HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Understanding Medical Necessity Improves Utilization Review Process, Reduces Denials

By Melinda Young

If payer denials are stacking up, it is possible case managers and other staff need more training on utilization review (UR) and medical necessity.

Denials also occur due to operational issues, such as lack of information at the right time, says **Hemant Gupta**, MD, MSc, lead national physician educator at Sound Physicians in Tacoma, WA.

"The team made a decision with preliminary data that led to a denial," he explains. "If it's just an operational issue, then don't get discouraged; just find out why these denials are happening."

Medical necessity was born of the federal legislation that created Medicaid and Medicare, and has been the cornerstone of UR ever since. Case management and UR in hospitals can become more efficient and successful only when everyone involved keenly understands what this means.

> DENIALS ALSO OCCUR DUE TO OPERATIONAL ISSUES, SUCH AS LACK OF INFORMATION AT THE RIGHT TIME.

"When Medicare and Medicaid were developed in the 1960s and President Lyndon B. Johnson initiated those programs, they put in the concept of medical necessity to attempt to manage the rising cost of healthcare," says **Cynthia Young**, BSN, MBA, RN, CMPC, care strategy consultant with MCG Health.

The Social Security Act Amendments — also called the Medicare bill — was signed by Johnson on July 30, 1965.

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"Is it medically necessary or is it not medically necessary are what drive the services rendered and to be paid for a consumer," Young adds.

Hospitals should ensure patients receive a level of care and interventions that are medically necessary and high-quality, says **India Watson**, RN, MSN, CCM, CMPC, manager of care strategies with MCG Health. Watson and Young have spoken at case management conferences on UR and medical necessity.

Assess Level of Care

Clinicians, along with UR staff and committees, must continually assess the level of care to ensure medical necessity. "Does this patient need to be in the hospital? Can we perform these services in an outpatient setting?" Watson asks. "Is it medically necessary, and does it meet the CMS definition of medically necessary?"

The goal of UR is to reimburse appropriately for necessary care because there is not an unlimited source of money to pay for medical services. "This activity is done on the insurance side, and the same utilization review activities have to be done on the provider side," Gupta says.

When medically necessary care is provided and everyone agrees the services were necessary, then it is reimbursed by payers, he says. *(See story on case studies of denials in this issue.)*

Prevent Transition Delays

Transition delays occur when organizations lack the metrics to understand bottlenecks and staffing shortage issues. The UR process provides an opportunity to collect data for targeted quality improvement.

"One of the common reasons for delays has to do with limitations in staffing in many of our hospitals," Young says. "Perhaps there's a procedure that needs to be done, but they won't call in someone after hours or on weekends."

For example, a patient may need an MRI, but has to wait until the next morning for the test, which could result in another overnight hospital stay. "There can be a variety of reasons for delays, so track them and study them. Action plans can be put in place," Young says. "The last thing the hospital wants is a denial, and denials can sometimes be the outcome of delays."

Optimal quality care and the most efficient practice from the UR

EXECUTIVE SUMMARY

The case management team should be trained thoroughly on utilization review and medical necessity to avoid payer denials.

- The goal is to ensure patients receive medically necessary, high-quality care.
- Hospitals might experience transition delays when tests are delayed by staff limitations.
- Errors in writing discharge orders and lack of transition planning also can cause delays and denials.

standpoint is for tests to be performed timely when they are needed, Young says.

Another common reason for delays is when the physician does not discharge a patient because of other pending hospital services that may not be related to why the patient was admitted to the hospital. "[Patients] may want to go ahead and get those preventable things done," Watson explains. "For instance, if someone is in the hospital for chest pain, and they want to get their annual colonoscopy completed, the patient may stay in the hospital an extra day to do that unrelated service."

These delays can be prevented by scheduling patients to return for the unrelated procedures, instead of keeping them in the hospital an extra night when it is not medically necessary, Watson says.

Other delay issues are related to someone forgetting to write the discharge order, or not planning far enough in advance for a transition to post-acute care. The solution to most of these delays and denials is to collect data on what happens and identify ways to improve processes.

"It's a very complicated thing. We stress that you need to capture information," Young explains. "Identify those gaps and document and study information so you can determine where to close the gaps and how to do that."

For example, if the data show a significant number of denials for hospital days due to delayed tests, then case managers could make a case for employing an imaging technician in the hospital on evenings and/or weekends.

"We're in the age of technology, and there are a lot of systems out there where the nurse reviewer would have exposure to evidence-based guidelines," Young says.

Case managers should review electronic information and measure outcomes. They should look for solutions that use relevant clinical information and evidence-based guidelines. "There is an ability to track medical necessity determinations to capture patients' status in terms of utilization review," Young says. "The industry is moving toward automation and documentation systems that display evidence-based guidelines as best practices." Paper documentation or documentation gaps create problems that an electronic system could fix.

While every hospital uses a formal UR program, not all include a process developed through use of evidence-based guidelines and standards and that is consistent with payers. "A hospital may use one set of guidelines and criteria sets, and payers may use different guidelines and criteria sets," Young says.

Organizations can improve consistency by using national guidelines and standards, such as those created by organizations like MCG, InterQual, and other groups, including national healthcare associations. For example, the American Society of Addiction Medicine uses its own criteria for UR and management. *(More information is available at: https://bit.ly/2RbRqT0.)*

"The professional associations like the American Medical Association and American College of Obstetricians and Gynecologists have protocols or standards that some people use," Young says. "When you're looking at a utilization review program, the gold standard or best practice is to use evidence-based guidelines."

These would include guidelines developed from studies that were published and peer-reviewed, she adds.

For example, a utilization reviewer should look at every medical treatment or procedure to compare against the guidelines, ensure they are medically necessary, and were performed in the appropriate setting, Watson explains. The goal is to help the patient progress through the continuum of care to better health.

"In the hospital setting, there are touch points that utilization review should follow with the patient," Young adds. For example, at admission, UR ensures the patient's condition and situation are appropriate for a hospital admission.

Evidence-based guidelines prepare the patient's care path and should match the tests and services ordered from day one. "Also, utilization review helps make sure the patient is appropriate to be discharged and helps to determine where they need to go," Young explains. "When a case manager is doing daily rounds, pull up the guidelines while asking where Mr. Jones is today and whether he has had his chest X-ray." It helps the case management team to use the guidelines to determine any unmet care needs as well.

Another need is for nurses to receive UR training, Watson says. Hands-on training is important, but it would be optimal to combine that with formal UR training provided through a collaboration with health systems and national organizations.

Vendors also should provide training on how to use and interpret evidence-based guidelines and their electronic integration with documentation. "Having efficient and appropriate documentation standards in place will help to drive that type of data-capturing," Young explains. "But more importantly, we should capture the story of what's going on with the patient from start to finish." ■

Target Low-Hanging Fruit in Preventing, Overturning Denials

Prevent breakdown in data exchange

By Melinda Young

Through training and following best practices, case managers and utilization reviewers can prevent and overturn payer denials.

Often, a denial results from omitted information. "It could be the low-hanging fruit of 'We didn't get the data we were needing, so we denied it,'" says **Hemant Gupta**, MD, MSc, lead national physician educator with Sound Physicians in Tacoma, WA.

The easy fix is to send them the missing information. The long-term, preventive answer is to find out why the information was incomplete. "Try to understand that there are many, many hands that cross this pathway," Gupta says. "If it's not a reliable pathway of crossing, the data doesn't get there."

Breakdowns in data exchange between health systems and payers occur when vital parts of the medical record, which were extracted in PDF, faxed, or emailed content, lack essential data.

"Say I had to diagnose a heart attack, but the labs weren't there," Gupta says. In that situation, the payer did not receive the appropriate lab work that documented proof of the heart attack diagnosis.

"Lab information didn't get to the utilization review nurse or doctor, so they didn't approve it," he adds. "This is not about just sharing information or giving electronic medical record access. There are different health systems and different levels of workflow for health information management and case management people."

The long-term solution is to collect information on how often denials occur due to particular issues, such as missing data. For instance, it could be that six times in the past month, data did not reach the right decision-maker, leading to a denial, Gupta explains. "Chalk that up to a complicated pathway and simplify that pathway."

Case managers and those in charge of UR should understand what information each player wants and how best to share data. Preventing denials takes less time and fewer resources than trying to overturn a denial. It is important to know a particular payer needs specific information highlighted in the data submission, or the overworked person receiving the information may miss something important to preventing a denial.

"As you discover documentation holes in the electronic medical record, you should be bringing this issue to the people doing the documenting," Gupta says. "You have to have an expert who knows how to read the record, has clinical knowledge, and who knows what data and criteria they rely on. It can't be just any person."

Ideally, the team should work well enough to meet all time-based deadlines and handle appeals. "Unless you have a dedicated team of people who know what they're doing, that gets to be a very sizable task for a case manager," Gupta says. "They have several daily activities they do in discharge planning, and it gets to be a very burdensome process, unless you have a dedicated team that is capable of handling it at an expert level."

For example, a patient with COPD can be hospitalized under appropriate medical necessity guidelines. A common question is why a COPD patient needs additional medical care on day two or three of the hospital stay. Are these additional hospital days medically necessary? How can the hospital prove it? Where is the documentation?

"For COPD patients, certain lab results are very important to get printed out and documented in the record, and they have to be reported in a certain way," Gupta says.

EXECUTIVE SUMMARY

The keys to preventing and overturning payer denials are to collect data to identify problem areas and to train staff in best practices.

- Missing or hidden lab data could result in a claim denial.
- The case management team should understand the information each payer wants and how best to share those data.
- Spoon-feeding information to payers' utilization review nurse is one good method.

If the essential lab results are buried in 50 pages of lab results, it is like finding a needle in a haystack. "This specific lab [result], if present, can easily be found and could overturn a denial," Gupta says.

The payer's staff review dozens of cases each day and are sifting through volumes of information. It helps if health providers highlight the essential data, making it easier to find. "This can be a very tiring day for a case manager, on the insurance side, and also on the hospital side. You need relevant, critical information to make the right decision," he explains.

It is up to case management/UR leaders to teach staff the relevant and critical pieces of information and how to send this information in a timely manner. If it is done correctly, they will win the case, even if it is denied.

"Many times, you will not get a denial because they found the data they were looking for, such as the amount of CO_2 dissolved in blood of COPD patients and that was elevated beyond a specific amount," Gupta says. "These data are important in a discussion of how sick the patient is and how the patient should be in the hospital instead of being discharged."

When this critical information is missing or buried in documentation, the risk of denial increases. Spoon-feeding information to the payer's UR nurse is a great way to reduce barriers and denials.

"Every time you do that and let the light happen at the end of the tunnel, it gets clearer and clearer," Gupta explains. "You learn case by case." ■

Patient-Centered Care Can Improve Transitions

First step: Listen to patient

By Melinda Young

Patient-centered care is a simple, evidence-based way to improve care transitions and patient outcomes. Hospital case managers can benefit from learning more shared decision-making tactics, a case management leader says.

"Patient-centered care is about putting patients at the center of their plan of care, while they're in the hospital," says **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, senior director, care management nursing at Cleveland (OH) Clinic. "It's not about telling the patient, 'You need home care and you need to follow-up with this doctor.' It's about helping the patient, listening to the patient first, and then discussing what are the patient's goals for this hospitalization and beyond."

Hospital case managers need to look beyond the discharge and the patient's post-acute care transitions. "The nurse case manager and/or social worker needs to look and think, 'What does the patient need after that?'" Davis says. "There is so much more that needs to be taken into consideration."

Case managers can ask:

- Are patients part of the organization's accountable care population?
- Are they part of a narrow network or specific insurance group?
- Are they insured?

"Just look at them as a whole, looking at what they were doing before they came into the hospital, what is their plan going forward after they leave the hospital, and how do we help them," Davis says.

Everyone on the team, from nurses to therapists and case managers, should be in the same mode. Case managers pull everything together and help coordinate care and inform the team about patients' wishes.

"The doctor might say, 'I want the patient to do this, but the case manager needs to be an advocate for the patient," Davis explains. "The case manager should say, 'They really want to go home and don't want to go to another facility, and what can we do as a team to help the patient go home?'"

Here are the steps case managers should take to improve patient-centered care:

- **Conduct a thorough assessment.** It starts with the case management assessment. Case managers should learn about the resources and support the patient might or might not have, Davis says.

An elderly patient may be frail and alone, but if the patient has access to savings, then perhaps he or she could afford to hire in-home help. Or, maybe the person holds a long-term care insurance policy.

"It's up to us to ask those questions and problem-solve with the patient about what might be available to them," Davis says. "Conversely, the patient might say, 'My daughter will help me, and it'll be great.' But if you ask the right questions, you

may find that the daughter lives in another state and calls every day, and that doesn't cut it."

• Discuss safe discharge with patients. It is important to talk with patients about what constitutes a safe discharge.

"Help patients understand what is realistic and what isn't," Davis says. "Sometimes, patients make bad decisions. This is their right. But we build in as much of a safety net as possible."

If a patient does not prove the optimal transition path, it is up to case managers to help make a good handoff to community resources and medical resources so the patient's decision is less likely to result in rehospitalization. Finding community resources during the COVID-19 pandemic has been especially challenging because many resources are more limited or no longer available, Davis says.

• Acknowledge limitations. Sometimes, it is not possible to meet the patient's desired needs and provide the safest possible discharge. "Some patients want to go home, but it's so unsafe, and that can cause real moral distress," Davis explains.

This is when case managers should emphasize to patients they can safely return home if they first spend time in a skilled nursing facility. Or, if the patient still resists transitioning to a nursing home, the case manager can help the patient connect with home health services, Meals on Wheels, and other community-based support.

The sickest patients might ask to go home with just a family member's care. If the case management team does not think this is adequate, they should plan to follow up regularly.

> "SOMETIMES, PATIENTS MAKE BAD DECISIONS. THIS IS THEIR RIGHT. BUT WE BUILD IN AS MUCH OF A SAFETY NET AS POSSIBLE."

"We have sent patients home with medical equipment and a family member who insisted they could handle it," Davis says. "We've all had our doubts about the very sick patient, and we're thinking, 'I don't know how a young, 20-something son will take care of his 50-something mother with all of the things going on with her.'"

But the patient and family insist, so they follow the patient's lead and put everything they can into place. "It really requires having vendors looking at the situation and helping to make decisions about what will work at home in terms of equipment and that kind of thing," Davis explains. "It can be very complex."

• Improve communication. "Usually, social workers are very skilled at having [tough] conversations with patients," Davis says.

It might be up to the team to advocate for a transition that provides services, such as rehabilitation, that the payer turns down. "Often, the case is the family agrees to do acute rehab or have the patient go to a long-term acute care hospital, and the insurance company says, 'No, they're fine to go to a skilled nursing facility,'" Davis says. "But you always advocate for the patient, taking it as far as you can and also taking it to do the appeal, as quickly as possible."

Case managers can ask the physician to schedule a peer-to-peer insurance-physician conversation to discuss making the change. If these efforts fail, the case manager should discuss this with the patient and family.

"Case managers need to understand all of the implications of transitions because they could go down a rabbit hole with the patient if they don't understand medical necessity criteria, Medicare, and compliance rules," Davis says.

For example, patients could use up all of their Medicare acute-care days and find their transition options are limited, so they cannot go to acute rehab or a long-term acute care facility, she says.

"It's important for case managers to keep all of those elements in mind, because otherwise they are not really helping the patient or the team," Davis says. "It's incumbent on us to wear all of these hats, and that's the level of expertise that would set us apart." ■

EXECUTIVE SUMMARY

Hospital case managers can engage in patient-centered care to improve care transitions and help patients meet their personal health and transition goals.

- Case managers should advocate for the patient's transition wishes.
- It also is important to talk clearly with patients about safe discharge.
- If it is not possible for a patient to transition to the facility he or she desires, case managers should explain this honestly, talking about safety and insurance issues.

Ethical Decision-Making for Case Managers

By Jeni Miller

Every day, hospital case managers must make decisions — large and small — that affect the lives of their patients. Some of these are ethical decisions — what the case manager "ought" to do in a given situation. Since many decisions must be made quickly, hospital case managers should consider their ethics and plan ahead rather than reacting solely in the moment.

"Ethics are our moral compass in providing care," says **Lisa Bednarz**, LCSW, ACM-SW, ASW-G, manager of care coordination and social work at NewYork-Presbyterian Hospital. "They provide direction and guidance in morally distressing situations."

Bednarz adds that "medicine is rarely linear," so considering ethics "helps us navigate the inherent ambiguities in the field."

Encountering Ethical Concerns

Since case managers see it all and might be involved in "morally distressing situations," how can they plan to confront difficult decisions head-on? The first consideration is becoming aware of some of the most prominent ethical concerns case managers face daily.

According to **Patty Kalnberg**, LCSW, senior social worker of care coordination and social work at NewYork-Presbyterian Hospital, "Ethical concerns come up most frequently around determining a patient's capacity."

She notes case managers should ask if patients "understand the consequences of their choices, such as refusing a treatment or a recommended discharge plan. There is frequently a tension between safety and self-determination."

Informed consent is an important subtopic that "can also lead to ethical challenges for the treatment team, including the case manager," Kalnberg explains.

Bednarz and Kalnberg also note another common ethical concern for case managers is surrogate decision-making for "patients without advance directives as well as general end-of-life decisions." Similarly, they say, ethical challenges can arise when case managers encounter patients of various cultural backgrounds "who may approach information-sharing and decision-making in different ways."

A final prominent ethical concern involves navigating social issues and ensuring everyone can access healthcare resources equally. "Given the limited healthcare resources in most areas, case managers must ensure open access to care by facilitating efficient delivery of care for all patients," Bednarz says.

Mitigating Ethical Challenges

Case managers should know how the law intersects with their work and decision-making, and understand cultural issues that might affect decisions.

"It is very important to have knowledge of your applicable federal and state laws and general cultural competency," Kalnberg explains. "Every hospital has an ethics committee, and anyone, including patients and families, can request a consult. This likely is the best tool at your disposal. There also are ethical frameworks that you can adopt and apply to your practice."

Hospital ethics committees and social work case managers often use clinical supervision to discuss ethical conflicts. "Nurse case managers can use their direct manager in the same way," Bednarz says.

Either way, case managers should discuss ethical challenges with an interdisciplinary team and pursue peer support. Through discussing difficult ethical dilemmas, they can

create a plan to mitigate potential problems and make the best possible decisions considering the circumstances.

Most importantly, case managers should not bow out of the discussion or be led to believe their perspective is not essential to helping the patient and community. "Case managers have a unique viewpoint: managing the patient as a whole and assessing them in the context of their environment and psychosocial needs," Kalnberg notes. "Patient needs are often greater than 'just' a medical diagnosis or acute illness and may take longer to address."

Another challenge "lies in the society in which we work and live, where our focus on individualism and warranted protection of personal privacy can often unintentionally exclude families and support persons from decision-making and access to information," Kalnberg says. "Finally, the professional requirements of regulatory bodies that focus on safe discharge planning can conflict with patient self-determination."

Developing an Ethical Framework

In addition to regularly checking in with the hospital ethics committee and meeting with an interdisciplinary team, hospital case managers can work to develop their code of ethics through continuing education on the topic. Knowing the plan and referencing it in a moment of ethical conflict can help save time and mental anguish. There is no shortage of resources for training.

Generally speaking, Bednarz shares, each discipline uses its own code of ethics. "For social workers, the National Association of Social Workers has an ethics consultation line for members. Also, many medical schools offer bioethics courses for medical professionals."

Case managers should be proactive when developing an ethical framework, not only for the sake of their patients, but for their own sake. Making difficult, life-changing decisions daily can take a toll on the case manager's mental health if not approached with caution and consideration. Regular education, discussion, and planning are necessary to safeguard case managers as they carry out their important work. ■

Caring for Homeless Adults Through Case Management

By Jeni Miller

As of 2020, more than half a million people were homeless in the United States.[1] When a case manager cares for a patient who has no home or permanent place of residence, the plan can change quickly.

While the general outline of the case management process might stay the same when serving a homeless individual, there are additional items to consider, says **Fred Dyer**, PhD, CADC, executive director of administration for the Hope Recovery Center in Minneapolis.

"From my experience, anywhere from 50% to 75% of individuals present with a co-occurring psychiatric or substance use disorder, which often can lead to homelessness," Dyer shares. "I've observed anywhere from 40% to 60% of people with those disorders who come into the hospital as being homeless and in need of case management."

As case managers carry out their role, they may run into roadblocks if the patient presents with substance use or mental health issues. "Often, [the patient's] mental illness — together with the stigma of homelessness, mental illness, and substance use — can impact the patient's acceptance and/or refusal of services," Dyer explains. "The stigma and shame with all of this is something that the case manager can help the patient work through to be more effective in the case management role."

Linking with Services

One thing that makes case managers more effective than nearly anyone else on the hospital staff is their vast collection of resources and networks.

"Case management is about linkage. [Homeless] individuals lack linkage, access, collaboration, the ability to connect, and an awareness of services," Dyer says. "In terms of someone connecting them or linking them — not just handing them a piece of paper with an agency name, but rather the willingness to walk alongside them or have a supportive adult to go with them — the case manager is that connection point."

Dyer calls this "strength-based case management," which takes place

when the case manager "promotes the use of informal helping networks." Homeless individuals benefit from these networks, as well as "assertive community involvement by a case manager," he adds. "A strength-based case manager knows their patient, their needs, and knows the patient like they know the back of their hand. It's all about the relationship between the patient and the case manager, and connecting the patient with the informal helping networks as part of that relationship."

According to Dyer, case managers should ask these questions: "What's already available that this family or patient might not know about? What haven't they accessed yet? Are there other services that they or their family members have not yet considered? Besides addressing their illnesses, what does this individual need right now?"

As the answers to these questions become clearer, the case management process can take on a more typical shape. "As always, discharge planning begins the day the patient is admitted. That's standard," Dyer explains. "Everything starts with an assessment. As the case manager assesses in multiple areas, they should be thinking in terms of what does this patient need, and what is going on right now? They're homeless. Can we get them linked to something?"

Case managers also can ask these questions:

- What is the patient's financial situation?
- Can we help the patient access entitlement services?
- Does the patient need help accessing a medical card?

Since the patient may only be in the hospital for a few days or a couple of weeks, it is important to complete a thorough assessment as early as possible, "even working to bring family members into play," Dyer adds.

Self-Care When Helping the Homeless

When working with this population, case managers might need to proactively take care of themselves to avoid burnout and compassion fatigue.

> "A STRENGTH-BASED CASE MANAGER KNOWS THEIR PATIENT, THEIR NEEDS, AND KNOWS THE PATIENT LIKE THEY KNOW THE BACK OF THEIR HAND."

"Self-care is crucial," Dyer explains. "Knowing when to back away or say no, having some boundaries, and remembering to take a break before you break — this is all extremely important. Even if you have to say to a discharged patient, 'At some juncture, I'm going to leave you instructions, and in an emergency you can call 911 or go to the nearest hospital. Those boundaries are crucial."

According to Dyer, some case managers have reported their hospital allows a patient to contact them "after hours," even at home. To avoid at-home calls, he emphasizes case managers should "reassure patients, face to face, of the plan and where they can go for help."

Other self-care for case managers include staying in close contact with supervisors throughout the process of caring for homeless individuals, especially those with substance use issues or mental illness. Some of the responsibility for this is on the supervisors.

"Whoever the supervisor is, the case manager needs to know that their door is always open," Dyer recommends. "Supervisors should conduct midweek check-ins with every case manager, asking, 'Is there anything I can do to help right now?' Case managers need to know that it's OK to ask for help, and they should receive the supervision and direction they need. Sometimes, case managers are reluctant to say 'no' for fear of losing their job, and oftentimes have persuaded themselves that they can handle more than what's possible. They set themselves up for burnout."

Dyer suggests case managers — who often are overloaded — ask if they can take on an assistant or carry a smaller caseload when they are working with homeless individuals who may need more care than other patients.

Another self-care consideration is managing the task of working to understand the issues surrounding homelessness and poverty, and the trauma that often is present both for the homeless individual and anyone serving as his or her caregiver. Research and reading certainly hold a place in gaining understanding, but so does talking with patients to better understand their situations.

However, Dyer shares a word of caution for case managers who diligently listen to their patients: "As they listen to how and why [the patient] became homeless, case managers can experience a sort of secondary compassion fatigue. Hearing all the stories, they may feel like they never get a chance to breathe. They need to remember to

take a deep breath, exhale, process, and discuss how this impacts them; otherwise, they can develop secondary traumatic symptoms."

Clarity of Purpose

Dyer reiterates hospital case management is not for everyone. Encountering homelessness and helping the patient out of his or her vulnerable situation carries much responsibility. Many nurses, social workers, and others entered case management to help people, but that mission can too easily become lost in the shuffle. In some situations, the overwhelming caseload or weight of the issues that plague their patients can feel like too much.

"Sometimes, the case manager may say to themselves, 'I didn't sign up for this … I have an MSW, I'm a therapist, I'm a nurse. I didn't sign up to see if someone has a bus card or if they have Meals on Wheels,'" Dyer says.

He notes case managers should truly consider their mission and "be really clear in terms of their purpose in being a case manager."

"What's driving them?" he suggests asking. "Are they just going to a job, providing services? Or is there something that intrinsically happens to them as they see people getting better, or observing them moving on and getting their needs met or getting back to normal? Case managers should ask whether they are still intrinsically motivated or if they've allowed external forces to dull their star."

A patient population like homeless adults can require more mental and emotional energy than other patients, and especially call for more introspection on the part of the case manager. For this reason, Dyer says, it is even more important for case managers to be "aligned with their mission and purpose in life, because if they're not aligned with that, then they won't be able to give it their all. When this happens, it's to the detriment of the patient."

Speaking with a mentor or trusted supervisor regularly can help keep the case manager aligned with his or her mission and purpose to better serve homeless patients and others in their care. ■

REFERENCE

1. Statista. Estimated number of homeless people in the United States from 2007 to 2020. March 23, 2021. https://bit.ly/2Qsg9T3

Best Practices for Amputation Recovery

By Jeni Miller

Case managers make a difference in the lives of their patients, even when patients are only in the hospital briefly. This is especially true when a patient is undergoing a life-changing or traumatic event, like limb amputation.

According to the Amputee Coalition, most amputations are due to vascular diseases like diabetes, followed closely by trauma and, less frequently, cancer. More than 2 million people in the United States are living with limb loss, with approximately 185,000 amputations occurring each year. The likelihood of a hospital case manager encountering these patients is quite high. *(More information is available at this link: https://bit.ly/3xgPWHN.)*

"Although these patients typically have other health issues, they are often in and out of the hospital within three to 10 days," says **Ryan Butler**, MS, CPO, clinical director at Nextremity Prosthetic Design LLC. "The case manager will only see them for about a week and then they are discharged."

During that time, explains Butler, the case manager plays a big role in helping to stabilize, plan where to send the patient next, and what resources are needed. Metropolitan areas usually have more resources for the patient while rural settings may have fewer options available. Connecting with the community and compiling a comprehensive resource portfolio for amputations can make a significant difference for the patient.

But even more importantly, case managers can help guide the patient on what to expect during recovery and after. In some cases, they might be the only person who can help a vulnerable patient find help for a successful and less traumatic experience.

"One problem is that patients can go through the amputation and yet not have a lot of information about the process and what happens next," Butler notes. "Understandably, the surgeons are concerned with the surgery, but not typically as much about prosthetics. Knowing what to expect in the first eight weeks is crucial."

After surgery, it is common for surgeons to place a post-op protector on a patient's limb, but some surgeons do not. For this reason, case managers should begin the process of connecting the patient with a prosthetic provider as early as possible, or even call a prosthetic provider to meet with the patient before surgery. However, case managers should look at the big picture to prevent miscommunication throughout the process.

"Some groups do fantastic," Butler explains. "A team mentality is so important, especially because there is often a big team at work for amputations. With so many people involved, communication may be OK, but not great. Sometimes, there is no one overseeing the whole process, and the patient unfortunately ends up with two providers of prosthetics due to miscommunication — or no provider at all."

When connecting the patient with a provider, Butler recommends case managers seek a prosthetic provider that consults more with the patient and takes the time to get to know him or her.

"Since the patient is often only in the hospital for a week, that's just the beginning of their journey," Butler says. "In an ideal world, prosthetic providers would work side by side with case managers to help with some of those initial conversations. Because of the nature of building a prosthesis, our visits are not just 15 minutes long, but often are a couple of hours because we get to know the patients quite well."

According to a survey from the Amputee Coalition of America, nearly 30% of amputees reported experiencing depression, especially if the amputation happened because of trauma. Younger people were more likely to experience depression than those aged 65 years and older. *(More information is available at this link: https://bit.ly/2PjlUSI.)*

Butler recommends connecting patients with the Amputee Coalition's peer visitor program to help amputees work through their grief.

"When you lose a limb, it's like losing a family member. It can be quite challenging," he says. "Talking with someone who has been there before — and having a case manager who is looking out for the patient's psychosocial well-being — can help. Taking care of a patient is much more important than just replacing a limb."

Part of the patient's mental health status also can be related to pain. While there is pain involved in the surgery and recovery process, the prosthetic device itself should not cause pain.

"The world of prosthetics is constantly changing, but the more modern prosthetic devices we make should not be painful or uncomfortable to walk with," Butler notes. "Years ago, people were putting up with a lot more. These days, if it's painful, something is wrong."

Perhaps the most significant area where case managers can make a difference for their amputee patients is mental health, which typically gets the least attention. However, it is important to remember that "often, the patient population that got into this situation is due to poor choices like not monitoring blood sugar or ulcers, not eating right, and then an amputation results," Butler notes.

This problem, Butler explains, combined with the biggest measure of success — patient attitude — means case managers can be "significantly helpful in guiding a patient in the right direction with wellness and attitude."

It is a "tricky problem to address," he says. But "case managers may be the first and best to bring up this conversation since they are well-versed in asking the right questions, and even the tough questions."

Patients also might ask case managers: "When will I walk again? How well will I walk again?"

"Case managers should know the answers to these questions," Butler explains. "For the patient, it often depends on how well they were walking prior to surgery, so the case manager can share that they might expect to return to that point. If they were walking with a walker, they will probably still use a walker following their surgery."

Butler notes below-the-knee amputations typically result in better outcomes than above-the-knee, but case managers should be prepared to share with their patients the more realistic expectation that it will take six weeks to three months before they will walk comfortably with a prosthesis. Even then, their success can depend on their fitness level.

Case managers should see the amputation patient as a whole person, caring for every aspect of their well-being and helping him or her achieve the best possible quality of life. ■

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HOSPITAL
CASE MANAGEMENT

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CE QUESTIONS

1. **The term "medical necessity" is the cornerstone of utilization review. Where did this term originate, according to researcher Cynthia Young, BSN, MBA, RN, CMP?**

   a. The Social Security Act Amendments of 1965
   b. The Healthcare Quality Improvement Act of 1986
   c. The Health Insurance Portability and Accountability Act of 1996
   d. The Affordable Care Act of 2010

2. **Approximately how many amputations occur in the United States each year?**

   a. 30,000
   b. 78,000
   c. 185,000
   d. 350,000

3. **What is a good long-term solution to reducing payer denials, according to Hemant Gupta, MD, MSc?**

   a. To train the case management team to quickly find data that could result in a denial reversal
   b. To ask physicians to send a case note for each difficult medical situation
   c. For utilization review staff to evaluate documentation for holes in medical necessity information
   d. To collect information on how often denials occur due to particular issues, such as missing data

4. **Which is one of the greatest challenges amputee patients face?**

   a. Depression
   b. Financial issues
   c. Job loss
   d. Finding physical therapy

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

A Tribute to a Case Management Pioneer: Karen Zander

By Toni Cesta, PhD, RN, FAAN

In August 2020, we lost Karen Zander, one of the true pioneers in hospital case management. Karen's name is synonymous with acute care case management. She spent a large part of her professional career advancing case management roles, models, and the measurement of case management outcomes. Karen was a contemporary of mine. My introduction to case management came in 1988, hers in 1985. That may not seem that long ago, but 1985 started the clock for case management in its movement from the community into hospitals. Karen is one of the main people who wound the clock. It is no surprise that her passing has made me think a lot about those early days and the difficulties she, and many of us, experienced. I believe that to understand where we are going, we need to understand where we have been. I would like to share the journey that brought us to this place in time in case management.

In 1985, the Centers for Medicare & Medicaid Services (CMS) introduced prospective payment and diagnosis-related groups (DRGs) to healthcare as a new reimbursement scheme for managing cost and length of stay. Before, there was no process for controlling either cost or length of stay. In fact, hospitals received more reimbursement if they used more resources on a patient and kept the patient in the hospital for longer periods. This was not meant to cheat the system. It was true in the 1980s that the use and availability of post-acute care were limited. It was general practice to allow patients to fully recover before they were discharged from the hospital. The bright light of healthcare shined on the hospital. Care began and ended there.

This was all well and good, but hospital care is expensive, and costs continued to rise. In addition, patients developed complications or experienced errors and falls while they were in the hospital for protracted periods. The thought of shortening length of stay required an entire paradigm shift for hospitals and healthcare systems.

THIS MANAGED CARE WAS OUTCOME-ORIENTED, PATIENT-BASED, SET IN A PARTICULAR TIME FRAME, AND FOCUSED ON THE APPROPRIATE USE OF RESOURCES FOR BOTH INPATIENTS AND OUTPATIENTS.

Then came case management. Long known as a community model in psychiatry and social work, the questions were simple: Could the principles of case management be applied to the acute care setting? Would it work? What would it look like?

When it is said that part of a person's success is being in the right place at the right time, I think this is true for Karen. She was working at New England Medical Center (NEMC) in Boston. NEMC wanted to try a new model to manage costs and length of stay, deciding a nurse-driven approach would be best. The model was called the Primary Nurse Case Management Model. This early model was based on the concepts of managed care. This managed care was outcome-oriented, patient-based, set in a particular time frame, and focused on the appropriate use of resources for both inpatients and outpatients. The case managers, who primarily were registered nurses, also provided direct patient care while the patients were on their units. Once the patient was transferred, the case managers coordinated the care of these patients throughout the stay, regardless of the unit. Care was coordinated through collaborative group

practice arrangements, using DRGs to identify the appropriate length of stay and critical pathways.

In hindsight, we can see the many flaws with this model. Despite these flaws, this was one of the first strategies a hospital used to manage costs and lengths of stay using RNs. It opened the door for many revisions and adaptations over the years as healthcare reimbursement changed, costs continued to rise, and lengths of stay shortened.

The original concept of direct patient care integrated with care coordination did not include some of the roles we consider fundamental to today's models. In fact, Karen added these roles, evolving her model over time. She started with what we think of today as a "purest" model, one in which RNs are clinically focused and not involved with the business side of healthcare. Discharge planning remained with social workers. Eventually, she added utilization review and discharge planning, and removed direct patient care. This transition was critical in the integration of roles that had been disconnected from each other. This disconnect had added to costs and lengths of stay.

As with any pioneer, Karen's success was in experimenting and revising as more information was gathered and outcomes were measured.

Critical Pathways

Karen pioneered critical pathways. These tools were adapted from engineering pathways developed to outline the critical, activities needed to complete a project within certain time frames. A delay in one task could potentially delay the entire project. Each team member's responsibilities in the completion of these tasks is clearly demarcated.

A simple example of building a house can explain the concept. First, cement makers must pour the foundation Then, carpenters must erect the frame. The electrician must wire the house, and the plumber must install the pipes and fixtures. Each activity must be completed within a certain time frame so as not to slow down the next worker in the process. It is simple but describes the logic of critical pathways.

Unfortunately, engineering and healthcare delivery have some fundamental differences. Patients bring a lot of variation, as do physicians and ancillary departments. It is difficult to stay on a straight path without deviation every day. Because of the variation in managing clinical care processes, the need to understand variation from the critical pathways became important. Monitoring variation became the next need in the process. Variances identified delays in care progression and fell into multiple categories that were like avoidable delays today, and became strategically linked to the critical pathways.

The table on page 3 is an early example of a critical pathway for uncomplicated myocardial infarction (MI). Please note the length of stay is much longer than today, and care progression is much slower. The first four days are included, but the expected length of stay is eight days. Because the case manager also was the bedside nurse, there is a lot of focus on nursing interventions and outcomes. This would evolve into multidisciplinary interventions and outcomes as the tool matured.

Note the excessive use of resources on an uncomplicated MI patient, including such interventions as cardiac rehab, a cardiac cath on day 3, and so on. It is interesting to see how things have improved over the last 30 years. Also note the discharge planning process — quite slow and performed twice a week.

Imagine trying to follow a tool like this on paper and without a computer, telling doctors they had to shorten lengths of stay and use fewer resources. Try tracking, collating, and analyzing variances on paper. I actually did all these things. It was time-consuming and minimally productive. In fact, at times, it felt like pushing a boulder uphill. Managed care was not prolific, and doctors believed any controls over resource use was an invasion of the physician/client relationship. They did not want their orders questioned, and made that quite clear. It took many years before the notion of managing length of stay and cost of care would take hold and become part of the daily vernacular in healthcare.

Part of that change in the physician practice patterns was attributed to the managed care penetration that took off in the early 1990s. This was the first time physicians were truly responsible for their resource consumption, as managed care organizations added a new layer of review to the requirement that patients meet medical necessity every day, and that cost of care was controlled.

It was around 1988, the time of the early critical pathways, that I met Karen. By then, she was known in the case management arena for her early work on critical pathways and was sought for her expertise. Many of us focused more on the pathways Karen developed than the case management model she had implemented at NEMC. They seemed like an excellent tool for those early acute care case management programs that were popping up across the country.

At that time, I was hired to direct a research study in New York City. The United Hospital Fund, a philanthropic organization, awarded

Critical Pathway for Uncomplicated Myocardial Infarction				
	Day 1: ED	**Day 2: CCU**	**Day 3**	**Day 4: Transfer to Medical Floor**
Consults			Cardiac rehab PT and OT	→
Tests	CBC ECG Electrolytes Cardiac enzymes Glucose BUN & creatinine Chest X-ray	CCU Assess enzymes Chem profile	ECG Electrolytes in a.m.	
Activity	Bed rest	→	Bedrest with commode PRN	Up in chair and progress Progression of self-care ADLs
Treatments	IV KVO Vital signs q 15 min	Daily weights Input and output VS q 4h and PRN	Heparin lock	VS q 8h
Medications	Nitrates, O_2 2-4 L Analgesics Lidocaine	→ Stool softener Beta-blockers Calcium channel blockers	O_2 PRN	→
Diet		Low cholesterol	→	
Discharge Planning	Begin ED evaluation	Complete intake assessment Assess home environment	Mutual goal setting IP and OP plans of care Multidisciplinary staffing twice a week Inpatient cardiac rehab	
Key Nursing Interventions	Orientation Assess and monitor Patient education	Orientation Assess pain Position for comfort Assess and monitor	Position for comfort Patient booklet given Orientation to TV channels Medication instructions Risk factor instructions	Assess patient readiness to learn Instruct on goal setting Stress management
Key Outcomes	Patient verbalizes pain; fears and anxiety; reason for hospitalization	Patient demonstrates use of call light Patient's behavior indicates pain reduction Patient verbalizes feeling less pain	Patient verbalizes understanding of diagnosis Patient voices concerns, if any Patient watches educational TV	Patient behavior shows progress toward acceptance of diagnosis Patient identifies learning needs Patient verbalizes own risk factors

CBC: complete blood count; CCU: critical care unit; IP: inpatient; KVO: keep vein open; OT: occupational therapy; OP: outpatient; PT: physical therapy

five hospitals with grants to try new care delivery models. How forward-thinking they were. They were seeking innovative models to control costs and lengths of stay, as well as improve patient and provider satisfaction. I became the project lead for the study at the Long Island Jewish Medical Center (now part of Northwell Health). Working under the vice president of nursing, we developed a model we thought might work to achieve these goals. This model did not use bedside nurses, but created a new role that we called the case manager. They managed the clinical care processes, but did not work on discharge planning or utilization review. I read everything I could about these topics and found Karen's work as well as the work at Carondelet St. Mary's Hospital in Tucson. As far as I am concerned, these nursing-led initiatives were the two case management models producing the most groundbreaking work at the time. Neither model is recognizable today.

I asked Karen to come to Long Island Jewish and present her critical pathways to our team of physicians, nurses, and administrators. We launched our new model on seven pilot units, and outcomes already were happening. Could the critical pathways bring us even further? Karen spent several hours explaining her work to the team. Even the physicians were intrigued by these novel ideas. I bought several of her early pathways, and we were off and running. As the grant proceeded, we adapted and modified them to our team's liking.

Changing Times

I remember feeling amazed with Karen's forward-thinking approach and her ability to make sense of it. The late 1980s and early 1990s were an exciting time in case management. Karen left NEMC and started her own consulting company. Her experiences as a consultant helped shape and form newer case management models.

While I stayed in the acute care setting and moved up from director to vice president to senior vice president, I also began refining and testing these early models. It was clear these methods worked, but it was hard to convince senior executives. Implementing these models required additional personnel. New departments had to be formed, and budgets created. A return on investment usually was necessary to convince leadership that case management was an intervention that could positively affect their bottom line in terms of quality and financial outcomes.

Right now, readers might be thinking not much has changed. In some ways, this is true. The struggle continued for a long time, and continues today in some organizations. Case management has been slow to standardize models, staffing ratios, and outcomes. This has added to the confusion as to its effectiveness and value. The introduction of bundled payments and other advanced payment models has helped bring case management into the limelight, but it remains a struggle. Community-based models are starting to emerge, but we are not quite there yet.

Looking Forward

Among the many struggles we still face, some good things have emerged. Many organizations have embraced case management, and some even staff their departments appropriately. Case managers are highly trained and can contribute to positive outcomes for their departments and their organizations. These positive trends help me feel proud of the work that Karen, I, and other early pioneers did and continue to do. In my own case management journey, I have been fortunate to meet professionals from Alaska to Florida, from California to Massachusetts. I have even traveled to South America, Europe, and Asia, bringing these ideas and concepts to other countries trying to implement similar programs.

The field of case management will miss Karen. So many of us will remember her fondly. Her spirit, her humor, and her apparent joy in her work always was obvious and will not be forgotten. ■