation and the 2014 use of observation warrants further explanation. In the 2014 use of observation status, inpatient vs. observation status was based strictly on anticipated duration of care — not the patient's level of care. According to CMS, even a patient requiring care in a critical care bed or telemetry, but whose stay will not span at least two midnights, should be placed in observation. Most patient stays shorter than two midnights generally are not appropriate for an inpatient admission, with the exceptions of transfer, death, unforeseen recovery, leaving against medical advice, and election of hospice care. The hospital can bill the stay as an inpatient admission if patients fall into any of those categories.

A patient may be admitted under extremely limited circumstances even if the stay is not expected to span two midnights. These include: new onset mechanical ventilation (not including surgical intubation), medically necessary procedures on the inpatient-only list, and others approved by CMS.

Physician Documentation

The Two-Midnight Rule also introduced changes to physician documentation requirements. The rule requires every inpatient admission to be certified by the physician of record. Certification occurs with a valid order for admission authenticated before discharge and in compliance with the Two-Midnight Rule. The medical record also must include a history and physical examination describing diagnosis and treatment plans for the patient. It also must include a discharge plan at the time of discharge. The physician also should be sure to document complex factors such as comorbidities, severity of symptoms, current medical needs, and the risk of adverse events.

Case managers must discuss the discharge plan with the physician of record. They also should ensure agreement with the discharge plan is clearly documented in the medical record by the physician of record. CMS does not require a certification form, although some hospitals use a form or template in their electronic medical record. It is up to the hospital whether to use a form or depend on the physician's documentation in the medical record.

Summary

In the March issue of *Case Management Insider*, we will continue our discussion on reimbursement by reviewing reimbursement in settings beyond acute care. ■