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Covering Case Management Across The Entire Care Continuum

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Going solo has challenges, but many rewards

Opportunities abound for independent CMs

If you're tired of the same routine, dealing with your organization's bureaucracy and policies and procedures, and being just another employee who has to take the cases your supervisor gives you, it might be time to look into starting your own case management business as a solo practitioner.

It's not an easy decision to move from working for someone else to working for yourself, but it's incredibly rewarding, says **LuRae Ahrendt**, RN, CRRN, CCM, nurse consultant at Ahrendt Rehabilitation in Norcross, GA. Ahrendt specializes in life care planning and case management.

The real advantage is that you can choose the cases you take, rather than having someone assign them, she says. "As case managers become more successful, they can turn down clients if they don't think they will be a fit," she says.

Independent case managers can focus on what they like to do and create their own schedule, fitting it in with their other commitments, adds **BK Kizziar**, RN, CCM, CLCP, owner of BK & Associates, a case management consulting firm based in Southlake, TX.

The time has come for independent case managers, says **Brenda Keeling**, RN, CPHQ, CCM, president of Patient Response, Inc., a Durant, OK, healthcare consulting firm specializing in regulations and compliance.

"When I started my business in 1995, people really didn't know what case management was. Now independent case managers have a world of opportunities. The healthcare industry realizes what case managers do and they clearly understand that it's an important role," she says.

Today's healthcare environment creates extraordinary opportunities for case managers who want to become independent case managers or direct-to-consumer case managers," adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm.

Independent case managers contract their services to organizations and individuals seeking them, Mullahy explains. Their services might include

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working directly with injured employees or claimants, acting as a consultant to a physician practice group or an employer organization, contracting with healthcare providers to design programs, or providing private case management directly to patients and therefore contracting with the patient or family members.

Case managers who restrict themselves to direct-to-consumer case management market their services directly to the community and are paid by the patient or family, rather than a third-party payer. Services may include coordinating care for a child, an aging parent, or a spouse with a complex medical condition.

After years of urging by the Case Management Society of America (CMSA), the Centers for Medicare & Medicaid Services (CMS) has created CPT codes for physicians to provide transitions of care, including contacting patients after they are discharged from the hospital, Kizziar points out. "The hospital case managers will alert physicians when their patients are discharged from the hospital and physicians are going to be responsible for contacting patients and working to ensure that the discharge plan is successful," she says.

The CMS regulations don't specify that a nurse should make the calls, but it still represents a tremendous opportunity for case managers to develop agreements with physician practices to track patients in the hospital and follow up after discharge, Kizziar says.

Families are beginning to understand the value of case management when they need help navigating the healthcare system and identifying resources and funding for loved ones with complex care needs, Ahrendt adds. "There's an increasing need for geriatric case management with the graying of the population, especially in the area of aging with disabilities," she adds.

Some case managers who become independent are outsourcing to hospitals to provide case management services on an as-needed basis, Keeling says. "They sign up independently or with an agency that handles PRN nurses," she says. Hospitals call a PRN (per diem nurse) to work as needed to fill in when the nurse employed by the hospital is sick or on vacation.

Case managers have the opportunity to provide services to individuals, companies, physician practices, or even contract with hospitals to perform their post-discharge follow up, Kizziar says. One possibility is to contract with employers to guide employees through the process of choosing insurance coverage.

Ahrendt points out that case managers also have opportunities in long-term care, disability, Medicaid, and other roles created from healthcare reform.

While there are opportunities, don't expect to find one single stream of referral sources that is sufficient for a comprehensive practice, Ahrendt advises. Develop a vision for your business in one year, five years, and ten years and proceed that way. Develop a good referral network.

"In these economic times, case managers are well advised to look at a broad area of practice and expand their opportunities by matching their skills with the products the market desires," Ahrendt says. For instance, in addition to case management, consider file review or legal nurse work.

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Do a lot of research into what the market is in your area to make sure there is a need for the kind of services you want to offer, Kizziar says.

Be willing to do many different things, she says. In the beginning of her practice, she became a certified Life Care Planner because there was work available in that area.

She did a lot of work with workers compensation and insurance companies as well. For instance, she was hired by a liability insurer for a restaurant chain to manage the care of a woman who slipped on a green bean at a salad bar and broke her hip. "The insurer wanted to make sure the woman got the care she needed and was so pleased with the company's response that she didn't file a lawsuit," she says.

Today, case managers have numerous opportunities to work as independent contractors, Kizziar says.

She now speaks at conferences, contracts with other independent case managers to cover their practices when they are sick or on vacation, and sometimes takes an interim position as a case management director for a hospital while the administration searches for a permanent director.

It took three tries for Brenda Keeling to find a market for her services that would pay the bills. She started out providing case management to individuals and families.

"I wanted to be able to work out of my home and choose my own schedule. I live in rural Oklahoma and wanted to provide a service for people who didn't have the option of having someone to help them navigate the healthcare system and identify resources," Keeling says.

The only problem was that while she had no shortage of people who wanted her services, she didn't have a way to get paid. "There was no payer source at the time and many people needed help with paying their bills, so they couldn't pay me," she says.

For a while, Keeling reviewed legal cases but found that many law firms had full-time staff to review medical cases and she wasn't making enough money to cover her living expenses.

Option three was a success. Keeling had experience in regulations and compliance as an employee of Oklahoma's Quality Improvement Organization. At the same time, hospitals were beginning to need help with compliance issues.

Keeling contracts with hospitals who are facing a Joint Commission survey or who need help avoiding denials from the Recovery Auditors or through CMS' readmission reduction and value-based purchasing programs.

"Now with value-based purchasing, the readmission reduction program, core measures, and other CMS initiatives, there's a demand for my case management experience as well as my regulatory experience," she says.

Keeling speaks on the national circuit and advises other case managers to persevere and stay the course through the rough times.

"It took a while to find my niche. It was always there but I didn't appreciate the expertise I had to share," she says. ■

Know the challenges before going solo

Be prepared for the business side

It's great to be on your own, make your own schedule, and do the work you love, but there are a lot of challenges associated with starting and maintaining a business as an independent case manager.

"People in healthcare are driven to provide a clinical product, but they are not as attuned to the business end of it. When other people were taking business courses, nurses were taking science. We aren't prepared for the grueling business side of practice," says **LuRae Ahrendt**, RN, CRRN, CCM, nurse consultant at Ahrendt Rehabilitation in Norcross, GA.

When you start a business as an independent case manager, you have the responsibility of handling all the business paperwork — reports, bills, tax forms.

"You can do the best work in the world but if you don't bill for it, it doesn't matter. You have to handle the paperwork and billing to keep your company alive," Ahrendt adds.

In addition to having the experience and confidence to take on big problems, solo practitioners also need to be willing to do the menial tasks, such as paperwork, billing, and filing, as well, adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY case management consulting firm.

Understand at the onset that if you don't work, you don't get paid, and you can't work if you're sick or on vacation, Ahrendt says. Self-employed case managers get no paid vacation or sick time and no benefits. You have to pay for your own health insurance, office supplies, office rental, business equipment, such as computers needed for the job, insurance, accounting and legal fees, and marketing costs.

In the beginning, expect your income to vary, depending on the workload. "I've found that it

seems to be feast or famine. I'm either so busy I wonder if I can get it all done or have nothing on the books," adds **BK Kizziar**, RN, CCM, CLCP, owner of BK & Associates, a case management consulting firm based in Southlake, TX.

She advises case managers to start out with a nest egg that represents what you anticipate you will need to live on for several months and keep that much in savings as you go along for those months when you don't have enough business to cover your bills.

When you analyze what income you will need to cover your bills when you're self employed, include the cost of health insurance and malpractice insurance as well as your household and living expenses. Look at what you'll need to practice, such as whether you have the kind of computer and software you need. If you are going to be traveling or visiting patient homes, make sure you have a reliable automobile and that you have the type of auto insurance you need.

Case managers have to negotiate contracts with individuals or companies with whom they do business, Kizziar says. When you do so, be sure you tally up your potential expenses and include that in your proposed contract along with the payment for your services. For instance, she's talking to a hospital in another state that is seeking an interim case management director for a 90-day period. "I'm asking for room and board and airfare so I can go home for a long weekend every three weeks," she says.

"Before starting their business, case managers need to identify a good attorney, a good accountant, and a good banker," says **Brenda Keeling**, RN, CPHQ, CCM, president of Patient Response, Inc., a Durant, OK, healthcare consulting firm specializing in regulations and compliance.

Independent case managers should incorporate to protect themselves from liability and choosing the right attorney is essential, but you also need an accountant to advise you about what kind of corporation will be most beneficial from a tax standpoint, she adds.

A lack of financial security is the biggest obstacle that prevents case managers from going out on their own, Mullahy says. "In an insecure economic environment, there really are problems from moving away from an employee role with a defined salary, health benefits, paid sick time, and vacation time to a situation where none of that is a given and cash flow is likely to be uneven," Mullahy says.

Social isolation may be a problem for independent case managers, Mullahy says. "There aren't any colleagues who are just steps away or in a nearby office to brainstorm with on complex problems," she says.

Entrepreneurship isn't for everyone, Ahrendt says. "There are aspects about being an independent case manager that are very attractive, but most individuals don't understand all that is involved until they get into it," she says.

To successfully become independent practitioners, case managers need to have an entrepreneurial spirit and a commitment to the job, Ahrendt says.

Case managers who want to venture out as solo practitioners need to have diverse and extensive experience both in their own profession (nurse or social worker) as well as experience as a case manager, Mullahy says. Ideally, case managers who want to work on their own should achieve certification, she says.

"In addition to professional and case management experience, independent case managers should have life experience and business savvy, have an understanding of the needs of the market, and be able to position themselves to meet those needs," Mullahy says.

"Find your niche and decide how hard you want to work," Kizziar says. "Some independent case managers work for a living. Others do the work to stay busy."

Finding your niche is important, but you need to be able to supplement with what pays the bills, she says. ■

Even if you build it, they may not come

Marketing is essential to success in business

It's not just enough to be a terrific case manager. To become a solo practitioner, you also need to be able to market yourself.

If you expect others just to knock on your door as soon as you start a solo practice, your business is doomed before you start.

"Case managers need to be able to tell the story of what they do, what they provide, and how they may be different from the competition," says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY case management consulting firm.

In some business areas that are beyond their expertise, some case managers may seek professional assistance. "One strategically important area may be

marketing but it comes with a price tag. There are more cost-effective ways to market yourself," she says.

Joining community organizations and serving on task forces and committees are other ways to market yourself, Mullahy adds.

Volunteer to author a column for a newsletter or your local newspaper and network with colleagues, business leaders, and those you have known in other settings, such as the PTA, church groups, and volunteer organizations, Mullahy suggests.

Offer yourself as a free speaker and share your expertise with potential clients, **BK Kizziar**, RN, CCM, CLCP, owner of BK & Associates, a case management consulting firm based in Southlake, TX, suggests. "When you offer free advice, there's often a reward on the other end," she says.

Kizziar offers a free presentation on managing the maze of healthcare to civic clubs and companies. She recently was asked by a bank to make the presentation to a group of retirees and has gotten calls asking about her services from members of the audience.

Case managers need to figure out where their niche can be, based on their area of specialty and their interests, Kizziar says.

Then, research the opportunities in your area, and contact the decision-makers in the segment you want to contract with and explain how your services can enhance their lives, Kizziar says.

A friend of Kizziar's put advertisements in community magazines in the northern states and offered to check on parents who live in the South. "She started an entire practice contracting with adult children to make sure their parents who retire to the South get the care and services they need," she says.

Nancy Polites, LCSW, C-ASWC, a partner in Elder Care Service, a case management firm for seniors, says that many of her South Florida clients find her on her Internet site.

"I highly recommend the Internet as a source for referrals, particularly if you're hired by the children of senior people who live in another state," she says.

In addition to consulting with hospitals, Kizziar also has a private case load, primarily of older adults, whom she works with over the telephone when they have questions about their insurance coverage and what it should pay. All come to her by word-of-mouth referrals.

She worked with one client's husband 10 years ago when she was under contract with a long-term care insurance company to develop a care coordination program and was mentoring the care coordinator who was working with him. "A year later after her husband died, the woman contacted me and asked me to perform the same services for her. She's gone from being totally independent to living independently in a retirement home to assisted living and now is in a nursing center," Kizziar says.

In the beginning, case managers need to be able to market their services, says **LuRae Ahrendt**, RN, CRRN, CCM, nurse consultant at Ahrendt Rehabilitation in Norcross, GA. "Once an independent case manager becomes known for his or her expertise and high standards, the individual and their name speaks for itself," she says. ■

Success means doing the right thing

Know the rules and follow them

To make a go of it as an independent practitioner, case managers must have a strong desire to do the job, know the rules and regulations involved in their profession, stand firm and resist the pressure to veer from doing things the right way, says **Brenda Keeling**, RN, CPHQ, CCM, president of Patient Response, Inc., a Durant, OK, healthcare consulting firm specializing in regulations and compliance.

It's not a matter of keeping people happy. It's a matter of doing the right thing for the patient, following the rules, and ensuring that your clients do the same. "A lot of times, hospital administrators don't like what I tell them, but when I show them the regulations and the numbers, they know I am right," she says.

For instance, hospital finance people point out that if only people who meet admissions criteria are admitted, the census will drop. In those cases, Keeling tells them of a young patient who was admitted for treatment for asthma after having only one breathing treatment in the emergency department. Evidence-based medicine recommends three treatments, and that is a standard requirement of payers. "The stay was denied, the hospital billed the family $40,000, and they ended up in bankruptcy court. Ignoring admissions criteria was financially devastating for the patient's family and the facility didn't get paid," she says.

When case managers care about doing the right thing for the patients, referrals will follow, she says.

If you consistently demonstrate a quality, ethical work product and are committed and passionate about the best outcomes, people will trust you and recommend you, says **LuRae Ahrendt**, RN, CRRN,

CCM, nurse consultant at Ahrendt Rehabilitation in Norcross, GA.

"The world of case management is pretty small, and individuals can't afford not to act in a high quality, ethical manner because people will know. You've got to be committed to your client's best outcome every time," she says. ■

Malpractice insurance is essential part of business

It protects you in case you're sued

Independent case managers should purchase malpractice insurance to protect themselves from possible legal action if the patients whose care they manage experience an adverse outcome, says **Elizabeth Hogue**, Esq., a Washington, DC, attorney specializing in healthcare issues.

"Our society is not getting any less litigious, and there is no doubt in my mind that case managers may be included in lawsuits if the plan of care they develop doesn't meet the patient's needs, is incomplete, or if the patient is referred to a provider that cannot provide appropriate care," she says.

If there is a lawsuit filed on behalf of a patient with whom you were involved, expect to be included, Hogue says. "Attorneys are trained to include everyone who sees the patient in any malpractice lawsuits they file. Their point of view is that they won't know who is responsible for the injuries or damages the patient received until they sort it out later during discovery. For the sake of risk management, they can't afford to overlook someone, and that means that case managers are going to be included," Hogue says.

If you are included in a lawsuit, your insurer will assign legal counsel who is solidly in your corner, Hogue says.

Malpractice insurance is relatively inexpensive and is readily available through professional associations at a reasonable cost, Hogue says. "Malpractice insurance is not so expensive that it's prohibitive, and the potential benefits far outweigh the costs," she says.

Self-employed case managers may not think of themselves as having deep pockets, but they do have assets that should be protected, Hogue says. The only way to ensure protection of these assets is to purchase and maintain your own insurance policy, she adds.

"It is untrue that if you have your own malpractice coverage you are more likely to be sued. In most cases, patients and their families have no way of obtaining information about whether or not you have malpractice insurance before they file lawsuits," Hogue says.

Even after a lawsuit is filed, rules governing discovery may prohibit attorneys for patients and families from getting information about whether you have malpractice insurance, and if so, the amount of coverage, she adds. ■

CM provides services to senior citizens

Contracts are with family members

Nancy Polites, LCSW, C-ASWCM, worked as a social worker for a home health agency, a hospital, and a hospice service before starting Elder Care Service, a case management service for seniors in 2007 with a colleague while she was living in California.

Polites moved to south Florida in 2008 and now provides case management services to elderly clients in Palm Beach and South Martin counties.

Much of Polites' business comes from family members who live in the North and have parents in south Florida who need care. She works with people who spend the winter in south Florida as well as those who live there permanently. "I get calls from people whose parents are in the area for the winter and they want someone to check on them and provide whatever assistance they need," she says.

She provides an array of services that include managing physician and dentist appointments and accompanying patients if needed, assisting with relocation if seniors need to move to a different level of care, responding with crisis interventions when needed, assisting with transportation, running errands, paying bills, and helping with legal documents such as advance directives and long-term care insurance issues.

When people contact her, Polites spends a long time on the telephone describing her services in detail, and if they want to proceed, sends them an agreement. Sometimes the patient pays for her services. Other times, the family pays.

When she's under contract, she visits the patient, preferably when a family member is present, and spends an hour and a half assessing the living situation and looking for safety issues, like throw rugs and electrical cords snaking across the floor.

She checks the cabinets and refrigerator

and performs a full nutritional and medication assessment, then writes a lengthy report detailing her findings and recommendations and sends it to the family as well as the patient.

Polites checks on clients whenever needed, helps coordinate their health care, and does tasks like picking up prescriptions or adult diapers when the senior needs them.

Polites doesn't charge for the initial calls, but after the contract is signed, she charges $100 an hour for services. She typically doesn't charge for travel time unless the patient lives a long way off and doesn't typically charge for errands like picking up medication for patients.

Polites has connected with colleagues who also provide services to the elderly. "We support each other and brainstorm on difficult cases," she says. ■

Patient-centered ED transfers boost safety

Focus on what's best for the patient

Many EDs have found ways to streamline their triage processes and slash door-to-provider times. Such department-level improvements are important, but eventually ED administrators have to deal with the inpatient side of the equation for those patients who need to be admitted for further treatment. This level of improvement is typically more challenging because it requires active collaboration between the ED and inpatient staff. However, administrators at Hallmark Health, which includes Melrose-Wakefield Hospital in Melrose, MA, and Lawrence Memorial Hospital in Medford, MA, have demonstrated that hospitals can make strides in this area, improving not just patient throughput but patient safety as well.

In June 2012, the two hospitals within the Hallmark system began to implement a new patient-centered transfer process for patients admitted through the ED. Under the new process, inpatient nurses come down to the ED to take reports on newly admitted patients. This transfer takes place at the patient's bedside in a process that includes the ED care team as well as family members. The inpatient nurse then accompanies the patient up to the inpatient floor.

The approach is part of an ongoing effort at Hallmark to enhance efficiency and quality in the ED while also boosting patient satisfaction. And administrators say it has delivered on all counts. Just six months after implementation, patient satisfaction has increased by at least one full percentage point on Press Ganey surveys. And administrators anticipate that data will soon show that medical errors or omissions have decreased by at least 50%.

Focus on handoffs

The new process followed roughly two years of changes that enabled the Hallmark EDs to reduce patient length of stay by as much as 20%, notes **Deb Cronin-Waelde**, RN, MSN, ONC, system director of Emergency Services at Hallmark Health. But she emphasizes that the group managing the process was not just focused on throughput. "It wasn't good enough to just be quick. We also wanted to make sure we were doing things correctly," she says. "So we used internal data as well as external benchmarking metrics to look at patient safety."

What became clear, says Cronin-Waelde, is that there were opportunities to improve safety during the critical handoff that takes place when patients in the ED are turned over to inpatient teams.

In particular, the data showed that it is not uncommon for critical information regarding allergies or other aspects of a patient's medical history to be inadvertently omitted in the transfer process, she says. "The medical history is important to share from one caregiver to the next," she says. "It is also important that each caregiver knows the actual plan of care in the successive hours."

For example, a patient who is admitted with a diagnosis of pneumonia needs to have certain things completed at specific times, so communication about the plan of care is vital, says Cronin-Waelde.

The administrators looking at this issue were particularly impressed with the work of Atul Gawande, MD, MPH, a surgeon at Brigham and Women's Hospital in Boston, MA, who authored *The Checklist Manifesto: How to Get Things Right* (Picador 2011). In this work, Gawande talks about the use of checklists in many other industries, and how this simple concept can also be leveraged in medicine. For example, Gawande writes about how an airplane never takes off the runway without completing a checklist, and how the same type of process can greatly improve safety in the medical setting, explains Cronin-Waelde.

"We decided to model some of that, so we looked at all of the areas of communication that were important [during a handoff], and then we got a multidisciplinary team together comprised of physicians, nurses, transporters, housekeepers, and anybody who is involved in the touching of a patient

and the admitting of a patient to the hospital," she says. "Everybody had their input."

The team conducted trials of several different approaches to the ED-to-inpatient transfer process, finally settling on a process that begins with a notification from the ED to an inpatient floor when a patient is expected to require admission. "That is communicated on our tracking board ... so as that process kicks in, the charge nurse assigns the patient to the incoming nurse," says Cronin-Waelde. "When the patient is ready to depart [from the ED], the inpatient nurse comes down to the ED and receives a bedside handoff, inclusive of the ED nurse, the ED physician provider, the inpatient nurse, and the patient, as well as any family members if they are there with the patient."

The assembled providers follow a checklist that is sequential in order, going through all of critical information about the patient that needs to be shared. And then there is time for any of the participants to ask questions, adds Cronin-Waelde. "It is a regulatory requirement that people have the ability to ask questions at the end of the encounter," she says. "This is great because then the patient feels like everyone knows what is going on, and a caregiver or family member has the opportunity to interject information that [the providers] may not know about."

Conduct trials

While the handoff process is working well now, it took time for the providers involved to adapt to the new approach. "Nurses, physicians, and staff are very used to working in particular ways. We have all been trained differently in some ways," says Cronin-Waelde.

For instance, initially the inpatient staff felt that it would be very difficult for them to leave their floors and their patients to come down to the ED, she explains. "They thought they would be off of their floors for hours, and that this would not take care of their patients," she says. However, when they tried the process they realized that it actually eliminated a lot of back-end work that they had been doing when they didn't have all the information they needed about incoming patients. "When you get all the information in real time at the bedside, all of that work goes away," observes Cronin-Waelde, "so they actually gained time on the inpatient side."

It also helped that the multidisciplinary team championing these changes took the time to conduct a trial of the reverse of this approach, in which the ED nurses would go up to the inpatient floors to give bedside reports. That approach didn't work as well because it left the ED physician out of the equation. Ultimately, the inpatient nurses themselves realized that the better process involved having them come down to the ED to take report on the patients, says Cronin-Waelde.

"There are hundreds of nurses, so it is hard to get everyone to really buy in until they have done it a few times and realize how much better the process is," she explains. "That remains one of the biggest barriers for sure."

To overcome resistance among inpatient staff, it is important to help them understand how critical it is for the ED to see patients quickly. "The ED waiting room is really the scariest place because even though we triage patients quickly, we really don't know what is wrong with them until we get hands on and have the providers see them," says Cronin-Waelde. "So it is a matter of getting the inpatient units to understand that the doors never close in the ED, and that we constantly have an influx of patients. That is our waiting room, but the ED is the inpatient waiting room."

Inpatient nurses are accustomed to a more controlled environment. Once the beds on the floor are full, and the nurses each have their four or five patients, everything is settled, notes Cronin-Waelde.

Consequently, it can take some time for inpatient staff to appreciate that providers in the ED can't attend to patients in the waiting room until they "fix the back door" and get patients who are waiting to be admitted upstairs, she says.

Stay focused on the mission

Changing the culture was one of the biggest challenges, according to **Steven Sbardella**, MD, the system director for the Department of Emergency Medicine at Hallmark Health. "Quite a few of our processes were aligned with our workload and responsibilities. We always would say that we have the patient in the forefront, but in reality we developed systems based on us," he explains. "We had to let our staff realize that they had to give something up [i.e., control] in order to make the patient the priority in all aspects."

Ultimately, the professionalism of the staff won out, says Sbardella. "They came to the conclusion themselves after looking at all the value-added data. This was a culture shift."

Cronin-Waelde's advice to colleagues who are interested in achieving similar improvements is to take the time to really know the process you have in place before trying to make changes. "Every hospital has different flow models, different challenges, and different processes, so the first thing out of the gate

is just to observe," she says. "Don't make comments on it, and don't try to change anything. Just look at it and start to get a feel for where the opportunities are."

Once you have a firm grasp on the process you have in place, then assemble a team that includes all the players, especially the frontline staff who will have to operationalize any improvements that the team designs, says Cronin-Waelde.

Sbardella advises ED leaders to remember that it will take some time to achieve lasting improvements. "Just keep the mission or mantra up front," he says. "Is this decision the best for the patient? Just keep bringing it back to that," he says.

Sources

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Study: Long nursing shifts linked to burnout

Experts: Guard against excessive overtime

While the 12-hour work day has become the norm for nurses, there is new evidence that such longer shifts are not necessarily a good idea, especially when nurses work several consecutive days involving 12-hour shifts, or they are required to put in excessive amounts of overtime. A new study, co-authored by **Amy Witkoski Stimpfel,** PhD, RN, a post-doctoral fellow at the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing in Philadelphia, found that nurses working these longer shifts are more likely to experience burnout and job dissatisfaction, and patients suffer consequences as well. The researchers found that not only are patients less satisfied when the nurses who are caring for them work longer shifts, but patient outcomes are negatively impacted, too.

The three-year study, which was published in the journal Health Affairs, was the first to look at the relationship between nurse shift length and patient assessments of their care, according to researchers.[1] It involved nearly 23,000 registered nurses from four states: California, New Jersey, Pennsylvania, and Florida.

The researchers report that the nurses working shifts of 10 hours or longer were up to two and a half times more likely to experience burnout and dissatisfaction with their jobs than nurses working shorter shifts. Furthermore, seven out of 10 patient outcomes were adversely impacted by the longest shifts.

Confront the disconnect

Despite the negative consequences of longer shifts, nurses still tend to prefer the 12-hour schedules, perhaps because these schedules typically enable nurses to work fewer days of the week, Witkoski Stimpfel says. "It seems as though there is a disconnect there," she explains. "We do see, both anecdotally and in this work, that the nurses are overall really satisfied with their scheduling, and it seems like they are participating in choosing their schedules. But at the same time, those are the nurses who are the most burned out."

In the study, 65% of the nurse participants worked shifts of 12 to 13 hours. The researchers report that as shift lengths increased, so did the likelihood that the nurses would report burnout or an intention to leave their jobs.

Furthermore, in hospitals that had higher proportions of nurses working longer shifts, there were also higher proportions of patients providing poorer overall assessments of how well the nurses communicated, how well their pain was controlled, and how responsive the nurses were when the patients needed help.

While it is not entirely clear why nurses would choose schedules that result in more burnout and dissatisfaction, Witkoski Stimpfel advises organizations to find out what their staff and administrators know about this issue. "Then do some staff education to help them start doing self-scheduling, and if they are choosing these [longer shifts], watch out for multiple consecutive long shifts in a row, and any rotating between day shifts and night shifts," she explains.

Another good option for management is to offer more flexibility in the hours nurses can choose to work. "Some places are starting to implement shifts as short as four hours, and they allow for nurses to come in and work [for shorter stints] during peak times or shift changes," Witkoski Stimpfel says. "This helps to give options to nurses who don't want to work such long hours."

Management can also take steps to enable

nurses to say "no" to overtime or "no" to coming in on scheduled days off, adds Witkoski Stimpfel. "At some hospitals, if you get a call to come in, it is expected that you come in," she says.

Consider flexible scheduling options

One health system that has introduced new solutions in the nurse shift arena is the Cleveland Clinic. In 2008, the health system launched a program that enables nurses to choose to work six hours or less on an as-needed basis. "The program was aimed at helping nurses who had left the workforce to be stay-at-home moms to be able to come back into the workforce, and so it got the name 'parent shift,'" explains **Nancy Albert**, PhD, RN, CCNS, NE-BC-FAHA, FCCM, the Cleveland Clinic's senior director, Nursing Research and Innovation.

However, Albert points out that the program is not just used by parents. She notes, for example, that many nurses choose to work the parent shift while they are students working toward advanced nursing degrees. "It is really meant to help units and floors overcome the burdens associated with incoming patients, patients being discharged, or patients going to the lab, X-ray, or other parts of the hospital for tests or treatments," she says.

While meeting the needs of nurses, the parent shift provides staffing flexibility to administrators. Duing the day shift, there is a lot going on in terms of nurses being interrupted and trying to do the best job they can for patients, explains Albert. "Having a nurse come in at 10 a.m. and having them stay until 2 p.m. can offer the nurse who is assigned as a patient care giver a lot of relief."

A parent-shift nurse can enable a staff nurse to take a lunch break, but she can also help to ensure that patients get their medicines on time, or get to tests and procedures when they are supposed to, says Albert. "Every manager who uses these parent-shift nurses may use them in a different way," she says.

Several EDs within the Cleveland Clinic Health System make use of the parent-shift nurses, according to **James Bryant**, RN, MSN, CEN, CCRN, NEA-BC, the associate chief nursing officer for emergency services. He explains that each ED is able to use these nurses in a customized way to meet the specific needs of the facility. The approach also enables the EDs to offer the nurses added scheduling flexibility, and he notes that a handful of nurses in Cleveland Clinic EDs take advantage of this option.

Ability to delegate is key

Nurses who choose to work the parent shifts are able to select the days and hours that they want to come in as long as these shifts also meets the needs of the nurse manager in their unit or department, says Albert. "There has to be a good match between the desires of the nurse and the manager on that floor. Then it works wonderfully," she says.

However, in exchange for this flexibility, there are significant trade-offs. Parent-shift nurses receive no benefits, and they receive lower salaries than regular staff nurses. "There has to be an incentive for someone to work full-time and also to work a full shift," explains Albert. "The parent-shift nurses may not have a full patient assignment, so they don't have the same level of stress or the same burdens that a typical staff nurse would have."

Despite these trade-offs, the parent shift has proven popular with nurses who may not be able to work on a full-time basis, but want to maintain their skills and stay involved in their profession. "The parent-shift people don't have to work any holidays, so it offers them great flexibility, and they get the rewards of having some interaction on the worksite, and keeping up-to-date in their skills," says Albert.

A key advantage for Cleveland Clinic hospitals is that these nurses are fully trained and oriented to the culture on the floors where they work. "It is not like we are bringing on people who are strangers to the floor; these are team members," says Albert. "They enable us to ensure that we are delivering the highest quality of care even when there are unit stressors going on like a lot of admissions coming in at once, or patients who need to travel to other floors for tests or procedures."

While nurse managers who elect to make use of parent-shift nurses must provide for these nurses in their budgets, there is no evidence that the approach has presented any administrative challenges, says Albert. However, for the program to work, she stresses that staff nurses need to feel comfortable collaborating with and delegating tasks to the parent-shift nurses. "Every floor has to decide how to best use these nurses so that they can be as effective as possible," she says.

Managers need to take the lead

While options like the Cleveland Clinic's parent shifts are helpful, Witkoski Stimpfel does not see 12-hour nursing shifts going away, and she doesn't recommend that. However, she is hopeful

that education about this issue will help both managers and individual nurses move toward sensible scheduling solutions. For example, she notes that nursing administrators can take steps to limit the number of 12-hour shifts that are clustered together, using more of a mix of 12-hour and 8-hour shifts. Another alternative would be to offer some type of hybrid schedule in which nurses provide direct patient care for eight hours and then do committee work or administrative tasks for the remaining four hours of a 12-hour shift, adds Witkoski Stimpfel.

When people are really fatigued, performance suffers, she says. "Our brain kind of tricks us. We feel OK, but we don't realize how impaired we might be," she says. "By scheduling smarter, we can avoid some of that because it is really hard to tell when you are at the point when you might be unsafe in practice."

It is going to take time to change a culture in which it is expected for nurses to work these longer shifts, adds Witkoski Stimpfel. This is why managers need to take the lead on providing education around this issue and providing support for a healthier balance in scheduling, she says.

REFERENCE

1. Witkoski Stimpfel A, Sloane D, Aiken L. The longer the shifts for hospital nurses, the higher the levels of burnout and patient dissatisfaction. *Health Affairs* 2012;31:2501-2509.

Sources

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CNE QUESTIONS

1. What are some of the pitfalls to becoming an independent case manager?
   A. No sick leave or vacation time.
   B. You have to pay for your own insurance.
   C. Covering expenses such as office equipment, legal fees and marketing.
   D. All of the above

2. According to Catherine M. Mullahy, RN, BS, CRRN, CCM, president of Mullahy and Associates, what is the biggest obstacle to becoming an independent case manager?
   A. Lack of financial security.
   B. Always being "on call."
   C. Having the motivation to stick to your schedule.
   D. Resisting the temptation to watch TV all day.

3. In order to get the word out that they have started a business as an independent practitioner, case managers should do what?
   A. Hire a well-known and expensive marketing company.
   B. Advertise on billboards near provider offices.
   C. Approach patients as they leave the hospital after treatment.
   D. Offer to write a column for the newspaper or newsletter, join community organizations and task forces, and provide free seminars on subjects on which you have expertise.

4. According to Elizabeth Hogue, Esq., healthcare attorney, having your own malpractice insurance does not increase your likelihood of being sued.
   A. True
   B. False

CNE OBJECTIVES

After reading this issue, continuing education participants will be able to:
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