Case Management ADVISOR™
Covering Case Management Across The Entire Care Continuum

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Opportunities are opening up in new practice settings

Medical homes, ACOs want case managers

As the healthcare industry shifts its focus to coordinating care and improving transitions, new opportunities are opening up for case managers in emerging practice settings.

"Case managers can be a great asset at every point in the continuum of care—physician offices, long-term care, subacute facilities, home health. There should be a case manager to tie all the pieces together at any place a patient enters the healthcare system for care," says **Marcia Diane Ward**, RN, CCM, PMP, a case management consultant based in Columbus, OH.

Case managers are going to have new opportunities in the community in medical homes and accountable care organizations, adds **Toni Cesta**, RN, PhD, FAAN, partner and consultant, Case Management Concepts, LLC, North Bellmore, NY.

"We've been talking about case management in the community for 25 years and it's finally starting to happen. Case managers in the community help patients navigate the healthcare system and support them in doing what they need to do to stay well. It's very exciting," she says.

Patient-centered medical homes offer new opportunities for case managers, says **Brenda Keeling**, RN, CPHQ, CCM, president Patient Response, Inc., a Durant, OK, healthcare consulting firm. "These case managers see the patients in the physician offices, visit them when they go to the emergency department or are admitted to the hospital, and follow up by telephone to

EXECUTIVE SUMMARY
The current emphasis on care coordination and improved transitions means new opportunities for case managers.
• Physician practices need case managers to work with their patients and make sure they are following their treatment plans.
• Transition case managers, who coordinate care through the continuum, are a new trend.
• The downside is that some people are being called case managers when they don't have the education, skills, or experience for the job.

AHC Media

make sure they are following their treatment plan. Places that are truly doing case management versus just utilization review are going to be far ahead of the pack in the future," she says.

Physician offices and group medical practices are continuing to present opportunities, adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm.

"This position gives case managers autonomy and flexibility as well as an opportunity to do what they went to nursing school for—work closely with patients and make a difference in their lives. Working with patients one-to-one over an extended period of time is rewarding, and case managers can make a great impact," she says.

Case managers who work in physician offices as part of Cigna's Collaborative Accountable Care model report that they enjoy their jobs because it enables them to deliver care and help patients improve their health, says **Harriet Wallsh**, director of Cigna collaborative care clinical operations. *(For details on Cigna's initiative, see related article on page 17.)*

Case managers who are embedded in a physician office develop a relationship with patients and get to see patients take accountability for their future help, something that doesn't necessarily happen in the hospital setting, says **Maria Strohmeyer**, RN, MSN, CCM, director of clinical services for Taconic Professional Resources, who oversees all of the case managers within the Fishkill, NY-based organization. *(For details on Taconic's embedded case management program, see related article on page 15.)*

"The biggest advantage of working as an embedded case manager is that you can make an impact on a patient's life, either starting with them when they are first diagnosed or even if they have had an illness for a while. Case management provides a nurse the opportunity to empower the patient with the skills for immediate and long-term self care," Strohmeyer says.

Many times, patients leave their physician's office with a feeling of uncertainty about what to do next, she says. "They have no knowledge of the road ahead and are afraid to ask a lot of questions of their physician. The case managers can support the patients where the physicians left off and assist them with adherence to the treatment plan as well as help them meet their short-term and long-term goals toward health," she says.

Specialty clinics are also hiring case managers for disease-specific care coordination, says Keeling. "This is a new trend that can be expected to continue," she says.

Transitional case management is another trend that's just getting started, Keeling says.

"With the changes Medicare has made in reimbursement and the emphasis on preventing readmissions, there are going to be additional opportunities for transition case managers. Case management throughout the continuum, from entry in the hospital through discharge and beyond, is slow to catch on but it represents the future of case management," she says.

Today's emphasis on care coordination means that people realize there are gaps in care but they don't always recognize where the safety net will be, Ward says.

That's because many people in the healthcare industry still do not understand what case managers

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do and the value they provide, Keeling adds.

"The spotlight is shining on care coordination and care transitions, but that brings up concerns about what could be the erosion of the profession because there is no definition around the role and function of case managers," says **Patrice Sminkey**, chief executive officer for the Commission on Case Manager Certification.

"We need to be very vocal regarding the role and function of case management. There are people being called case managers who don't have the education and experience and who aren't practicing case management," she adds.

Some organizations see no problem with calling everyone in the case management department a "case manager" regardless of his or her training, experience or credentials, Mullahy says.

For instance, some physician offices are hiring medical assistants to perform pre-authorizations and are calling them case managers, Keeling says.

In other situations, organizations use other titles such as navigator, care manager, advocate, coordinator, and coach, Mullahy adds.

"These have served to undermine and diminish the profession and create confusion. However, when one looks at each of those titles, each is, in fact, part of the role and function of the case manager and the case management process," she says. ■

CMs work as a team with physician practice staffs

Initiative improves care, reduces costs

By embedding case managers to coordinate care for the sickest patients, Taconic Professional Resources is helping physician practices in New York state provide better patient care aligned with the Institute of Healthcare Improvement's Triple Aim initiative: better patient care and improved health for populations at a lower cost.

"Team-based care management is essential for primary care and specialty care providers in today's healthcare environment. Our case managers collaborate with the care team at physician practices to manage care for patients with the highest healthcare needs. Having an embedded case manager in the office allows physicians to focus on treating a patient's disease process or current condition," says **Maria Strohmeyer**, RN, MSN, CCM, director of clinical services for Taconic Professional Resources, who oversees all of the case managers within the Fishkill, NY-based organization.

The case managers also collaborate with the physician and other members of the care team to address issues that may affect successful implementation of the treatment plan, such as comorbidities or psycho-social factors, she adds. "The case managers provide educational materials or referrals to supportive resources within the patient's medical neighborhood to foster improved health. Physicians often don't have time to address these issues during a typical office visit, but they can greatly affect that patient's health outcome," she adds.

Although the case managers are employed by Taconic Professional Resources, they become part of the practice. "We provide training, placement, oversight, and the paycheck but they become part of the practice, developing a close working relationship with the patients, physicians, and the rest of the care team," she says.

Taconic case managers are RNs and have a minimum of ten years experience working in the clinical setting, as well as case management experience. They either are certified in case management or are required to obtain certification shortly after employment with Taconic. Before being assigned to a practice, they receive extensive training on how primary care offices operate, the concept of patient-centered medical homes, managing transitions of care, using their assigned practice's electronic health record, and how to manage a critically ill and chronically ill population. Taconic Professional Resources also provides ongoing support, mentoring, and training.

When the organization began its embedded case management program, the only practices that were assigned a case manager were part of Taconic Independent Practice Association, a sister organization to Taconic Professional Resources. Now,

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Taconic Professional Resources embeds case managers in 74 practices in the Capital District-Hudson Valley area in New York as part of the Centers for Medicare & Medicaid Services' Comprehensive Primary Care Initiative.

- The case managers collaborate with the physician and other members of the care team to coordinate care for the patients with the highest healthcare needs.
- They are employed by Taconic but become part of the team at the practice.
- They work with patients in person and over the telephone and help them follow their treatment plan.

the organization is providing case managers for 74 practices in the Capital District-Hudson Valley area under a four-year grant from the Centers for Medicare & Medicaid Services' Comprehensive Primary Care Initiative. The organization provides training and education to the practices as they transform into patient-centered medical homes. "We are working with the 74 practices to achieve milestones that will transform primary care providers to be more in line with the future of healthcare. All of these practices function with the patient as the center of the team and with coordinated care provided within a primary care office," she says.

Some of the case managers are embedded in multiphysician practices. Others work in solo practices.

"The biggest challenge the embedded case managers face is assisting the practice in transforming the current workflow to accommodate a new model of care. Once this is accomplished, the physicians and staff in the practices see that embedded case managers add value," Strohmeyer says.

The embedded case managers focus on the patients at highest risk, those considered critically or chronically ill with multiple comorbidities and who require support in following their treatment plan and managing their conditions, as well as patients going through transitions in care. In most cases, these patients represent 20% of the practice's entire patient population.

Patients with the higher risk scores are referred to case management. These typically include patients with diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease, or cancer, as well as patients who have chronic conditions with psycho-social components. Some patients have stable medical conditions but with psycho-social conditions that increase their risk score temporarily. For instance, a patient may not be able to afford his medication, lives alone with no family support, or recently experienced a sudden change in health status.

In addition, any patient who is being admitted to or discharged from a hospital to a skilled nursing facility or who is going home with significant needs is referred to case management. In the case of hospitalized patients, the case managers follow up by telephone once the patients are discharged to find out how they are doing. They review the treatment plan, perform medication reconciliation and ensure that patients have a follow-up appointment with their primary care physician.

When patients are referred to the case managers, they perform a comprehensive assessment, either by telephone, or in person if the patient is referred during an office visit. The assessment determines what patients know about their conditions and treatment plan. It includes information on the patients' living situation, nutritional status, family or caregiver support, financial issues, and any barriers to care. Using motivational interviewing, the case managers find out the patients' goals and concerns. Once they complete the assessment, they coordinate with the physician and other care team members to come up with a care plan that supports the treatment plan's overall goals.

"We want patients to take ownership of their own care by collaborating with the case managers and the care team on agreed-upon goals for improved health," she says.

The case managers monitor the patients by telephone as well as in person. When patients come into the office, the case managers may meet with them before or after the visit with their provider. If patients need more follow-up, they call them at regular intervals to answer questions and find out how they are managing their condition and if they are having any issues that need attention. "The goal is to prevent visits to the emergency department and hospital admissions by getting patients back into the office before their conditions spiral out of control," Strohmeyer says.

The case managers and patients review the care plan at each visit or during each telephone call. If certain things aren't working as expected, the case manager and care team can tweak the plan. "The plan is constantly being evaluated, and updates are implemented as needed," Strohmeyer says.

When the goals are met, the patient may be discharged from case management or placed on a maintenance plan where the case manager follows up at less frequent intervals to help the patient maintain stable health.

How the case management program works varies among the practices. "The collaboration between the case manager and the care team can be very formal or informal, depending on the workflow implemented in each practice," Strohmeyer says. Some practices have formalized patient-centered medical home meetings during which the team presents cases and collaborates on the issues that need to be addressed and how they might improve coordinated care for a patient. Some case managers and team members collaborate in the hallway between office visits or at the end of the day.

"The most important thing is to keep communication open between members of the care team and the case managers. The case managers work continuously to become part of the care team so they are not seen as an outside entity," she says. ■

CMs in physician offices report high satisfaction

They collaborate with health plan resources

Nurses who coordinate care for patients in physician offices as part of Cigna's Collaborative Accountable Care model have a high rate of job satisfaction, says **Harriet Wallsh**, director of Cigna collaborative care clinical operations.

"Nurses got into the profession because they care about patients. They like to deliver care. If they can reach out and help a patient keep healthy and improve his quality of life, they have had a positive impact on a person and enjoy their job," she says.

Care coordinators are a key component to Cigna's Collaborative Accountable Care initiative, Wallsh says. "The care coordinators are the pivot point between the doctor and Cigna. They are employed by the Collaborative Accountable Care organization and work closely with Cigna health improvement programs and services to make sure patients get the care they need to optimize their health. By working with the Collaborative Accountable partners to leverage our collective strengths, we are improving patient care and satisfaction and lowering costs," she says.

Cigna started its Collaborative Accountable Care initiative in 2008 and now is working with 86 practices with more than 35,000 physicians. The goal is to expand the program to 100 practices in 2014. Cigna compensates the physicians for medical and care coordination services and has a pay-for-performance program to reward physicians if they meet targets for improving quality and reducing costs. The initiatives have produced a lower cost trend, and patients in the program have fewer avoidable emergency department visits, fewer gaps in care, better compliance with evidence-based care, and receive more preventive care.

Care coordinators are clinicians and receive extensive training that includes face-to-face education, webinars, telephonic training, and outreach on a regular basis. They are connected to resources within Cigna who can assist them in meeting patient needs.

For instance, one care coordinator worked with a family whose child was being released from an inpatient psychiatric facility on a Friday afternoon and couldn't get a behavioral health follow-up appointment for 30 days. The care coordinator contacted Cigna's Behavioral Health staff, who arranged an outpatient visit for the child the next day.

The embedded care coordinator role is tailored to what each individual practice needs and how the practice operates. Some may coordinate care for patients in multiple practice sites and work in a central location contacting patients strictly by telephone. In other cases, the care coordinators may be embedded in the practice site and see some patients in person when they come into the office or when they are hospitalized if the practice is near the hospital.

The care coordinators identify patients with whom to intervene through multiple reports Cigna provides at regular intervals, listing patients who have been hospitalized, those who have gaps in care, and those who are at risk for high healthcare costs.

When patients are in the hospital, the care coordinators are alerted and call the patients while they are in the hospital, or within 72 hours of discharge to ensure a smooth transition. They find out how they are doing, answer any questions about their treatment plan, make sure that they have filled their prescriptions, and arrange for follow-up appointments as needed.

"The care coordinators make sure patients get back to see their primary care provider quickly and have a specialist appointment if they need one. They go over the treatment plan and medication regimen and make sure the patients have everything they need to avoid a readmission," she says.

The care coordinators also contact patients who are on a monthly predictive modeling report that identifies patients who are at risk for high healthcare costs. This includes patients with excessive inpatient admissions or emergency department visits, those with high-risk injuries or illnesses, or a combination of conditions that trigger an alert.

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As part of Cigna's Collaborative Accountable Care initiative, physician practices hire care coordinators who work with patients on following their treatment plan and link them to Cigna resources when needed.

- Care coordinators are clinicians who receive extensive training.
- Their role is tailored to the individual practice's needs.
- Cigna provides regular reports that identify patients in the hospital, those at risk for interventions, and those with gaps in care.

For instance, if the report shows that a patient has been to the emergency department more than three times in six months or six times in 12 months, the care coordinator reviews the medical record to determine the diagnosis and reason for the visits, then follows up with the patient to find out what the issues are. "It could be that the patient wasn't using an asthma inhaler as directed or taking insulin regularly and had an acute episode. Or the patient was having a medical issue, such as frequent migraine headaches, and didn't realize he could call the primary care provider for treatment," Wallsh says.

In those cases, the care coordinator works with the patients to get them a primary care appointment to treat the problem, educates them on how and when to take insulin or use an inhaler, and/or educates them on the appropriate use of the emergency department.

Cigna sends care coordinators monthly gaps in care reports, shares the same information with providers, and sends letters to the patients reminding them to get the recommended preventive test or procedure. The care coordinators follow up with patients on the list to help overcome whatever obstacles they have to following their physician's recommendations for preventive care.

They also contact patients who are not filling their prescriptions, determine the reason, and can call on Cigna's pharmacy staff for assistance. For instance, if patients say they can't afford the medication, the care coordinator can call on Cigna's pharmacy staff to help the physician identify alternatives. "The pharmacist may help the patient fill the prescription through Cigna's mail order program monthly, instead of quarterly, with an aligned patient cost or, in some cases, may be able to get the patient free medication," she says.

The care coordinators work closely with Cigna's case managers, disease managers, and health coaches to make sure patients' needs are met. Often, they collaborate with the Cigna case management staff to develop a coordinated care plan. For instance, Cigna's case managers typically coordinate care for conditions that include cardiac, complex gastrointestinal, and respiratory conditions. When patients need complex case management, the Cigna case managers take over coordination until the patient stabilizes, then turn it back over to the embedded care coordinators. However, the two clinicians may continue collaborating on the patient's care.

The care coordinators follow up with patients at intervals that vary according to patient needs. They may work with some for a short period of time or follow others indefinitely.

"By coordinating our resources with those of the Collaborative Accountable Care office, we are helping our members get healthier and stay healthier, and saving money at the same time," Wallsh says. ■

Health plan coordinates Medicaid member care

CMs provide long-term coordination

Recognizing the problems that Medicaid recipients face and the challenges health plans often encounter in reaching them to coordinate care, Passport Health Plan, with headquarters in Louisville, KY, takes a multi-pronged approach to providing case management for its members.

Case managers on the Rapid Response Team work with members who have short-term needs and need help accessing resources such as transportation and housing assistance, while the health plan's complex case managers provide longer-term care coordination. In addition, Passport has embedded case managers in primary care and behavioral health clinics to provide face-to-face assistance.

"In the past, the case managers mostly worked with members with multiple medical and/or behavioral health issues who required complex care, but we found that our case managers were spending a lot of time with members who had more immediate needs. We found that it was more efficient to have a separate group of case managers work with members who needed assistance for 60 days or

EXECUTIVE SUMMARY

At Passport Health Plan, one team of case managers helps patients with short-term needs such as transportation assistance, the health plan's complex case managers provide long-term care coordination, and case managers embedded in clinics meet members face to face.

- The Rapid Response Team links members who call to whatever resources they need, whether clinical or non-clinical.
- Complex case managers coordinate care for members with intensive needs and multiple co-morbidities.
- Case managers embedded in medical and mental health clinics assist members and build trust.

less," says **Cheri Schanie**, RN, BSN, CCM, manager of case management and care coordination.

After a successful pilot project in 2011 in which case managers were embedded in a primary care office and a community mental health clinic, the health plan expanded the program and now case managers meet face to face with Passport members at 33 sites.

"Medicaid members are a vulnerable population and encounter multiple challenges in their everyday life. We are trying to cover as many bases as we can to see that these members get the healthcare services they need," Schanie says.

Passport has publicized its Rapid Response telephone line to members, practitioners, and community advocacy agencies as a way that members can get short-term assistance. "The Rapid Response Team is trained to link members who call to whatever resources they need, whether they are clinical or non-clinical. Sometimes members are doing well except for one issue, such as being out of their medication. Other times, when the case managers talk to them, they determine that the member could benefit from complex case management once the issue is taken care of and makes a referral," Schanie says. For instance, someone who calls the Rapid Response line may need assistance finding a specialist in pain management or may be about to have his or her utilities cut off.

The Rapid Response case managers collaborate with provider offices or community agencies to get the issue resolved. "Our ultimate goal is self management. Often, the members are so overwhelmed that they don't know where to start. We try to get assistance set up, such as arranging for transportation to a doctor's appointment, then educate them on how to do it for themselves," she says.

For instance, a member who needs to take medication for a chronic condition may call after he has taken his last pill and the prescription needs prior authorization. The case manager on the Rapid Response Team would contact the physician and get the prescription filled, and conduct a short assessment while the member is on the phone to determine if he needs to be referred to complex case management.

"We try to get the urgent issues turned around quickly, but we also want to find out if the members need additional support from another case management team," Schanie says.

The complex case management team works with members with intensive needs such as multiple diagnoses and comorbidities. When they receive a referral, the complex case managers conduct an extensive assessment that includes a full medical history, medication review, mental health status assessment including cognitive functioning, substance abuse, ability to perform activities of daily living, caregiver support if any, and cultural or linguistic needs. Working with the member, they develop an individual care plan and set goals that the member agrees to try to reach.

"We also look at barriers to meeting the goals and what Passport benefits or community resources we could access to help meet the goals. When we refer a member to resources, we follow up to make sure they are able to access them," she says.

The case managers follow up with members at intervals determined by the acuity and complexity of the case. Initially, they may call the member every day, then taper off as the member improves.

Passport has disease managers who work with members with chronic conditions including asthma, chronic obstructive pulmonary disease, heart failure, and obesity. They are disease-focused and refer members with comorbidities and complex needs to the complex case managers. The health plan also has case managers who focus strictly on certain complex conditions including HIV/AIDs, sickle cell disease, cancer, transplants, and developmental disabilities.

Embedded case managers meet with Passport members when they see their providers and collaborate with the providers to coordinate care. "They put a face and name to Passport. It's hard to build trust when you're just a voice on the phone. In addition to building trust, having the opportunity to meet with members where they are receiving care decreases the chance for miscommunication or lack of connection. Our goal with this program is to meet as many members as we can to familiarize them with Passport," Schanie says. The embedded case managers in the physician offices make sure all members have had the recommended preventive screenings and help them overcome barriers to following their treatment plan. "They identify gaps in care and help our members access the myriad of programs Passport has to help them improve their quality of life," she says.

The case managers in the mental health clinic are a liaison between the mental health practitioner and the primary care physician.

"Many patients have medical issues that have not been addressed for a long time. The case managers help them make an appointment with their primary care physician and alerts the embedded case manager at the medical office if there is one," she says.

The embedded case manager at a mental health clinic worked with a member with schizophrenia who needed a hernia repair but hadn't seen a medical doctor in years. The case manager set up an appointment with a surgeon, but the patient got tired of waiting and left. She set up another appointment and alerted the embedded case manager at the medical clinic. She sat with the man and kept him occupied until he saw the surgeon.

"The mental health case manager saw him later and he was so grateful to have his problem solved. That's our goal — to assist our members in getting the care they need," Schanie says. ■

CMs being recognized but not compensated

Learn how to sell your value

While new regulatory mandates and payer requirements are making case management essential, case managers are still not getting the recognition they deserve in the form of increased compensation, says **Brenda Keeling**, RN, CPHQ, CCM, president of Patient Response, Inc., a Durant, OK, healthcare consulting firm.

The industry is beginning to recognize the value of case management; however, in some hospitals, case managers still aren't being paid as much as floor nurses, she says. "In rural hospitals, it's a fight to get case management positions and to pay them what they are worth," she says.

Marcia Diane Ward, RN, CCM, PMP, a case management consultant based in Columbus, OH, reports that her friends who are case managers are getting cost-of-living raises of 2% to 3% a year. "But whether they work in the insurance industry or the healthcare delivery industry, case managers often comment that most of what they do is paperwork and they don't have the advocacy role they once had," Ward says.

Achieving certification may be one way for case managers to get a bonus or an increase in salary, adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm.

"Many organizations will recognize and offer a slight salary increase for case managers who are certified. Even if organizations do not support certification, I strongly believe and encourage individuals to pursue this as a goal for themselves," she says.

Case managers who responded to the Commission for Case Management Certification's annual trend survey, sent to 5,000 certified case managers, report that their salaries are rising, says **Patrice Sminkey**, chief executive officer.

Many organizations are either requiring that case managers be certified when they are hired or that they become certified within two or three years, Sminkey says.

"Our certificants tell us that they have experienced an increase in pay once they get their CCM and that they have greater opportunities for advancement," she says.

But some case managers are leaving the profession because of low salaries and huge workloads, Ward points out. "One friend, who had been a case manager for eight years, took a job as a hospice nurse and has a much larger salary. In addition, she feels that now she is making a difference to her patients," she says.

Another of Ward's friends started her own business as an independent case manager and found a niche with money management companies who are looking for services to benefit their older clients. "They hire her to set up services for their clients and for life care planning," Ward says.

As case managers are being asked to do more for less, they are getting frustrated and have a high burnout rate, Keeling adds. "Everyone tends to forget that nurses get into the profession because they have a passion for caring and nurturing. When they feel like they are just pushing papers and not affecting patient care, they lose their effectiveness," she adds.

"Case managers are going to have to beef up the way we explain our role. We can't blame the salaries and workload on the industry and economics. We have not done a good job of educating people about case management and selling our role," Keeling says.

In the past, there has been a major focus on the utilization review side of case management, which has lead people to think of case managers as the chart police, she says.

"Case management isn't the kind of profession that has lobbyists who can promote our value. Organizations have got to see the return-on-investment and the data isn't easily available to show the value that case managers bring to the table," Ward says.

In fact, many case managers may not recognize the value they add to their individual setting, or they lack the skills to communicate their value

effectively, Mullahy says. But because case managers create additional overhead for the organizations that hire them, they need to obtain baseline financial data to demonstrate what savings case management interventions attain, she adds.

"We need to understand what the outcome could be [e.g. clinical, patient satisfaction, decreased hospital readmissions, financial impact, etc.] for the specific practice setting we are in, define just how we can achieve those outcomes, know what success will look like in that practice setting, and then communicate those results to those who need to know in a manner that is relevant and understandable to them," she adds. ■

How do your transitions of care rate?

A look from the other side

In the brave new world of healthcare, what goes right and wrong in patient care can't be blamed on someone else along the continuum of care. Rather, with the advent of Accountable Care Organizations, everyone has a part to play, and learning to play it well may make the difference not just in the quality of care provided to patients, but in whether an organization survives financially.

It was with that background that **Ning Tang**, MD, an internist at the University of California, San Francisco, wrote a piece in the August issue of the *Journal of Hospital Medicine*[1] outlining what she, as a primary care physician, sees as imperatives for hospitals in creating an ideal transition of care.

She outlines seven things that need to happen during the hospitalization: communicating with the primary care physician on admission, involving that doctor in discharge planning early, letting the doctor know when his or her patient is discharged, completing discharge summary at discharge, scheduling follow-up appointments by the time the patient is discharged, making sure the patient has or can get needed medications at the pharmacy, and educating the patient about managing his or her condition.

Tang outlines another seven items that are the purview of the primary care physician and his or her clinic staff within the first three days after discharge: ensure follow up appointments with the primary care physician are made, coordinate care, get the patient to medical stability, make sure patients with new symptoms have access to the physician, track readmission rates, and track and review frequent flyers.

What she notes in her article are all things seconded by other primary care physicians. What they say could be the inspiration of quality improvement projects that could transform transitions of care and make them better for everyone on the continuum. Below are five that could bring their wish list to fruition.

Ulfat Shaikh, MD, MPH, MS, associate professor of pediatrics and director of healthcare quality at UC Davis School of Medicine, is working on a project with clinicians and residents in pediatrics to improve transitions of care by getting the parties involved to communicate better.

Among the communication elements they are working on in her project are improving the timeliness and quality of discharge communications. "The Joint Commission has mandated what a discharge summary should include, and while most have the essential elements, they don't come in a form that the outpatient provider can make easy use of."

For example, Shaikh notes that if medications were changed while the patient was in the hospital, there needs to be a way to flag that in the summary, and include an explanation about why the medications were changed and how long they should be continued, or continued at that particular dose. "You rarely see something where the medications piece is completely missing, but you'll often get this long list of meds and no indication of why they were changed. I want to see that reason and for how long the change should last."

1. **Consider a chart audit that looks at unplanned readmissions and how many of them had changes in medications or dosages during the first hospitalization with notations on the rationale for the changes.**

Shaikh agrees with Tang that timely delivery of discharge summaries is vital for a good transition. "Most outpatients who are readmitted go back to the hospital in the first few days or first week. If the discharge summary isn't sent to the primary care physician immediately on discharge, then I have to recreate the hospitalization from the patient's perspective alone, which is hard and may not be completely accurate." Those missing pieces are often enough to tilt a patient into a situation where a return to the inpatient setting is required. If you can't get it to the primary care doc the day of discharge, then make sure it's there within 24 hours. That gives the doctor time to look through it before the patient comes in, usually on day three or four.

And make that summary succinct — about a page is usually enough. It needs to include all the pertinent information, but it shouldn't go on for pages. "I need to be able to absorb the information in a short patient encounter," Shaikh notes.

2. **Educate physicians on ideal length of discharge summaries.** What is the existing average length? Keep track of that number and post a trend chart. Reward those who have the best succinct summaries.

The way discharges are communicated is crying out for some standardization, Shaikh says. "If there is a discharge coordinator who can bring order to that process — make sure that there is a one-page discharge summary faxed or emailed within 24 hours, that it includes a list of pending labs, that everyone uses the same templates and language — that would go a long way to improving things." Shaikh is clear that a bunch of lone wolves doing things their own way won't play in the new healthcare world order. Everyone will have to quickly come to an agreement on the information included and the way to present it.

One thing she thinks would help make up for any lapses: Make sure a discharge summary leaves with the patient, too. That way, if something goes wrong in the process of faxing or emailing a copy to the primary care physician, the patient has one she can bring with her to the follow-up appointment, says Shaikh.

3. **Consider a QI project that tracks readmission rates for patients who get a copy of their discharge summary compared to patients who don't.**

One of Tang's colleagues at UC San Francisco, **Molly Cooke**, MD, says that what happens in transitions can range from the ideal described in literature to nothing. "Getting nothing still happens," she says. "Can you believe it?" Cooke, who is president of the American College of Physicians and the director of education for Global Health Services at UC San Francisco, has a fairly sick patient panel — she has specialized in the care of patients with HIV, among others — and they are often in the ED. "The most common thing I get is an electronic communication that my patient has discharged from the hospital and told he needs to make an appointment with me in three days. I may get nothing more than that."

The university's health system has a shared electronic health record, so sometimes there is a way to find out more, says Cooke. "But the ED may use a template that says the following: that my patient was seen for chest pain and that certain tests were done but nothing alarming was found. It will note that my patient needs to see me in three days. But that third day may be a Saturday and I can't do that suggested interval."

She says it's even more frustrating that it's often not clear to her why the patient, having just been cleared by ED docs, needs to see a primary care physician in such a short period of time. "If he isn't having acute coronary syndrome, but they fear that, it could be a reason to be seen quickly. But it doesn't say that. I need clear information about why they want me to see him in a particular interval. Without it, the patient has expectations that something is going to happen or be done, or there is something to worry about. If it's a 72-year-old who just wasn't feeling well generally, there is more reason to get a quick appointment than if it was a 20-year-old with anxiety and a tight chest."

A template that includes clear spots for information on pending tests, when to see the patient next, and why would be much more helpful, Cooke notes. "And include a list of red flags that, if we see them, mean we should call the hospital provider."

Good transitions of care require more than just checking off a list of to-do items, Cooke says. Those check boxes are great for internal and external quality metrics. But they say nothing about high-quality communication, which doesn't always happen. Many physicians use templates of admission notes, or copy and paste notes from one part of a record to another. Those copied bits can include statements that the inpatient doctor has contacted the primary care physician to notify her of the patient's admission when that didn't happen this time. Or last time. It happened three or four times ago, and the inpatient doctor is simply copying the admission notes over and over.

4. **How many charts of readmitted patients and frequent flyers have cut and pasted portions of charts from one place to another with no changes at all?**

5. **Facilitate a meeting between primary care and inpatient physicians about what data needs to be transmitted when. Compare it to what you are already doing.**

If you find gaps between what is needed and what is done, Shaikh says, that's fodder for a great QI project that could pay dividends — not just in quality of care, but in actual financial benefit.

REFERENCE

1. Tang, N. (2013), A primary care physician's ideal transitions of care—where's the evidence?. *J Hosp Med*, 8: 472–47 ■

Satisfaction surveys can improve patient safety

Patient satisfaction surveys often are thought of as a tool for more of the business side of healthcare than risk management, but they can be a useful way to help improve patient safety. What you find out about a patient's experience could reveal shortcomings that need to be corrected.

Satisfaction surveys already might address issues that directly affect patient safety, such as communication with the patient, explains **Ann Whitehead**, JD, RN, vice president of risk management and patient safety for the Cooperative of American Physicians (CAP) in Los Angeles.

"The information you glean from a patient satisfaction survey, if the questions are worded carefully, can tell you about more than just customer service issues," she says. "If they are unsatisfied with some type of communication by physicians or nurses, that is a warning sign for safety. If the patient does not feel that the communication back and forth is adequate, that can lead to a number of errors and quality issues."

Whitehead offers this example of how a survey question can reveal potential patient safety issues: The patient is asked to agree or disagree with the following statement: "The nurse asked me to talk about my current health concerns."

"The person who is asking the question needs to elicit from the patient what is going on in order to provide the proper care, and that requires asking the patient to talk about the situation rather than just looking at the complaint on the chart and proceeding," Whitehead says. "Mistakes can be made, or you can have a mistaken impression of what the patient's problem is. You certainly get customer service information from that response, but a low score can indicate that your clinicians are not taking the time to listen to patients."

Other questions could hit on issues such as documentation and discharge. Responses could indicate that patients found discrepancies in what they told the doctor or nurse versus what was recorded. Or patients might report that they were sent home without adequate explanation of their medications or follow-up needs. All should be red flags for a risk manager, Whitehead says.

Whitehead cautions that risk managers cannot depend solely on complaints or threats to sue. The fact that patients do not complain does not necessarily mean they are satisfied with the care they are receiving, she says. The best survey questions elicit information from the patient about real events that transpire between the physician, staff, and the patient during treatment encounters or hospital stays.

Chances are good that the information useful to a risk manager already is being collected in the hospital's patient satisfaction surveys, Whitehead says. "What's important for the risk manager is to get involved in the process," she says. "Get the information from the surveys and find the questions that could have an impact on patient safety, then request the data so you can dig deep. Find the person who calculates all the information from the patient satisfaction survey and let that person know you are eager to hear of any results that could affect patient safety and quality."

COMING IN FUTURE MONTHS

- Tips for monitoring and training case managers
- Are you providing culturally competent care?
- Meeting the special needs of the elderly
- Case management in accountable care organizations

It also is possible to add questions to the survey that are tailored specifically for risk management concerns, Whitehead says.

"In most cases, the information is already there in your facility somewhere, and you just need to find it," she says. "More data is always good when it comes to improving patient safety, so don't overlook what's already available to you." ■

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's free blog at http://hospitalreport.blogs.ahcmedia.com/. *Case Management Advisor's* executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute. ■

CNE QUESTIONS

1. According to Marcia Diane Ward RN, CCM, PMP, there should be a case manager to tie all the pieces together at any place a patient enters the healthcare system for care.
   A. True
   B. False

2. What is the minimum number of years of experience in the clinical setting that Taconic Professional Resources embedded case managers have?
   A. Five years
   B. Ten years
   C. 15 years
   D. 20 years

3. How soon after discharge do case managers in Cigna's Collaborative Accountable Care initiative contact patients?
   A. Within 24 hours
   B. Within 48 hours
   C. Within 72 hours
   D. Within a week

4. Case managers who are on Passport Healthcare's Rapid Response team typically work with patients who need support for how long?
   A. 60 days or less
   B. Three months
   C. 90 days
   D. Indefinitely

CNE OBJECTIVES

After reading this issue, continuing education participants will be able to:
1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.

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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. Scan the QR code below or 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. ■