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PART

Practice Settings and Models of Care

As the delivery systems of health care change with advances in technology, funding streams, and legislation, case management practice settings evolve. Beginning as a community based in public health, case management has grown to add value to workers' compensation, liability, disability, and health insurance, and to locations of care including hospitals, accountable care organizations, direct to consumer, the home, long-term care, and many more. Each practice setting has its own unique structure, features, and financial incentives that shape the practice of medicine and case management. The Standards of Care and Standards of Practice give shape to each practice setting to maintain case management consistency and quality. Part III offers an in-depth look at six of the most prominent practice settings today.

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CHAPTER 5

Hospital Case Management: Changing Roles and Transitions of Care

Hospital or acute care case management is one of the largest settings for case managers, second only to that of managed care. We have witnessed the continuing evolution of the role and function of those in this practice setting, from what might be considered the first generation, a clinical model introduced by Karen Zander at the New England Medical Center with a nurse case manager at the center, from 1985–1991; the second one spanning 1991–2001; and the current third generation, beginning in 2001 to the present.[1] Over the last few years, however, and especially with the financial penalties being imposed around hospital readmissions, no other practice setting has undergone such dramatic changes. Fortunately, these will result in positive results for patients, institutions, and most notably, case managers. An examination of the past will allow us to understand all of this better.

At the time of the HMO Act in 1990, and with the initiation of prospective payment systems, hospitals were under tremendous pressure to downsize and reduce costs. Two professional groups became the responders to this "call for action." Nurses, who conducted utilization review activities, and social workers, who were involved with patients requiring placement in rehabilitation or skilled facilities, provided interventions that reduced the length of stay, while meeting the regulatory and medical necessity requirements of the payers. Several case management models were used by hospitals in the 1990s, including *consolidated* models with the nurses and social workers in their separate departments performing their assigned functions and reporting to one director, and an *integrated* model in which the activities of utilization review and case management were now the responsibility of one role. This role, for the most part, was assigned to the nurses and resulted in the downsizing and sometimes elimination of many social work departments. In many hospitals today, practitioners define their role in terms of utilization review and discharge planning. Regrettably, and we have all witnessed this, many patients were being discharged "sicker and quicker," only to be readmitted days or weeks later. Little concern about these readmissions was being raised by those involved in the process, from the case managers all the way up through hospital administration. In discussion with case managers working in hospitals, I would often ask and in fact challenge them to respond to what would seem to be someone's responsibility to ensure that patients being discharged "sicker and quicker" actually were safe in their homes; that equipment did arrive and was working; that home care and therapy services were appropriate; that medications were understood; that follow-up appointments had been secured; and so on.

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Responses were somewhat discouraging, and occasionally disturbing. Comments ranged from, "Our caseload doesn't allow for the time to do that" to "We give them a discharge checklist when they leave with numbers to call" to "It's really not in our position description and the hospital is concerned about our liability." The most distressing response, however, which was unfortunately confirmed by others in attendance at one of our seminars, was: "Well, the hospital has been having financial problems and if the patient comes back, that provides additional funding . . . and I need and want to keep my job."

It is said that teachers learn from their students, and this in fact presented me with a lesson that had concerned me for years. Why was this readmission problem occurring? Why were the numbers of patients who were caught in this cycle increasing? In reality, there were even some disincentives that discouraged a better process, one that would promote a safer and more effective discharge to the patient's home or alternate setting. The disincentive? The reimbursement that would occur for each subsequent admission was the answer. Although I came to appreciate this dilemma a bit better, I believe that as nurses, social workers, and case managers we are held to higher standards and have legal, moral, and ethical obligations to our patients. When these case managers knew all too well about the "frequent flyers" that they saw all too often, I wondered,

> Why were the problems not being identified and resolved?
> Why were they not creating innovative programs to keep these patients safe?
> Why were folks not paying closer attention to the transitions of care as patients moved across the continuum?

Although having the reimbursement issue caused us to have somewhat of a conflict of interest, do we not have a responsibility to protect our patients from the kinds of incidents and complications that we know are all too common these days in our hospitals (e.g., nosocomial infections, medication errors, increased costs, and the anxiety and discomfort that results from each hospital admission)? Despite these occurrences in hospitals all across our nation, the readmission cycles continued. Consider the following: Nationwide the length of stay has decreased, whereas the nationwide rate for adult medical-surgical patients, depending upon the diagnosis and the payer, has risen from a range of 5–29% after 30 days to an average of 19%.[2] In an article in the *Professional Case Management Journal*, author Karen Zander, who has spent the better part of her career creating case management programs for hospitals, shared the following:

> . . . Although there are many factors at play, the increased readmission rates should be considered an embarrassment to patient management, and a cry to hospitals to help us make strong and immediate corrective actions . . . considering unplanned readmissions as well as visits to the emergency department shortly following discharge as failures, no other business would accept such a high failure rate. . . .[3]

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More and more often, professionals were being engaged in activities that removed them further and further from the patient. Most entered case management, because in hearing the definition, not only from one organization but from no less than three professional/credentialing organizations, they really did believe that they would be able to make a difference. They *heard* that case management was highly specialized, targeted to the small group of complex, vulnerable patients at risk for the problems and complications that could occur in the increasingly convoluted healthcare system, and they entered this profession to make a difference. Unfortunately, so many were disappointed. As more and more non-patient-related tasks were added—chart reviews; LOC (level-of-care determination); LOS (length-of-stay reviews); appeals and denials; coding and documentation; preparation for the CMS Recovery Audit Contractors (RACs), whose goal is to recoup inappropriate payments; and on and on—some of these individuals came to realize that what was being called "case management" was not what they thought it was . . . or could be.

It's important, I believe, to have a discussion about utilization review/management, because although in many hospitals it continues to be a large portion of a case manager's day, it really is *not* within the definition of case management itself. Consider the following:

> Utilization management, commonly and incorrectly included among care management subtypes, identifies the presence of: 1. an insurance benefit and 2. medical necessity. It does not assess, assist, and advocate for patients with barriers to health, that is, educate or problem solve, but rather adjudicates whether a health service is covered, needed, and should be reimbursed. Because utilization management is not a patient "helper" function, it is not considered under the term care (case) management but rather is a benefit management activity.[4]

The aforementioned is not intended to dismiss the relevance or importance of utilization management services. Those professionals who are engaged in this activity, as well as involvement with RAC audits, LOC determination, documentation, and coding, are providing services directly related to the financial reimbursement of the facility—and for each facility that is indeed an important function. It has nothing to do, however, with identifying appropriate patients, assessing their needs, communicating and collaborating with others, advocacy, care coordination, developing and evaluating care plans, and everything else defined in the *process* of case management toward the goal of improving patient outcomes.

Change *is* occurring in hospital case management today, and although it would have been wonderful if the leaders in case management in the respective hospitals could have led this initiative, unfortunately, another factor is largely responsible. What is this you might ask? Once again, financial reimbursement is the answer. This time, however, it is

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the *lack* of reimbursement that will be the result when CMS (and others in the commercial payer sector that will surely follow) enacts its recommendations regarding reimbursement. Beginning on or after October 2012, a Hospital Value-Based Purchasing Program (HVBP) will use a complicated formula to reward or penalize hospitals for how well they perform. Eventually, hospitals that are in the top tier of hospitals with 30-day readmissions for the diagnoses selected by CMS (congestive heart failure, pneumonia, and acute myocardial infarctions) will be penalized by 1% of their total discharges; by 2% in fiscal 2014; and by 3% in 2015. Additional diagnostic conditions are expected to be added.

So the focus of case management in hospitals is or will be changing. This model will need to be a transformative one, and organizations will need to engage physicians, utilize resources more effectively, and enact processes that that will drive the progression of care and result in outcomes that are measurable and demonstrate a return on investment. For those case managers that truly enjoyed their role as reviewers and chart auditors, the change to newer roles and responsibilities may be disquieting. Doing what we've always done, no matter how good we were at it, will not obtain the results we need. We will have to look to new ways of looking at old problems. The processes defined by CMSA and CCMC (see Chapters 1 and 3) are the ones we need to embrace. Our role as patient advocates, which is at the very heart of case management, will mean a movement away from something known to a far more complex and hopefully more rewarding role. Because this is an evolving process, case managers will need to define their new roles in the hospital. Unfortunately, there is not a standard reference model or an evidence-based one—a valid prototype, if you will. Zander notes that in their book, "The Leader's Guide to Hospital Case Management" Daniels and Ramey affirm this and observed five distinctive models over the years that they have been working with and researching hospital case management. The models are:[5]

- Clinical (as implemented by Zander), characterized by direct patient care responsibilities
- Collaborative practice involving a multidisciplinary team approach using clinical pathways, variance reporting and teaching plans to evaluate care
- Population models where case managers are assigned to service lines or have involvement with specific conditions (e.g., congestive heart failure)
- Functional, which encompasses utilization review and discharge planning
- Clinical resource management model, in which case managers have a collaborative relationship with attending physicians and/or hospitalists with a goal of moving the patient through the acute care continuum

Each of these models has strengths and weaknesses, and the hospital's culture and politics often have more influence on the purpose and role of a case management program than what would be proposed by the leaders of case management in the organization. We will

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also need to be able to leverage our position in the organization with both hospital administration, which is concerned about financial viability and its reputation in the community, and the medical staff, who for the most part lack business savvy and just want to be able to do what they believe is best for their patients on behalf of the patients. As Daniels states, "... we are burdened by a lack of understanding of just what constitutes hospital case management practice, model designs efforts are a challenge ... highly painful for organizations that still consider UR and DCP (discharge planning) as the scope of case management practice."[6] Creating a "one-size-fits-all" model may not be an attainable goal; however, a look to our standards of practice will be of great assistance—if we operationalize them.

Case managers in every practice setting, but especially those in hospital settings with the new looming financial consequences upon them, cannot afford to wait for the perfect case management model. We can, however, address and then create solutions for many of the challenges and problems that our patients face and that become consequential to the many hospitals across our country.

Daniels, as she discussed in "Introducing HCM v3.0: A Standard Model for Hospital Case Management Practice," shared that over the years as a consultant she conducted surveys of hospital case managers. Several questions were asked to determine the kind of preparation they received, their perception of the intent of the hospital's case management program, and expectations of the HCM role. The question that perhaps provided the best insight: "How do you know that you are making a difference?" Many of the responses are quite enlightening, and in addition to the standards of practice and various definitions of case management, provide a wonderful framework for the creation and development of a program that will really optimize the potential for success. Some of the responses included the following:

- HCMs are proactive patient care advocates.
- HCMs serve as facilitators and patient care navigators to promote progression of care.
- HCMs are valued as consistent resources to the patient, family, and clinical team to keep the progression of care moving forward.
- HCMs are able to overcome roadblocks to progression of care so that the patient is minimally exposed to the iatrogenic risk of hospitalization.
- HCMs proactively anticipate post–acute care needs and take necessary steps to put them into action.
- HCMs partner with nurses, doctors, and other professionals to promote quality of care standards through knowledge of evidence-based protocols ... core measures of quality, hospital consumer assessment of healthcare providers and systems.
- HCMs demonstrate their value with measurable outcomes.[7]

Although there may not be consensus about a definitive model for HCMs, research has been conducted over the years, including that by Terra, who concluded that there is

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adequate evidence-based literature to acknowledge several key factors that would seem to underscore the components of advocacy, structure and operations, progression of care, and value:

- The preferred case management model results in measurable outcomes that can directly relate to and are in alignment with organizational strategy.
- Monitoring the delivery of patient care against evidence-based guidelines can identify opportunities to facilitate improved services.
- An effective program should be integrated, including both nurses and social workers.
- Patient and family contact is a required component.
- A successful case management model will recognize physicians as valued customers with whom partnership can positively affect outcomes.[8]

As stated previously, the problem that has been noted at every level is that of readmissions. A landmark study in 2009 found that almost 20% of Medicare beneficiaries who were discharged from hospitals were *readmitted within 30 days*. Of the *medical* discharges/readmissions, there was no follow-up visit to a physician in over half of the cases; of the *surgical* discharges/readmissions, more than 70% were readmitted for a *medical* condition. Not surprisingly, the estimated cost of avoidable rehospitalizations within 30 days of discharge has soared to a massive $44 billion.[9] Readmissions and their causes have not usually been high on anyone's radar, typically because they occur one patient at a time, each with a somewhat different scenario, including diagnosis, prognosis, age, and the like. However, a few diagnostic conditions have been identified that statistically have a higher rate of readmission than others, and confirmation of this is typical because I frequently ask folks if they know who their "frequent flyers" are in their respective institutions. Regrettably, although these patients are known, the management of their care never seems to change from one admission to another. Adding to the problems is the reality that in the subsequent admissions, there is frequently a different team of physicians, nurses, case managers, social workers, and so on—even different hospitals. In the rushed environment and the desire of all to move the patient along the continuum, we fail to take the time to look backward before we move forward—a process that would seem to be rooted in common sense and curiosity, but again, never seems to happen. This too, thankfully, is changing. We need to be able to examine just what went wrong either while the patient was in the hospital or when he or she went home. Identifying singular accountability for the outcomes of satisfaction and readmissions has been lost between the cracks of busy units in which no one "owns" the patient.[10]

Interestingly Zander notes that, as far back as 1921, Mary Burns, a registered nurse, outlined four recommendations as a result of 200 patients discharged from four hospitals in Cleveland, Ohio. They continue to be valid today.

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1. The patient's confidence in, and cooperation with, the treatment must be solicited.
2. Health teaching must include an understanding of the present illness and the means of preventing recurrence.
3. The patient must be included in planning for his aftercare.
4. Records of hospital and dispensary treatment received by the patient should be maintained to facilitate communication among medical agencies.[11]

These recommendations, had they been implemented, would seem to have been a highly successful strategy for more successful discharges from hospitals. However, today's litigious environment, care complexity, and more constraints and regulations have made everything more complicated. Zander cites the following as just a few of the challenges:

- Insufficient time to really know about a patient and family, let alone teach them.
- More steps have been added to the discharge process, including the federally required Important Message (CMS Office of Public Affairs, 2007) and Patient Choice.
- Insufficient number of post-acute agencies or specific types of beds e.g., bariatric or renal dialysis.
- There is *no one person* whose responsibility it is to know and teach the patient . . . and in fact there is massive role confusion and blame.
- Hospitalists serving as the attending physician for more and more hospitalized patients.
- Emergence of shifts convenient to hospital staff but not necessarily conducive to team meetings with family members.[12]

There seems to be considerable difference in the literature not just in the definition of case management and delineation of its role and functions in the hospital setting, but even which patients would meet criteria for this intervention. If we accept that case management should be focused upon those most at risk, then it would also seem appropriate that not every patient in a hospital should be seen by a case manager. In many hospitals today, however, especially those that continue to have utilization review and the other financial reimbursement activities as part of that role, case managers are seeing every patient. There is a saying that if you manage everything, then you manage nothing. It is also true that no matter the setting in health care, there is a smaller group of individuals who have a disproportionate share of the problems and incur the greatest costs. To that end there needs to be a methodology to identify *appropriate* patients for hospital case management services. This does not require an in-depth, comprehensive assessment by a member of the case management department of every inpatient, nor

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do our standards of practice mandate it. In fact, our standards of practice and process of case management requires that there is a case finding, screening, and stratifying risk process in identifying appropriate patients for our services. In a hospital, the clinical team already has two documents that could readily serve as a screening tool. Every patient has an admitting history and physical by an admitting physician, and every patient has an initial patient assessment conducted by a nurse.[13] Utilization of these documents with the appropriate "red flags" as triggers could certainly allow for a more effective assignment of case managers *only* to those patients who meet the established criteria. Some indicators for case management might include age, living situation, previous admissions, cognitive deficits, or sociologic issues that alone or in combination with other factors might warrant the intervention of a hospital case manager. As in all other areas and practice settings where case management is available, there is a responsibility to provide it in the most efficient manner. With the realignment of resources, and a focus upon the *process* of case management rather than utilization review and financial reimbursement issues, case managers can provide an intervention that will make a difference to the patient, family, providers, hospital, and payers.

Many demonstration projects have been conducted not only to identify the factors that result in these rehospitalizations, but also to provide evidence-based guidance and direction to hospitals and their case management staff. In a highly successful and innovative collaborative effort, several prominent organizations (Health Services Advisory Group, Inc.; the Quality Improvement Organization for Arizona; and the National Transitions of Care Coalition [NTOCC] coordinated by the Case Management Society of America [CMSA] in partnership with Sanofi-Aventis, U.S.) came together and produced a white paper titled, "Care Transitions Bundle: Seven Essential Intervention Categories." The full document is available at www.ntocc.org; however, the seven essentials are summarized here:

1. *Medication management:* Ensuring the safe use of medications by patients based on their plan of care, counseling about their medications, and a plan for medication management as part of their overall plan of care.
2. *Transition planning:* A formal process that facilitates the safe transition of patients from one level of care to another, an identified practitioner to facilitate and coordinate that transition, and management of the patient and family's transition needs.
3. *Patient and family engagement/education:* Patients and their families need to have an understanding of the nature of their diagnosis and their plan of care, and need to be able to develop self-care management skills.
4. *Information transfer:* There needs to be a timely and effective method of sharing information about the patient with the patient/family and those that will be involved with his or her care.

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5. *Follow-up care:* Patients and families need timely access to key healthcare providers after an episode of care, as required by the patient's needs and condition.
6. *Healthcare provider engagement:* Clearly identified primary physician; use of nationally recognized practice guidelines; and open and timely communication among the providers, patients, and families.
7. *Shared accountability across providers and organizations:* Ensuring that a healthcare provider is responsible for the care of the patient at all times.[14]

In another evidence-based initiative funded by the Agency for Healthcare Research and Quality, Project RED (Re-Engineered Discharge) is a research group at Boston University Medical Center that develops and tests strategies to improve the discharge process in a way that promotes patient safety and reduces rehospitalization rates *and* has resulted in a marked improvement in patient satisfaction (https://www.bu.edu/fammed/projectred/).

With an understanding of the history of hospital case management; a recognition of some of its problems; a willingness to embrace something different, yet evidence-based; a realignment of resources; and a real desire to focus upon what matters, case managers can make a difference—one patient at a time!

NOTES

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