HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE



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# As COVID-19 Vaccine Rolls Out, Leaders Need to Roll Up Sleeves

*Not clear about vaccine timing*

*By Melinda Young*

The good news toward the end of 2020 was the emergency approval of two COVID-19 vaccines. Like certain celebrities, the "vaccine" did not need a first name or modifier. Everyone heard of the promising data coming out of Pfizer and Moderna, showing the vaccines to be about 95% effective against preventing COVID-19 in people who received two doses. Other vaccines also showed promising results, and the Food and Drug Administration has already given emergency use authorization (EUA) to the Pfizer and Moderna vaccines.

Doses of the Pfizer vaccine, which was the first vaccine given an EUA in the United States, were distributed to all states, but in quantities that would force officials to prioritize those who should receive the first doses.

Case management administrators should anticipate uncertainty in vaccine distribution, says **Tinglong Dai**, PhD, associate professor of operations management and business analytics at Johns Hopkins University Carey Business School in Baltimore. Dai also is core faculty at Hopkins Business of Health Initiative.

> CASE MANAGEMENT ADMINISTRATORS SHOULD ANTICIPATE UNCERTAINTY IN VACCINE DISTRIBUTION.

Physicians, nurses, and healthcare workers in hospital intensive care units, emergency departments, and long-term care facilities were at the



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front of the line to receive the COVID-19 vaccine in December and January. Other hospital workers and healthcare professionals in ambulatory settings also were expected to be in the first or second phase of vaccination.

"The timing of a vaccine would be uncertain," Dai says. "I wouldn't expect it to be later than March, so providers should get ready from both a supply and demand perspective."

For vaccines that require two shots, employees will need to receive the same type for both shots. When administering shots, leaders should consider timing. For vaccines that need cold storage, leaving shots out to warm may spoil the batch.

"From the supply side, they have to think about how they are going to apply the vaccination schedule, carefully, to make sure they use the vaccine when it comes in," Dai says.

The Centers for Disease Control and Prevention (CDC) issued recommendations on how to prioritize the first phase of vaccination. States have been left to decide which healthcare workers will be vaccinated first and which might have to wait for later phases of vaccine rollout — maybe even different COVID-19 vaccines — as supplies run out.

"Healthcare workers interacting with patients are in the first prioritization by the CDC, and this will be endorsed by most states," says **Eli Rosenberg**, PhD, associate professor in the department of epidemiology and biostatistics at the University at Albany School of Public Health, SUNY – The State University of New York in Rensselaer.

Hospitals could mandate vaccinating all employees who have direct patient contact in the same way they mandate flu vaccination, Dai says.

Since it is unlikely there will be as many doses of vaccine available as needed through the winter of 2021, there could be a conflict between health system demand for vaccine and available supply.

"I think there will be a stressful situation because we'll see a lot of shortages of vaccine in the first few months," Dai says.

In some places, hospital case managers likely were included in the first phase; in others, case management leaders still are waiting for word about when their staff can be vaccinated. In a minority of hospitals, the vaccine is optional, creating more questions and logistical issues for directors and administrators.

## EXECUTIVE SUMMARY

The new vaccine candidates provide good news for a pandemic-weary healthcare world, offering case managers and other hospital professionals an opportunity to become vaccinated against COVID-19.

- Case managers should expect uncertainty about how the first vaccines are distributed.
- Regardless of whether an organization mandates all employees to receive the shot, case managers and others should be vaccinated to protect themselves and their patients, researchers say.
- Leaders should educate staff about the vaccines and their efficacy and safety profiles.

"One of our two main hospital systems said [in early December] that they were not mandating the COVID-19 vaccine," Rosenberg says. "Among our rank and file, there is a lot of hesitancy."

Vaccine hesitancy is a problem that case management leaders and other administrators will need to overcome because of the problems that arise when staff refuses to be vaccinated.

"In addition to vaccines protecting [individual workers], vaccination can reduce absenteeism from the workforce at a time when we need all hands on deck," Rosenberg says. "We have a very tired and exhausted workforce as it is, and we don't need even more absenteeism due to exhausted and sick employees."

There is a moral imperative to vaccinate healthcare workers, he adds.

With a little education, leaders can help staff understand how and why the vaccines are safe. For example, the Pfizer vaccine and some other vaccine candidates are messenger RNA (mRNA) vaccines. They provide genetic information for cells to produce the proteins or antigens encoded by the mRNA.[1]

"The mRNA vaccines trick the body into making just the spike protein of the virus, which is the target of these neutralizing antibodies," says **Sean A. Diehl**, PhD, associate professor in the department of microbiology and molecular genetics at Larner College of Medicine at the University of Vermont in Burlington. "In a safe way, you can induce the appropriate immune response that is directed just to the spike protein, which is also what we found in natural infections."

The vaccine copies this action in a way that is clinically safe and does not require the host to become infected, Diehl says.

"The vaccine does not use the complete virus," he adds. "It is not in itself harmful to the host; they don't contain any of the dangerous parts of the virus because they are not viral vaccines."

RNA vaccines do their job and then are taken away, naturally, by enzymes in the body, explained **Kathleen M. Neuzil**, MD, MPH, FIDSA, director of the Center for Vaccine Development and Global Health, and Myron M. Levin professor in vaccinology at the University of Maryland School of Medicine in Baltimore. Neuzil also is co-director of the COVID-19 Prevention Network and is a fellow in the Infectious Diseases Society of America. She spoke about COVID-19 vaccine research at IDSA's web briefing on Dec. 3, 2020.

> "WE HAVE A VERY TIRED AND EXHAUSTED WORKFORCE AS IT IS, AND WE DON'T NEED EVEN MORE ABSENTEEISM DUE TO EXHAUSTED AND SICK EMPLOYEES."

"We wouldn't accept any prolonged side effects from these RNA vaccines," Neuzil says.

In a Phase III trial that included 44,000 participants, Pfizer's data revealed that its safety profile was similar to other viral vaccines over a median of two months. Vaccine reactions included short-term, mild-to-moderate pain at the injection site; fatigue; and headache.[2] Many Americans also are concerned about the speed with which the mRNA vaccines were created and studied in clinical trials. People need to know the idea of making mRNA vaccines did not begin in 2020, Diehl says.

"The vaccine field has wanted to do this for a while," Diehl explains. "The idea of using mRNA vaccines against key parts of the virus has been around during other pandemics, the 2014 Zika virus, and H1N1 [influenza] in 2008, but the mRNA vaccines never made it to approval because those pandemics went away."

With the COVID-19 pandemic, researchers built on that earlier research and reached the clinical trial stage quickly.

"This will open up the possibility of using this technology to do other vaccines in the future," says **Robert Salata**, MD, professor of medicine, chair of the department of medicine, and a physician and chief of University Hospitals Cleveland Medical Center. Salata participated in Phase II and Phase III of the Pfizer vaccine trial.

"Part of this research has moved quickly, but no corners were cut, and that's an important concept here," Salata says. "I've never seen a clinical trial conducted so carefully and scrutinized so much."

Usually, there are not 30,000 to 60,000 people enrolled in vaccine clinical trials, Salata notes.

"It's very costly to conduct a trial of 44,000 people, which is the case for Pfizer," he says. "Having this many people gives us comforting information about initial efficacy and

short-term safety, and we'll follow these folks for a longer period of time, making sure nothing comes up later." ■


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# Case Management Is Critical to Bundled Payment Programs

*Case managers follow patients for 90 days*

*By Melinda Young*

A healthcare organization's Medicare Bundled Payments for Care Improvement Advanced (BCPI Advanced) program resulted in lower hospital readmission rates.

The program reduced readmission rates from 30% to 19%, says **Karen Vanaskie**, DNP, CCM, ACM-RN, chief clinical officer at Innovation Care Partners in Scottsdale, AZ.

The five-year program, which started in October 2018, is scheduled to run through December 2023.

"Case management is critical in this program because the bundled payment is initiated at the hospital level," Vanaskie explains. "When patients are admitted, on Medicare, and have a diagnosis in the bundle, case management starts that journey and lasts for 90 days."

If the hospital miscalulates during discharge planning and sends patients to an incorrect setting, resulting in a hospital readmission, that adds to the cost of the patient's 90 days of care, she explains.

"You have to build a program that wraps around the patient and provides a continuum of care focus, and that's where case management is so critical," Vanaskie says. "Case managers identify at-risk patients when they come into the hospital and then wrap the most appropriate services around them at discharge, seeing that they receive the right level of care."

Case managers need to know how to transition patients to the best level of care for their needs.

"We do training for case managers along the continuum, and even in outpatient care," Vanaskie says. "We bridge communication throughout the continuum, especially at handover points from hospitals to the next level of care, or from skilled nursing facilities to home health, or from home health back to the primary care provider."

These transitions need to be handled with precision. "We built a tighter program of handoff, but call it handover of care — a gentle handover of care," she explains. The program also provides training to the entire inpatient team, including a hospitalist and physical therapist.

"Hospitals and hospitalists have aligned risks in the event the BCPI patients should cost too much, so we work with them as a team," Vanaskie says. "We have a tool called 'right location' to predict where the patient's next level of care should be."

As a patient's medical situation changes, the tool's prediction might not be accurate at the precise moment of discharge, but it is generally a critical tool in identifying risk, Vanaskie says.

"It helps us provide care at the right location when patients leave the hospital, and then it helps prevent readmissions, which would add cost to that 90-day period."

Case managers use the tool in patient screenings. "Case managers work with the hospital team and hospitalist to make sure everyone is in agreement and can transition patients to the next care," Vanaskie explains. "We ensure that for everyone transferring, there is a continuity of care form so we don't miss critical pieces of information when we hand over that patient to the next level of care."

The continuity of care form includes key information about patients' treatments in the hospital, their medications and procedures, how long they were in the intensive care unit, and the plan of care. Transitional case managers fill out the continuity of care form on paper. It takes about 10 minutes to complete, Vanaskie says.

Everything is written on a single document so the next care team has the best information available when

treating patients. Case managers review the form with the next providers. For example, they make sure intake coordinators at skilled nursing facilities understand the handover.

"Advance directives are in the continuity of care form," Vanaskie notes. "That's when they're ready to leave. We want to make sure there's the best information handed over to the next team."

Case managers meet with patients to review the main highlights of the continuity of care form.

"The big focus is on medication and any changes to patient's medication," Vanaskie says. "Because we're in a pandemic, they always go over advance directives."

The transitional case managers work with hospital case managers, patients, and patients' families for three to five days before discharge. They are very involved with the discharge plan, she notes.

"If we think the family is able to provide care for the patient, then we keep the primary care provider aware through the whole continuum of care, from post-acute to home with home services," Vanaskie says. "We also help patients get to their primary care provider appointment."

The program staffs a care coordinator in the primary care office. When home health is about to close the case, there is a discussion with the care coordinator, who helps make an appointment for the patient to meet with the primary provider.

"Then, we monitor the patient with a phone call follow-up or visit the patient, usually about 45 days after discharge," Vanaskie says.

Since the program is financially responsible for the patient's care for 90 days, the care coordinator's role is important for staying on top of how that patient is doing, she adds. The transitional case management team also follows patients into the skilled nursing facility or acute rehabilitation care settings. They check up on the patients either virtually or in person, when it is safe. They attend all the patient care conferences.

"We only send patients to our preferred provider skilled nursing facilities," Vanaskie says. "It's key that you trust the performance of the next site of care. If they are a poor performer and have a lot of readmissions, it will impact the BCPI performance. We send patients to post-acute settings we know have high quality and lower readmissions."

If a post-acute care provider's performance is subpar, they are put on an action plan. Their next quarter's data are assessed for signs of improvement.

"We have 26 preferred provider skilled nursing facilities, so we do have quite a few choices. We placed them strategically around all six of our hospitals," Vanaskie says. "When we meet with patients, we explain that we monitor the skilled nursing facility's quality, and so we feel confident in sending them to these post-acute providers."

In some cases, patients who have been discharged home cannot visit their primary care provider's office. The program employs a nurse practitioner and paramedic who can visit as part of post-acute mobile care, she notes.

"They have equipment and can do labs, breathing treatments, IVs, and medicine — like a mobile urgent care," Vanaskie explains. "What we don't want is for people to go back to the hospital unnecessarily, and a lot of patients don't want to go to the hospital. It's the last place they want to go, and Medicare pays for mobile care — like a home treatment." ■

# Q&A: CM Leadership During Pandemic Surge

*Director explains how much things changed in the last year*

*By Melinda Young*

Case management leaders have been navigating another COVID-19 case surge. **Angie Roberson**, MSN, RN, ACM-RN, director of case management at Spartanburg Regional Healthcare System in Spartanburg, SC, works in one of the worst-hit counties in one of the worst-hit states during the late 2020 and early 2021 surge of COVID-19 that swept across the United States.

*Hospital Case Management* (HCM) asked Roberson to explain how her case management department has managed the surge and changes their hospital experienced during the crisis. Here are her responses, delivered via email, in this question-and-answer story.

**HCM:** During the pandemic, what have your case managers experienced as the biggest changes to pre-pandemic times?

**Roberson:** The changes have varied as the pandemic continued. Early on, not allowing visitors was

a stark change. The job of case managers is to ensure patients and their care partners are involved in the care and transition plans. Restricting visitors meant we had to call caregivers to keep them informed. Case managers typically use all of their senses during conversations and assessments. Not being able to see a care partner's face and reactions prompted us to rely on other skills. Some were able to use FaceTime and other virtual means, if possible. We are thankful that some visitors are now allowed, although it is limited, and we appreciate the ability to meet face-to-face again with care partners.

Another interesting change relates to patients and families who desire to go home vs. going to a skilled nursing facility for short-term rehab needs. More frequently, families are choosing home care with supportive services.

Many things are now being done virtually as opposed to face to face. For example, now that elective surgeries are performed at some facilities, patients are receiving virtual patient education prior to surgery rather than in-person classes.

**HCM:** What types of transitions of care have COVID-19 patients needed? How did case managers find the level of care patients required after hospitalization?

**Roberson:** Patients who were positive for COVID-19 have needed the same care and resources as patients without COVID-19. Home health, hospice, and skilled nursing facilities have been the most common post-acute resources. Because of this, in the early days of the pandemic, post-acute facilities and agencies worked diligently to make adaptations to safely deliver care to COVID-19-positive patients.

Locally, we have excellent relationships with our post-acute providers. That allowed for open conversations regarding the needs of hospitalized patients. I am proud of our healthcare system for working collaboratively with our local skilled nursing facilities. Pre-established relationships and communication have been key to finding the needed resources and solving any challenges.

**HCM:** As the pandemic continues and surges into the winter months, what preparations are your case managers and department making to handle what comes next?

**Roberson:** We are focusing on the well-being of our staff: offering virtual educational sessions and promoting self-care and the use of our employee assistance programs. We recognize that our associates are also dealing with the effects of COVID-19 on their families and life outside of work. We need to support our associates as the pandemic continues. Their health is critical to supporting the needs of our community.

Because we have several facilities in our system, our case management team is prepared to cross-cover in times of crisis.

Our knowledge of the local, state, and national situation allows us to be prepared as the pandemic continues. We are maintaining open lines of communication with community agencies and resources to provide support to one another.

**HCM:** Case managers at some hospitals across the country struggled to transition patients with COVID-19 to skilled nursing facilities, even with two negative tests. Was that something your department also experienced? How did you cope? Also, how will case managers handle it if that happens again?

**Roberson:** We were fortunate that two skilled nursing facilities agreed to set up units to care for COVID-19-positive patients who were ready for post-acute care. I credit open communication and established relationships. Currently, the CDC [Centers for Disease Control and Prevention] guidance no longer supports the two negative test strategy, and our local facilities are following CDC guidelines regarding accepting patients.

No matter the issue that arises, we will work collaboratively through open communication with our local skilled nursing facilities.

**HCM:** What are some lessons learned about how case managers can cope with crises, like this pandemic?

As a leader, how have you helped case managers cope and prepare for further crises?

**Roberson:** Case managers are problem solvers, not only professionally, but personally, too. This means we sometimes carry a heavy load at work and at home. It's critical to rest and lighten the load by taking care of ourselves.

We have proven throughout the pandemic how flexible and nimble we are. Recognize the team, say thank you often, and be kind, always. ■

# Home Devices Expand Telemedicine Options

*Program allows case managers to provide ongoing patient oversight*

*By Jeni Miller*

As telemedicine use increases, case management professionals can harness its benefits to improve outcomes and provide a better experience for patients and physicians. According to McKinsey, healthcare providers saw 50 to 175 times more patients via telemedicine visits in 2020 compared to previous years.[1] COVID-19 played a large part in the increase as providers worked to minimize exposure to the virus. However, many patients still need proper monitoring.

Leaders at the University of Miami Health System launched the UHealth Televigilance program, which was developed to monitor symptoms remotely in patients with COVID-19.

"The UHealth Televigilance Program arms specific patients discharged from the ED [emergency department] or inpatient service with TytoCare devices," says **Sabrina Taldone**, MD, medical director of the UHealth Televigilance program in Miami.

These home health devices allow patients and their caregivers to electronically monitor and transmit health data to their provider and the patient's electronic medical record, Taldone says. But it does not just end there.

"The physician reviews the data, and if there are concerning vital signs, then the provider follows up with a telemedicine visit," Taldone says. "The provider can remotely conduct a thorough physical examination by having the patient or caregiver use the device's adapters, which allow the provider to examine the patient's heart, lungs, mouth, ears, and skin."

Some issues can be managed further via telemedicine, while those who need higher levels of care enter the triage process.

Taldone says the program's goal is to improve transitions of care for patients with COVID-19 infection who were discharged home from the ED or inpatient service, as well as prevent repeat ED visits and readmissions.

As of December 2020, more than 60 patients have participated in the program. Taldone and her team will analyze hospitalization length of stay, readmissions, and mortality outcomes.

This information could be valuable to case managers at other facilities, especially those in hospitals serving a large population of patients with COVID-19. In those cases, every bed freed up for another sick patient counts.

"For monitoring symptoms of COVID-19, this tool is fabulous — it's an outstanding extension of healthcare," says **Mindy Owen**, RN, CRRN, CCM, principal of Phoenix HealthCare Associates in Coral Springs, FL. "Some patients with flu-like symptoms can easily be treated at home, while some will need acute care through the ICU [intensive care unit]. For patients who can be managed in their own home environment, monitored by a physician, this tool is a true advantage."

Having the results directly feed into the patient's health record also helps make the connection with case management, Owen says.

"The tool helps give the case manager another valuable view of the patient," she explains. "The case manager can then do oversight regarding which resources are needed in the home environment for the patient to stay there. It's easier to identify the specific tools for activities of daily living when it's obvious what the patient's symptoms are. It is also then possible for case management to follow up and make sure all is working well in that home."

In addition to providing more detail to the case manager, the program also allows other healthcare team members, like respiratory therapists or pharmacists, to consult easier.

"Bringing other members of the team to the table is critical in these situations," Owen says. "The tool is not just to monitor, but an opportunity to bring the

team together. The great thing is that case management gets a clear understanding of what the physician is monitoring and what might change in the care plan depending on that. Ultimately, it's for the good of the patient."

"We aim to improve the quality of patient care in transitioning patients to the outpatient setting," Taldone says. "Patients with COVID-19 and their caregivers have tremendous fear about what will happen to them when they return home, so patient education plays a crucial role."

Using telemedicine and remote monitoring to its fullest extent is a group effort that requires a high level of quality communication.

"Launching a patient monitoring program like the UHealth Televigilance program requires interdisciplinary team efforts," Taldone says. "Effective communication facilitates patient education and the opportunity to improve the patient experience."

Even as the results of the UHealth Televigilance program are assessed in the coming months, Taldone says expansion of the program is certainly possible.

"Various departments have met with our team, and they are considering expanding the UHealth Televigilance program in their areas of patient care, from cancer to surgery," Taldone says.

Owen agrees and hopes this will be the case.

"After COVID, I hope this program doesn't go away, but rather shows itself as an opportunity for patients and providers to stay connected through telemedicine, especially for those with chronic conditions," Owen says. "Of course, it will only be stable if Medicare continues to keep the rules and regulations in place for the reimbursement of telemedicine.

"COVID-19 has brought to the forefront much more in telemedicine than we've ever experienced before," Owen continues. "It's been out there, but there hasn't been a push for reimbursement for telemedicine to the extent that there is today. With COVID-19, CMS took an in-depth look at reimbursing [telemedicine] activities at a much higher rate because professionals were telling people to stay home, yet we have to take care not to exacerbate a patient's other comorbidities."

When the patient's main symptoms and comorbidities are under control, home often is the best place for recovery. "For both patient and family, there isn't anyone out there who says, 'Oh, I want to go to the hospital,'" says Owen. "Going in typically increases the stress level for the family as well as the patient. During COVID-19, the family often can't even accompany the patient at all. Telemedicine options can reduce stress for the patient and family."

Owen says this is an essential part of recovery for many patients whose health is negatively affected by stress.

"That can't be minimized," she says. "A tool such as this is a blessing to be able to offer as a service to allow patients and family a less stressful situation — or even give them an option when it's not possible to find a bed in a hospital situation."

Hospital case managers and other healthcare professionals should continue to monitor the developments in telemedicine programs, and consult with their team regarding best practices for making the best use of it throughout the case management process. ■

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# Centralized Utilization Management: The Good, the Bad, and the Best Practices

*By Jeni Miller*

Challenged with employing enough staff in case management departments, the need for expertise in every role, and the increased requirements from payers, case management leaders are evaluating centralizing utilization review. This centralization carries both benefits and challenges, some of which are amplified because of the current healthcare climate.

Centralized utilization management (UM) involves separating the utilization management function from the bedside hospital case manager role. Sometimes, staff who are refocused to utilization management only are moved off site, or remain on site but separated in an office or other space. Either way, these staff members focus on these three types of utilization management:

• **Prospective:** Before patients arrive at the hospital;

• **Concurrent**: The day-to-day review of hospitalized patients;

• **Retrospective**: Managing patients who have been discharged from the hospital.

"Hospitals vary in how they manage the UM functions. Some hospitals have UM specialists only doing UM on admission; others may have the UM specialists performing UM on certain payers," says **Beverly Cunningham**, RN, MS, ACM, partner and consultant at Case Management Concepts in Dallas. "This can be quite confusing for both physicians in knowing who is responsible for the UM function and the case management department staff, as the UM function is dependent on some social work functions as well."

## Gain Consistency

However, there are several reasons health systems have chosen to consolidate their UM functions. First is the multitude of payers, each with their own ways of determining medical necessity criteria.

"It can be confusing and time-consuming to keep up with all the rules, both by commercial payers, state payers, and the federal government," says Cunningham.

In addition, it is difficult to fill all the case manager positions in hospitals. When the UM component is removed from the bedside RN case manager role, these staff members often can work from home, says Cunningham.

This allows the RN case manager at the bedside to focus more on care coordination, clinical discharge planning, and resource management, says Cunningham. Giving the UM functions to another case manager allows them to act as specialists and become experts in understanding payer requirements.

**Brian Pisarsky**, RN, MHA, ACM, is senior vice president at Kaufman Hall, a consulting firm in Chicago.

"[Centralizing] can more easily align payers and facilities," says Pisarsky. "Everyone knows who is talking to whom. You have one person or group of utilization management staff who deals with one payer for the whole system. With greater consistency in communications between the payer and the health system, the health system is more likely to get paid and diminish costly denials."

"IT CAN BE CONFUSING AND TIME-CONSUMING TO KEEP UP WITH ALL THE RULES, BOTH BY COMMERCIAL PAYERS, STATE PAYERS, AND THE FEDERAL GOVERNMENT."

Pisarsky notes many hospitals are simply seeking a more consistent approach across the enterprise, allowing for common goals and objectives across the system.

Data analysis is one way to gain more consistency, which is another factor hospitals consider in the decision to centralize, says Pisarsky. If this is a goal for a particular health system, it is important to have a solid backup plan in the event of an interruption to service or power.

Health systems can use compiled data from across their facilities to drive decisions at their organization. "For example, if data show that there has been an increase in denials from a certain payer, this can drive conversations with the payer to determine the cause of the increase," Pisarsky says.

"The level of detail that is available when data from all facilities are consolidated is often much higher, leading to an improvement in reducing denials before they occur," says Pisarsky. "There's no winning with denials — if you don't get paid the first time, it takes time, energy, and money to get it worked out after the fact to make it right."

Denials not only create more work for the hospital case manager, but also create frustration for the patient by potentially adding out-of-pocket expenses, affecting their length of stay, or holding up their discharge plan.

## Avoid Another Silo

Although consolidation and centralization can help make data more accessible and useful, opponents point out that it could create another silo, leading to longer stays and more denials due to lack of quality communication between UM professionals and bedside case managers.

"It definitely has the propensity to add another silo," says Cunningham. "UM is a time-sensitive function, often dependent on the specialist having conversations with the physician. This adds more work for the physician, in answering communication from the specialist, as well as the RN case manager in the hospital."

Cunningham says slower or nonexistent communication also can cost the hospital more money.

"When the time-sensitive function is lost, there is the opportunity to have a patient in observation service level of care, when they could possibly have been transitioned to inpatient," she says. "The hospital then loses the higher-paid level of care reimbursement because observation service is typically paid less than inpatient. This is especially true in the case of Medicare patients and the Two-Midnight Rule."

Pisarsky agrees, and reiterates the need for solid communication when utilization management functions are centralized or otherwise moved off site.

"Without direct patient interaction or time with peers, utilization management professionals must focus on constant communication with on-site case managers as well as department leadership," says Pisarsky. "Otherwise, yes, it could create silos or longer stays because utilization management is not seeing what is going on firsthand with the individual patients on the unit."

Similarly, putting someone with clinical knowledge on the floor can be crucial to ensuring the process flows smoothly. If a hospital moves the UM functions under finance, it can present extra challenges the team will need to discuss and mitigate.

"This can be challenging because there are now two different departments responsible for this very important function that is not only focused on finance, but [also] the clinical aspect of the patient," says Cunningham. "Finance leaders do not understand the clinical focus of the UM function. [At the same time], the RN case manager in the hospital still has the responsibility to understand UM and its role for each of their patients. If the UM function does move under finance, the case management leader should work very closely with the leader of that UM function."

## The Effects of COVID-19

Regardless of whether organizations and professionals desire it, COVID-19 has forced many to provide off-site UM. In those situations, not all data may be centralized, but the necessity for carrying out the UM role from home is a reality for many.

"Right now, the kids are at home, people are adjusting to life away from the health system, and it's been a big change," says Pisarsky. "Lack of relationships and face-to-face communication — and case management is really a face-to-face relationship — means that the team of case managers, physician advisors, social workers, and case management leadership needs to be in continual discussion to iron out all the wrinkles. I would say a weekly face-to-face communication plan is needed to transition toward leading practice."

On the administrative side, the effects of COVID-19 on UM remain prominent. Hospitals are working to find ways to manage these effects.

"COVID has really impacted every function in a hospital," says Cunningham. "Some payers have decreased the UM expectation of hospitals. However, it is still the responsibility of the hospital to manage the utilization component for patients. We do not know yet how payers will be reviewing for denials of patients in the hospital during this public health emergency."

During and after COVID-19, hospital case managers — especially those engaged solely in the utilization management role — have the opportunity to use their skills for the benefit of the patients and hospital. Some tricks of the trade can help make for a more efficient process, regardless of whether UM is centralized.

For those who are focused on the UM role, Pisarsky advises starting the utilization review earlier in the morning and not letting it fall to the bottom of the priority list.

"I know sometimes something has to give in the very hectic world of case management," he says. "If this falls to bottom of the priority list, then the hospital doesn't get paid and it compounds the resources required from everyone. Utilization management is as important now as it has ever been, so getting it right is important. The good thing about

centralized utilization management is that we get better at something if we do it every day — and we can use data to drive our decisions."

Cunningham stresses the importance of excellent communication and attention to the UM function as a priority. "Case management leaders need to ensure that collaboration among staff is present and that there is a sense of urgency in this function," she says. "There should be adequate staffing to allow for both the UM specialist and the RN case manager to have time to communicate and collaborate."

Understanding the advantages to centralizing utilization management functions as well as the potential pitfalls puts hospitals and case managers in a position to make the best informed decision to maintain successful case management programs. ■

# Tips for Fostering Effective Relationships Across the Long-Term Care Continuum

*By Jeni Miller*

Case management is a relationship-based profession that benefits health systems, patients, colleagues, and case managers.

Establishing strong relationships with representatives from the long-term care continuum, including skilled nursing facilities, rehabilitation centers, memory care units, and assisted living and independent living communities, is important for case managers.

**Lindsey Broyles**, HFA, is the executive director of Coventry Meadows Assisted Living in Fort Wayne, IN. *Hospital Case Management* (HCM) asked Broyles what case managers should look for when planning a transition to long-term care. Broyles offers tips on how to foster relationships with representatives at long-term care facilities.

**HCM:** How can case managers best form solid relationships with local long-term care facilities?

**Broyles:** The best way for case managers to form a mutual relationship is to follow up with the admission directors regarding referral updates. The admission director is responsible for growing census in the community, [while the] case manager [focuses on] safe and efficient discharge planning from the hospital. If the two roles merge their goals together to help one another, the relationship will be strong.

**HCM:** What are the best questions for case managers to ask about facilities?

**Broyles:** It's important that the case manager understand the insurance contracts, location, and service lines associated with each facility. The case manager has to work quickly to start discharge planning on day one. If the case manager knows which insurance and service lines the facility accepts, this will expedite the process. Families and residents also want to make it convenient for families to visit while in the long-term care facility. Knowing the locations of the facilities helps narrow the decision that's to be made.

**HCM:** What are some red flags that case managers should look for in long-term care facilities?

**Broyles:** The best way to discover red flags about a long-term care facility is to ask questions of residents and family members and listen carefully. If there is a patient who admits from a long-term care facility but does not want to return to their facility, ask why.

Likewise, ask the residents who want to return to their facility, why. The word-of-mouth discussion about a facility will give the most accurate account of patients' day-to-day experiences.

**HCM:** How can developing a good working relationship with local long-term care facilities help make the discharge planning process smoother for case managers?

**Broyles:** Communication is the bridge to a smooth process. If you have developed a relationship with the admissions director, the communication and flow can be seamless. ■

## COMING IN FUTURE MONTHS

- COMPASS study shows benefit to CM for stroke patients
- Post-acute CM program is patient-specific
- Organizations develop COVID-19 recovery programs

HOSPITAL
CASE MANAGEMENT



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# CE QUESTIONS

1. **What were the most common adverse reactions among participants in the Pfizer COVID-19 vaccine trial?**

   a. Short-term pain at the injection site, fatigue, headache
   b. Fever, migraine, nausea
   c. Hives, loss of smell and taste
   d. No reactions

2. **According to Karen Vanaskie, DNP, CCM, ACM-RN, a continuity of care form contains key information, including:**

   a. plan of care, discharge summary.
   b. patients' treatments in hospital, medications, procedures, and length of stay in the intensive care unit.
   c. patients' demographics, family and caregivers, contact information, primary care providers.
   d. medications, hospitalization history, outpatient services.

3. **Healthcare providers saw ___ to ___ times more patients via telemedicine visits in 2020 compared to previous years, according to a McKinsey report.**

   a. 20, 50
   b. 50, 100
   c. 50, 175
   d. 100, 200

# 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.