HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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Making pharmacists part of the multidisciplinary team

Their expertise can help improve outcomes

If your hospital doesn't use pharmacists to collaborate with the multidisciplinary team, review medication during the patient stay, and participate in discharge planning, you might be missing an opportunity to improve patient care and reduce readmissions.

"Medications are one of the most common interventions that patients receive while they are in the hospital. A patient's medication list from admission through discharge and beyond is often complex and sometimes contains discrepancies that need to be corrected, despite everyone's best efforts. Pharmacists have the expertise and knowledge to review the medication and suggest changes," says **David Chen**, RPh, MBA, director of the American Society of Health-System Pharmacists' (ASHP) Pharmacy Practice Sections and the ASHP's Section of Pharmacy Practice Managers.

Involving pharmacists in the multidisciplinary treatment team is a growing trend, Chen says. "Hospitals are realizing that pharmacists have

EXECUTIVE SUMMARY

Having pharmacists on the multidisciplinary team can help ensure that patients progress well in the hospital and that they follow their medication plan at home and avoid emergency department visits or readmissions.

- Pharmacists can review medication lists and correct problems as well as ensuring that patients receive the right doses and selections of medication for their ages, weights, and conditions.
- They can help case managers and social workers deal with complex prescription benefits plans and help with preauthorizations and other issues that can potentially delay filling prescriptions.
- Pharmacists can use their knowledge of medication to recognize when a patient may not be able to afford a medication and to suggest less expensive alternatives to the physician.

the expertise to ensure that patients receive the right doses and selection of medication for their disease states, weight, and age as patients prepare for discharge and can be involved in follow-up telephone calls to ensure that patients have filled their prescriptions and are taking their medication correctly," he says.

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In addition, pharmacists can improve patient access to prescriptions by eliminating barriers that delay filling prescriptions and managing difficult prior authorization processes, he says. "Pharmacists can help the case managers and social workers deal with complex prescription benefit plans. More and more insurers are requiring preauthorization for prescriptions. Pharmacists can address this issue before discharge and make sure patients have everything they need to get their prescriptions filled," he says.

Pharmacists can advise physicians on choosing medications that are in the patient's insurance company's formulary and those that are affordable, Chen says.

"There are more than 85,000 drug products in the market place and more than 110,000 diagnoses. There's no way a physician can be knowledgeable about everything, and that's why pharmacists are an important part of the treatment team," adds **Michael Powell**, MS, FASHP, executive director of pharmaceutical and nutrition care at The Nebraska Medical Center in Omaha.

About 40% of patients fail to get their prescriptions filled within two weeks of discharge, and of those, 80% never get them filled; in the vast majority of cases, it's because they can't afford the medication, Powell says. *(For details on how pharmacists at The Nebraska Medical Center interact with patients and collaborate with the treatment team, see related article on page 16.)*

"Pharmacists have the knowledge to point out when a patient may not be able to afford a medication and suggest a substitute. Cost of medication is something that rarely is on the radar screen of doctors and nurses," adds **Amy Boutwell**, MD, MPP, president of Collaborative Health Strategies, a healthcare consulting firm based in Lexington, MA.

When case managers and pharmacists work together, everybody wins, says **Brenda Keeling**, RN, CPHQ, CCM, president of Patient Response, Inc., a Durant, OK, healthcare consulting firm.

She tells of a situation in which a physician gave a patient on IV antibiotics in the hospital a prescription for oral antibiotics to get filled at home. The patient's daughter was savvy enough to ask the hospital pharmacist about the medication and discovered that it would cost the patient $1,500. "There was no way the patient could afford it. Fortunately in this case, the pharmacist

was able to consult with the physician and suggest an alternative. If not for the pharmacist, the patient most likely would not have filled the prescription and would have possibly ended up back in the hospital as a readmission," she says.

Multidisciplinary rounds, when the team gathers to discuss the care plan, is the perfect time for pharmacists to review medications and give input into patient care, expressing concerns about doses or potential drug interactions, Boutwell says. Then as discharge approaches, the pharmacist should review the prescriptions the patients will take after discharge.

"Medication management when the patient comes into the hospital and leaves is perhaps the most important medical issue that needs to be attended to, from both a patient safety aspect and from a medical quality standpoint," she says.

Many hospitals use a discharge checklist to make sure that all the recommended tasks are completed before discharge, such as reviewing medication and the patient's ability to pay for it, educating the patient on the medication regimen and discharge plan, determining the patient's support system and needs after discharge, and making sure the patient has a follow-up appointment with a physician and has transportation to the appointment.

"The checklist is overwhelming for any one person, whether it's a nurse, a doctor, or a case manager. It makes more sense to step back and work as a team, assigning the best person to the task. When it comes to medication issues, pharmacists are the experts," she says.

"The pressure on the healthcare system to improve care helps us identify who on the healthcare team is trained and well suited to do various jobs. In the old model of hospital care, doctors and nurses divided discharge planning tasks. We weren't very thoughtful about who was the best professional on the team to perform this work," she says.

Involving pharmacists in patient care not only results in using the best professionals to do the job, it helps break down the silos in which healthcare professionals often operate, Boutwell says.

"It makes so much sense to engage the pharmacist as part of the healthcare team. Pharmacists have the opportunity to help coordinate care as they work with the rest of the treatment team to ensure that the patients receive the care they need while they are in the hospital and are fully informed about their medication, how to take it, and the importance of following their treatment plan," says **Patrice Sminkey**, chief executive officer for the Commission for Case Management Certification.

There is a huge opportunity to improve patients' medication adherence, and pharmacists have the knowledge and expertise to do so, Sminkey says.

Patients often are discharged with numerous oral medications and a complicated and confusing medication regimen, she points out. Some medications have to be taken with food, some on an empty stomach. Some are taken twice a day, others every other day. "When my mother was discharged with multiple medications, I felt a little overwhelmed, and I have years of experience in healthcare," she says. Having an expert spend time at the bedside educating the patient is a simple solution that could vastly improve outcomes, she says.

Pharmacists are the best-equipped members of the team to educate patients about the importance of taking their medication and to help them understand a complex medication regimen, Chen says.

Interventions by pharmacists in addition to the regular discharge teaching help patients feel more confident in following their medication regimen, Chen says. "Pharmacists recognize the complexity of the medication regimen and have the knowledge to help patients understand it," Chen says. In some hospitals, pharmacists contact patients after discharge to discuss their medication regimen and help patients navigate the issues with medication they may be having, he adds.

Pharmacists are invaluable when it comes to medication reconciliation, Chen adds. When patients are in the hospital, the treatment team focuses on the reason for the hospitalization, but many patients have chronic conditions or comorbidities and take medication for that as well. "The way our healthcare system operates, each specialist may be looking at his or her particular piece," Chen says. Pharmacists look at how all the medications fit together—those that patients were taking when they came in and those they take in the hospital, as well as those prescribed upon discharge. They can review the medications as they change during the inpatient stay and make sure patients are taking the right medication and right dosage, he adds.

For instance, many seniors are taking six to 10 medications and seeing different specialists. The pharmacist has the ability to step back and look at the patient's situation in its entirety, focusing

on the medications and how they fit together, Chen says.

"There is tremendous value in having a pharmacist review all medications at the time of discharge," Keeling says. "Often, patients don't understand their medication instructions and a thorough medication reconciliation review is not completed, so patients don't follow their plan and end up back in the emergency department or the hospital," she says.

Hospitals are expanding the role of pharmacists as one of several new strategies to use the workforce they have in a better way, Boutwell says.

"Pharmacists and the allied professionals that support them are well suited for this job. It provides job satisfaction for pharmacists as well as providing a service to other clinicians and patients," she says.

Some hospitals are developing pilot programs that move pharmacists from the pharmacy to the floor for a few hours a day. They attend multidisciplinary rounds to help with medication reconciliation and to review medication lists for interactions and dosages, Boutwell says.

Sminkey tells of one model in which a retail pharmacist comes to the hospital bedside and reviews the discharge medication with the patient. "This is a small model with outcomes yet to come, but it's logical to think this would improve outcomes. A pharmacist can help patients understand the need for medication adherence, identify compliance issues, and review the medications for duplications and interactions," she says.

In some hospitals Keeling has worked with, pharmacists are involved in discharge planning rounds every day. In others, pharmacists are assigned to specific units and work closely with the case managers to review every order the patient receives.

"The only problem is that it's difficult to find enough pharmacists for the job," she adds.

Some hospitals are using pharmacy residents to help facilitate education and discharge planning, Chen says. Others are using the revenue generated from their outpatient pharmacy to hire additional pharmacists.

As hospitals recognize the value of pharmacists in supporting the prevention of readmissions and improving care, they are beginning to reassess where they allocate resources and are investing in increasing efficiency in patient treatment and the discharge planning process, he says. ■

Pharmacists see patients through discharge

They call those at-risk for readmission

At the Nebraska Medical Center in Omaha, pharmacists interact with patients from admission through discharge and beyond, conducting medication reconciliation and education, and working with the multidisciplinary team on the treatment plan.

Pharmacists see many patients in person, starting on Day 1. "They don't see all of the patients with stays of a short duration, but they do review the medical history taken by nurses and, based on their experiences, follow up with patients who need it. Every patient history is either taken by a pharmacist or approved by a pharmacist, who uses the information to work with the multidisciplinary team to build a treatment plan," says **Michael Powell**, MS, FASHP, executive director of pharmaceutical and nutrition care at the medical center.

The pharmacists visit patients throughout their visit, checking on what has been prescribed and the potential for interactions. As discharge approaches, the pharmacists review the discharge prescriptions, conduct medication reconciliation, and educate the patients on their medications and the importance of taking them as directed. Pharmacists make follow-up calls to certain high-risk populations within two to three days of discharge to patients with conditions that are at risk for medication mismanagement. They make sure the patients have filled their prescriptions, understand their medication regimen, and answer any questions.

"When patients are admitted, we get a complete

EXECUTIVE SUMMARY

At The Nebraska Medical Center in Omaha, pharmacists are part of a multidisciplinary team and see many patients in person starting on Day 1.

- Every patient history is either taken by a pharmacist or reviewed and approved by the pharmacists.
- They review the discharge prescriptions, conduct medication reconciliation, and educate the patients on their medications and the importance of taking them as directed.
- Case managers work with pharmacists to identify patients who are at high risk for readmissions and need follow-up calls and collaborated to develop a medication instruction sheet.

record of what a patient is taking before admission and determine what, from a pharmaceutical standpoint, might have contributed to the admission, such as therapeutic failure or drug interactions," Powell says.

At The Nebraska Medical Center, pharmacists collaborate with all disciplines as part of the treatment team, making rounds and attending multidisciplinary team conferences. Instead of just reacting to medication orders from a physician, pharmacists at The Nebraska Medical Center give physicians advice on how to build a treatment plan. "When the pharmacist collaborates with the physician, it decreases the likelihood of an adverse event or a medication reaction. Pharmacists can help physicians avoid using an IV drug or an injectible drug when an oral drug will be just as effective," Powell says.

When the pharmacists assess patients, they evaluate their financial position, find out if they have insurance, and if it includes drug benefits. The pharmacists can call on the hospital's pharmacy financial counselors to help patients without insurance or drug coverage access pharmaceutical assistance plans to get the medications they need.

"Many of the patients who don't fill their prescriptions can't afford them. Our pharmacists help physicians plan a medication regimen that patients can afford and try to head off any problems that would interfere with the patients following their treatment plans," he says.

The hospital is beginning a discharge medication program that delivers medication directly to the patient at bedside. "This assures us that the patients have the medication they need when they leave the hospital," he says.

The pharmacists collaborated with the case managers to develop a medication instruction sheet that includes the name of the drug, a picture of the drug, and the times it should be taken. They work with the case managers to identify patients who are at high risk for readmissions. In those cases, the pharmacists help with patient education and in some cases, teach patients how to set up a medication container to schedule doses.

"We know that when patients don't take their medication properly, it can have a significant impact on their health, so try to make sure patients understand the importance of taking their medication. Frequently, when they are about to be discharged, patients are anxious to get home and don't listen carefully to their discharge instructions. That's why we make follow-up calls and give them an opportunity to ask questions," he says.

The hospital has assigned pharmacists as pharmacist coordinators for patients with conditions that put them at risk for treatment failure, including heart failure, organ transplant, and pain management. "The pharmacists are experts in therapies for the diagnoses and provide extensive education to the patients as well as working closely with the treatment team to plan the discharge and the medication regimen. Our involvement with the organ transplant team is very intensive. We have three pharmacist coordinators who work with all disciplines, including case management," Powell says.

The hospital is developing a staffing model redesign so pharmacists can expand their ability to initiate a pharmaceutical case management program. The goal is to develop a pharmacotherapy program for every patient. The initiative includes patients with high-risk diagnoses including heart failure, diabetes, and other chronic diseases with high readmission rates. Once the patient is admitted, the pharmacist completes an assessment and suggests a medication treatment plan for the duration of the inpatient stay. "The pharmacist interventions help avoid adverse events caused by interactions and potential therapeutic failure," Powell says. ■

Hospital brings discharge meds to the bedside

Initiative aims to prevent readmissions, errors

To ensure that patients get their medication at discharge and that the prescriptions are reconciled with current and home medications, Strong Memorial Hospital at the University of Rochester (NY) Medical Center has established a pharmacy program that brings pharmacy services to the bedside at the time of discharge.

"Failures and delays in filling prescriptions at the time of hospital discharge contribute to poor outcomes and readmissions. In addition, errors in discharge prescriptions are common and contribute to adverse events and poor patient outcomes. We started this program to improve the discharge process, ensure that patients have access to the medications they need, and decrease the 30-day readmission rate," says **Carrie Polandick**, RPh, staff pharmacist at the 900-bed hospital. The pharmacy program covers 500 beds.

EXECUTIVE SUMMARY

The pharmacy at Strong Memorial Hospital in Rochester, NY, fills about 75% of the prescriptions that patients are given at discharge.

- Pharmacy technicians coordinate discharge times with unit-based care coordinators and deliver medicine to the bedside.
- Prescriptions are printed out on the unit and sent to the pharmacy by pneumatic tube.
- A pharmacist reviews the prescriptions for drug interactions and medication errors and gets corrections made before the patients leave the hospital.

Polandick works with four pharmacy technicians, who visit the patient floors to coordinate discharge times with care coordinators and deliver the medications to the bedside. The technicians have a minimum of five years experience and have passed the New York State certification exam. They are equipped with cell phones and pagers and are assigned to a floor, covering five units.

The program fills about 75% of the prescriptions that patients at Strong Memorial Hospital are given. "We work on 30 to 80 discharges a day, and the last time we tallied it, we were filling about 2,000 prescriptions a month," Polandick says.

Each morning, the pharmacy technicians get a list of patients, go to the floors, and meet with the care coordinators after each unit's rounds to find out which patients are being discharged and the approximate time they'll be leaving.

The technicians return to the hospital's outpatient pharmacy and assist Polandick as prescriptions come in. Prescriptions are printed out on the unit and sent to Polandick via pneumatic tube by the care coordinator or the nursing staff. Each floor places a different color sticker on the prescriptions to distinguish the discharge prescriptions from the other prescriptions the department receives.

Polandick reviews all the prescriptions for errors and drug interactions and reconciles them with current and home medications. "I routinely detect errors in the prescriptions and work with the provider to get them corrected before the prescriptions are filled. When a patient takes a prescription to a community pharmacy and the pharmacist finds that the dose is wrong or the drug interacts with another drug the patient is taking, it is difficult to correct from the outside. We take care of these problems when the patient is still in the hospital," she says.

The pharmacy techs prioritize the prescriptions according to the expected discharge time.

"We may have a day to fill prescriptions or need to get them done in 15 minutes, depending on when the discharge orders are written and when the patient's transportation home arrives," she says.

Polandick and the pharmacy tech communicate back and forth during the day with the care coordinators on the unit. For instance, if a drug is expensive or a patient has a high co-pay, the technicians can work with the care coordinator or social worker to provide a coupon from a drug manufacturer or link the patient with the hospital's patient assistance fund.

When patients are ready for discharge and their transportation home arrives, the care coordinators notify the technicians. The pharmacy technicians gather the prescriptions along with change if the patient is paying cash. Otherwise, they take the credit card machine, deliver the medication, and obtain a signature.

Bedside delivery of medication is a convenience for patients and families as well, Polandick says. "Patients want to go home and go to bed when they are discharged. When they go home with their medication, they don't have to wait for the prescription to be filled or stay at home alone while their caregiver goes to the pharmacy. The nurses also like the program because they know that patients are going home with what they need to succeed," she says. ■

Condition Code 44 or Condition Code W2?

CMs should know the difference

When a review of an admission determines that a Medicare patient didn't meet inpatient criteria and the patient has already gone home, hospitals now have a way to be reimbursed for diagnostic and therapeutic services.

The Centers for Medicare & Medicaid Services' Inpatient Prospective Payment System final rule for fiscal year 2014 allows hospitals to file a provider liable claim using Condition Code W2 if the hospital performs a self-audit and makes a post-discharge determination that a

EXECUTIVE SUMMARY

When hospitals determine after discharge that a patient did not meet inpatient criteria, they can file a provider liable claim using Condition Code W2 and be reimbursed for all services as if the patient were an outpatient, according to Deborah Hale, CCS, CCDS.

- The claims must be filed within 12 months after discharge.
- The medical record must be reviewed by the physician advisor and the utilization review committee before the claim is submitted.
- It is still advantageous to get the patient status right up front.

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patient stay wasn't medically necessary or if the Medicare Administrative Contractor (MAC) or Recovery Auditor (RA) deny the claim. However, the claims must be filed within a 12-month period after discharge and RAs are looking at claims that are as old as three years, so a hospital's best recourse is to rely on internal auditing, says **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK.

"Much of this is a billing issue, but case managers need to understand the concept and the difference between filing a Condition Code 44 and a provider liable claim using Condition Code W2 and know which one is appropriate," she adds.

Hospitals can file Condition Code 44 to change a patient's inpatient status to outpatient with observation services and to bill all medically necessary outpatient services but only if the change in patient status is made before discharge, the hospital has not submitted a Medicare claim for the admission, and the attending physician and a member of the utilization review committee concur in the decision.

"It's always advantageous to get it right from the beginning, but the Condition Code 44 rules still apply. If hospitals can't get the care order right from the beginning, Condition Code 44 is the most financially beneficial avenue for hospitals to take," Hale says.

In the final rule, CMS emphasized that only a person with admitting privileges can make the decision to admit and added that case managers should be available at all times to assist the physician in making the decision, Hale says.

If hospitals miss an opportunity for Condition Code 44 because they did not determine that a patient didn't meet inpatient criteria until after discharge, and they make the determination within 12 months, they can file a provider liable claim with a Condition Code W2, Hale says.

Hospitals still have to go through the physician advisor and utilization review committee process to file a provider liable claim using Condition Code W2, she adds. If the utilization review committee determines that the patient did not meet criteria for an inpatient stay after discharge, CMS will pay hospitals for all hospital services that were furnished and would have been reasonable and necessary if the patient had been treated as an outpatient rather than being admitted, except for services that specifically require an outpatient status, such as emergency department visits, outpatient treatment, and observation services.

When the provider liable claim and Condition Code W2 is used, hospitals can bill only for services provided after the admission order is written, Hale points out. The hospital must also file separate claims for emergency department treatment, observation services, and any other outpatient services the patient received before being admitted.

In the past, if hospitals missed out on an opportunity to file Condition Code 44, they could file a provider liable claim but could bill only for a limited list of diagnostic services and not therapeutics.

After the Recovery Audit appeals process began, in some cases when a hospital appealed a denial for an inpatient stay, the administrative law judge would order the MAC to pay for all Medicare Part B services as though the patient had been an outpatient from the beginning, Hale says.

"The administrative law judge instruction wasn't popular with CMS, but it led to the 2014 IPPS Final Rule instruction allowing hospitals to file a provider liable claim for therapeutics as well as the diagnostics," Hale says. Effective Oct. 1, 2013, the final rule allows hospitals to self-audit after patients are discharged, and if the utilization review committee determines that the stay didn't meet inpatient criteria, the hospital can file a provider liable claim with a Condition Code W2 and bill for therapeutic and diagnostic services under Medicare Part B, Hale says.

"What the rule did was shift from RA, MAC and Comprehensive Error Rate Testing (CERT) denials to allowing the hospitals to self-audit and self deny," she says. ■

Free heart failure clinic aims to cut readmissions

Targeted patients often have limited funds

When Mountain States Health Alliance determined that a third of its heart failure patients were readmitted within 30 days of discharge, the Johnson City, TN, health system opened a free heart failure clinic at its flagship hospital, Johnson City Medical Center.

When the hospital analyzed heart failure readmissions, the team determined that one reason patients were being readmitted within 30 days of discharge was that they couldn't get a follow-up appointment with a primary care provider within seven days, says **Genia Lauro**, RN, director of cardiovascular services. There were also socioeconomic reasons that patients needed to be readmitted. Many of them couldn't afford their medication and didn't get their prescriptions filled, she adds.

Patients with limited funds and no insurance often don't have a primary care provider and don't go to the doctor for follow-up visits because they can't afford it, says **Julia Bates**, NP, the nurse practitioner who runs the outpatient heart failure clinic. In addition, if patients don't have the money to pay for their medication or don't take it as directed, they end up back in the hospital, she adds.

"When we look at the total picture, by offering the free clinic and avoiding readmissions, we are saving the hospital money. One admission costs thousands of dollars. In addition, we are improving patients' quality of life by helping them learn to manage their disease so they don't need to be hospitalized," Lauro says.

The clinic opened in August 2012 in a space in the hospital. "It's a convenient location and the patients know where to find it," Bates says.

Most of the patients are referred to the clinic when they are still in the hospital. "I try to see all the heart failure patients when they are in the hospital to find out how much they understand. The goal is for me to see all patients in the clinic at least once," Bates says.

A nurse also makes follow-up calls to heart failure patients within 72 hours of discharge to make sure they have filled their medication, to go over their discharge instructions, and make sure they have a follow-up appointment in the clinic.

Bates gives the patients her telephone number when she visits them in the hospital and encourages them to call with questions. Some patients call her with questions before their first visit to the clinic.

"Patients receive education at discharge, but many times, they just want to go home and don't listen. Then when they get home they have questions or their family members have questions," Bates says.

The hospital also encourages patients to walk in to the clinic any time, even before their appointment, if they are having problems. "We want them to come to the clinic before their condition deteriorates to the point that they go to the emergency department and/or are admitted," Lauro says.

When patients come to the clinic, Bates conducts an assessment to find out how much they understand about heart failure and how to manage it and if they have social and financial issues. She helps patients who need it sign up for medication assistance and starts educating them on how to manage their disease and what signs and symptoms indicate that they should call their physician or come to the emergency department.

"Heart failure is not going away. It only gets worse. Patients who are in Stage 3 or 4 don't have a good quality of life. We want to help them understand what they need to do to stay active and in good health as long as possible," Bates says.

Often it takes multiple repetitions for patients to fully understand their treatment plan, Bates says. "Continuing education and continuing support is very important. They still want to be normal and eat what they want. Having someone they can call for encouragement or to answer questions is very important," she adds.

She encourages patients to call her whenever they have questions or concerns. "I get a lot of tele-

EXECUTIVE SUMMARY

Mountain State Health Alliance opened a free heart failure clinic after determining that patients' inability to get a timely follow-up appointment and financial issues were the cause of many readmissions.

- The clinic is in a convenient location, across the street from the hospital.
- The nurse practitioner who runs the program sees many of the patients while they are still in the hospital to inform them about the clinic.
- Interventions include help signing up for medication assistance, education for patients and family members, and ongoing support.

phone calls on Friday because people are worried about the weekend and don't want to have to go to the emergency department," she says.

Following a heart failure diet may be the biggest challenge for many people, Bates says.

"I try to teach them how to be smart about what they eat and read labels. If they really like a food that they shouldn't eat, they know to cut down on the portions and balance it with other foods. It often takes six or more appointments before they understand, but I have patients in their 80s who know how to balance their diet," she says.

Whenever possible, Bates includes family members in the educational sessions.

"How well people do often depends on the family. They need to understand heart failure, what signs and symptoms indicate problems, and the challenges that the patients face. Whoever is cooking for the patients need to understand the importance of a low-sodium diet," she says.

Bates gets a daily report of heart failure patients who have been admitted. If they are readmitted, she visits them and collaborates with the patients and the hospital social worker to come up with a plan to avoid another readmission. "We do everything possible to give them a chance but we still have patients who die because of non-compliance. One heart failure patient was just 39 years old when he died, but despite everything we tried, he continued to smoke and drink alcohol," she says.

Bates also presents classes at the Health Resource Centers in Johnson City and Kingsport, TN. "Our community has a large population with heart failure. We want to teach them how to take care of themselves so they will do well and stay out of the hospital," she says.

The patients who come to their appointments and follow their treatment plan do very well, Bates says.

"I have patients who were in here every month and now I don't see them for six months. But if they don't show up for their appointments and don't take care of themselves, they end up in the hospital," she says. ■

2013 Salary Survey Results

The value of CM is being recognized — but where is the pay?

Compensation often doesn't reflect the workload

Case managers are working long hours and most get only cost-of-living raises, readers of *Hospital Case Management* reported in the annual salary survey.

However, thanks to the Patient Protection and Affordable Care Act and other initiatives from the Centers for Medicare & Medicaid Services (CMS) and commercial payers, case managers are getting greater recognition for the value they bring to the healthcare system, experts say.

"The value of the case management profession is being recognized, and the changes in the healthcare system are making case managers essential, but case managers still aren't being appreciated and incentivized from a financial perspective," says **Brenda Keeling**, RN, CPHQ, CCM, president of Patient Response, Inc., a Durant, OK, healthcare consulting firm.

A few respondents to the survey reported no change in salary or a salary decrease, but most who replied reported a 1% to 3% raise last year.

The majority of respondents to the 2013 salary survey report that they got a raise last year, but a few case managers reported no raise or a decrease in salary. The majority of raises were in the 1% to 3% range. The majority of respondents to the 2011 and 2012 surveys also reported raises of 1% to 3%.

According to **Patrice Sminkey**, chief executive officer of the Commission for Case Manager Certification, more than 5,000 case managers who responded to the organization's recent trends surveys reported that salaries are rising. The commission includes case managers from all settings, not just hospital-based case managers.

"We see a positive trend in recognizing the value of case managers and the need to compensate them, particularly if they have demonstrated their knowledge and proficiency by becoming certified," she adds.

Hospital Case Management readers are older and experienced case managers, with the vast majority of respondents reporting being over 50. Almost all

respondents reported healthcare careers that span 25 years or longer. Many have been case managers for 13 years or longer.

Today's case managers are well educated. The majority of respondents to the salary survey have a bachelor's degree or higher, and many have completed a post-graduate degree.

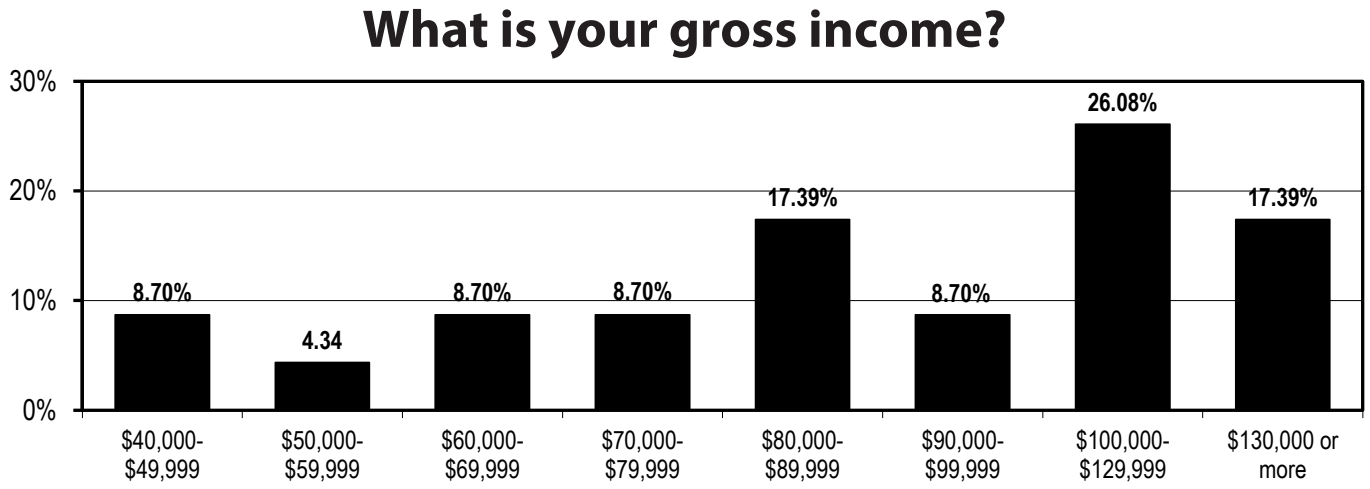
Years ago, hospital case managers were willing to accept lower salaries than their counterparts who were bedside nurses in exchange for evenings, weekends, and holidays off, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant, Case Management Concepts, LLC, in North Bellmore, NY. Now that case managers are rotating weekends and holidays and often work beyond the 9 to 5 time slot, salaries have to be commensurate with nursing salaries, she adds.

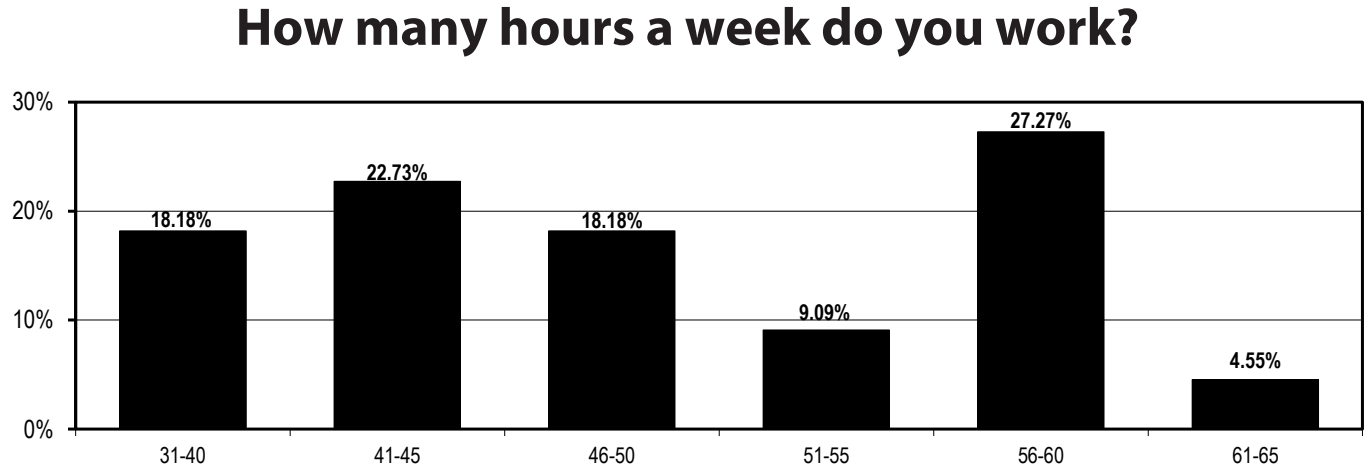
In the past, case management was attractive because the hours typically were 9 to 5, Monday through Friday, Keeling points out. "Case management has become a seven day a week job. Now a lot of hospitals have case managers in the emergency department and admissions 24-7. The problem is that hospitals are having problems staffing these positions, and many case managers end up working extra to take care of all shifts," she says.

For instance, **Beverly Cunningham**, RN, MS, vice president of resource management at Medical City Dallas Hospital, reports that attracting staff who will make good case managers has become more difficult as providers and payers across the healthcare spectrum recognize the value of case managers. "Our challenge is how many other entities we are in competition with — skilled nursing facilities, rehabilitation providers, home care, long-term acute care hospitals and now the payers, accountable care organizations, and medical homes. They all want a case manager," she says.

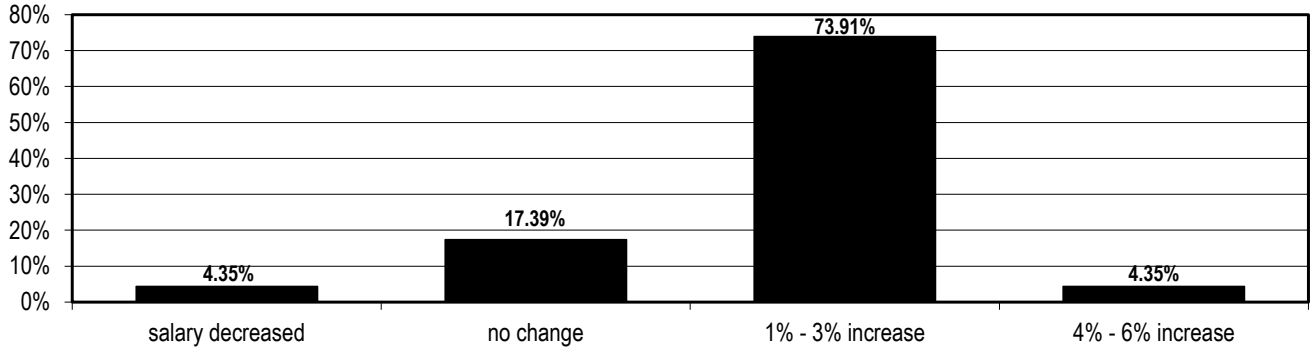
Some case managers are leaving the hospital setting for positions with the insurance industry, Keeling points out. "The third-party payer duties are usually 9-to-5, the pay generally is better than what hospitals offer, and often case managers can work at home and contact their clients telephonically," she says.

Case management caseloads have definitely

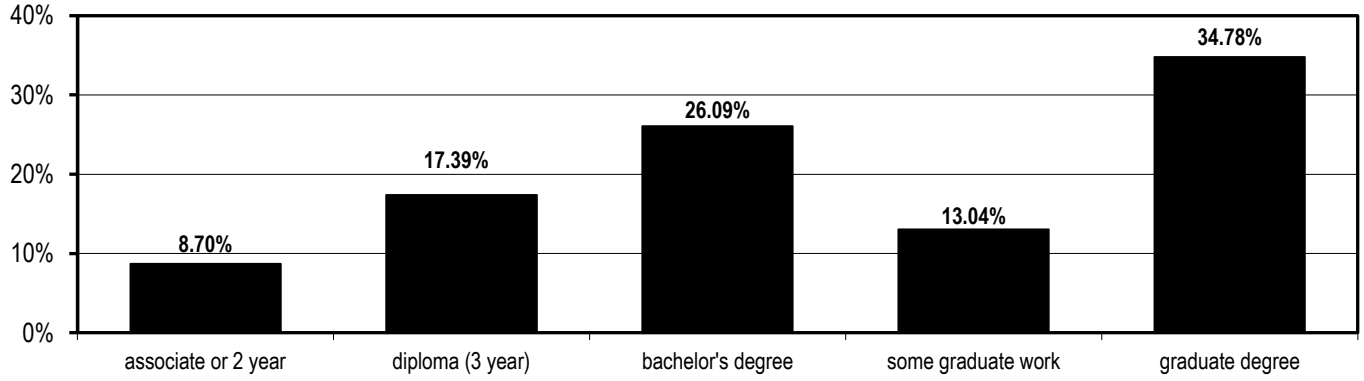




How has your salary changed?



What is your highest degree?



gotten better, but they haven't decreased to the extent they should, Cesta says. In some hospitals, the case management department is not adequately staffed, she adds.

"When I speak at conferences, there still are case managers who raise their hands and say they have a caseload of 30 or more patients. Case managers are taking on more jobs now that CMS is penalizing hospitals for excess readmissions and has launched other programs that affect reimbursement. But in most cases, they aren't being paid for the new work," Cesta says.

"Case managers are very busy, have a hectic schedule, and often feel pressured. Universally, I hear from new case managers that they didn't realize how difficult the job was when they looked at it from outside," Cesta say.

Case management software and the addition of clerical support have increased efficiency and made it possible for case managers to take on more, she says. "Back in the day, case managers spent a lot of time at the fax machine. A lot of the busy-work has shifted to electronic tools and in some cases clerical staff, and that makes it possible for case managers to tread water with high caseloads," she says. ■

CNE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

- identify the particular clinical, administrative or regulatory issues related to the profession of case management
- 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
- discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

COMING IN FUTURE MONTHS

■ Are you providing culturally competent care?

■ Involving the community in transitions in care.

■ Discharge planning for hard-to-place patients.

■ How your peers are preparing for Medicare audits.

CNE QUESTIONS

1. According to Michael Powell, MS, FASHP, executive director of pharmaceutical and nutrition care at The Nebraska Medical Center in Omaha, what percentage of patients fail to fill their discharge prescriptions within two weeks?
   A. 20%
   B. 40%
   C. 50%
   D. 80%

2. Before patients are discharged, what do pharmacists at The Nebraska Medical Center do?
   A. Review the discharge prescriptions.
   B. Conduct medication reconciliation.
   C. Educate patients on their medication and the importance of taking them correctly.
   D. All of the above.

3. According to Deborah Hale, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, if hospitals miss an opportunity for Condition Code 44 because they did not determine a patient did not meet inpatient criteria until after discharge, and they make the determination within 12 months, they can file a provider liable claim with Condition Code W2.
   A. True
   B. False

4. According to Julia Bates, NP, nurse practitioner at Mountain State Health Alliance's free heart failure clinic, what may be the biggest challenge that heart failure patients face?
   A. Following a heart failure diet.
   B. Paying for their medication.
   C. Getting enough exercise.
   D. Getting regular appointments with their doctor.

CNE INSTRUCTIONS

Nurses participate in this continuing education program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■