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Hospital Case Management

A Review: 2019–2022

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ABSTRACT

Purpose/Objectives: In June 2019, a Case Management Society of America (CMSA) task force published "The Practice of Hospital Case Management: A White Paper." This was an important first step to outline the value of hospital case managers (HCMs) and to put forward recommendations for how to operationalize a major change in most hospitals for how case managers can practice.

The SARS-CoV2 (COVID-19) pandemic drastically changed the practice of all interdisciplinary work within hospitals. The White Paper recommended that HCMs follow a select patient population through the hospital. Hospital case manager leaders realized that HCMs can work remotely and communicate with patients because meeting them in person was not an option. Hospital case managers are still resistant to leaving the hospital unit–based model, even after they experienced the value of this concept during the height of the pandemic.

Primary Practice Setting: Acute care hospitals.

Findings/Conclusions: The White Paper recommended separating HCMs from utilization management. One unintended consequence is the loss of necessary knowledge and competencies. These are related to compliance with the Centers for Medicare & Medicaid Services Conditions of Participation and regulatory mandates that can affect patient care and financial well-being. Hospital case manager leaders must stay current with these government requirements for hospitals and for all levels of care and keep the case managers informed, proficient, and fluent when coordinating the care of patients.

Implications for Case Management Practice: Hospital case manager practice is evolving; change is the single constant in health care. This review of the CMSA Hospital Case Management Whitepaper demonstrates that in just three short years, the landscape of health care can change dramatically.

Today's HCM leader must proactively address a multigenerational workforce, lack of title protection, and the COVID-19–induced "Great Resignation." The value of the HCM has never been more apparent as during the pandemic as the need to "empty beds" is critical, and the HCM is the professional who has the skill to provide efficient and patient-centered care coordination. The HCM leader practices positive leadership techniques that benefit the leader, the HCM, and most importantly the patient.

Key words: *Case Management Model Act, hospital case management, title protection*

In June 2019, a Case Management Society of America (CMSA) task force published "The Practice of Hospital Case Management: A White Paper." This was an important first step to outline the value of hospital case managers (HCMs) and to put forward recommendations for how to operationalize a major change in most hospitals for how case managers can practice.

Even while some HCM leaders began to consider the White Paper recommendations and how to implement the necessary changes relevant to their hospitals, all of health care was rocked by the SARS-CoV2 (COVID-19) pandemic. It drastically changed the practice of medicine, surgery, nursing, and all interdisciplinary work within hospitals. In the early days, confusion, distraction, and panic on how to stay safe and keep our patients safe predominated over every other initiative that was previously considered by hospital leaders (Robbins et al., 2020).

For example, HCMs who previously could not imagine working remotely were forced to interview patients and their families from a location removed from the nursing unit with phones and electronic technology due to strict isolation requirements. Although these were not ideal circumstances for many HCMs, the forced and dramatic change revealed that remote work with patients, even within the hospitals, is possible and can, in concert with face-to-face time, be efficient and meaningful for the patients and the HCMs.

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In the early days (of the pandemic), confusion, distraction, and panic on how to stay safe and keep our patients safe predominated over every other initiative that was previously considered by hospital leaders.

The pandemic ushered in changes perceived as both positive and negative that will be discussed throughout this article, as the pandemic must be considered a seminal event both now and far into the future.

HCM Role and Focus

The CMSA White Paper acknowledges that a geographic nursing unit assignment for an HCM has value when the hospitalists and the care team are assigned to the same unit and the patients are grouped by specific clinical needs. In this scenario, the entire interdisciplinary team is unified by the shared clinical and financial purpose, goals, and outcomes (McLaughlin-Davis, 2019). However, most hospital units are not entirely homogeneous and not every patient on a nursing unit requires an HCM. The need to quickly establish an HCM to a patient ratio during morning assignments should not trump using HCMs to effectively coordinate care for the patients who need the specialized service. The task force outlined how HCMs should provide HCM services only to patients who require them and to ensure continuity; whenever possible, the patient should be followed by the same HCM.

Although the White Paper discusses the reality that HCMs are not restricted to nurse case managers and social worker case managers, the task force found that these two disciplines are predominate. However, the authors have also found that many still have not fully embraced their necessary role to coordinate care with the patient and the interdisciplinary team.

Assigning an HCM to a specific nursing unit when patients can be transferred within the hospital and off of that unit is detrimental to the patient's care coordination plan. It is in the authors' experience that assigning an HCM to a patient population versus a hospital unit is one of the most difficult changes to make. Hospital workflows are built around the HCM sitting on a particular hospital unit and in many ways that HCM desk is the focus of the interdisciplinary team as the patient's care coordination plan is developed. The authors know that all care coordination is by definition patient centered and yet, it can be HCM centered by nature of where they sit and the number of patients on the hospital unit they carry on their list.

Although other members of the interdisciplinary team play key roles in assisting the patient with a safe coordination plan, HCMs often slip into the more passive role of "discharge planner." The task force made clear in the White Paper that HCMs are not discharge planners. For example, a physical therapist may recommend acute inpatient rehabilitation for a surgery patient with limited function and mobility. Consequently, some HCMs will submit a referral for acute rehabilitation. However, the HCMs should know whether this recommendation aligns with the patient's short-term goals and wishes. They should also know whether the patient can be admitted to an acute inpatient rehabilitation hospital or unit, based on the criteria for admission and their insurance coverage. The HCMs can and should advocate for the patient to receive the ongoing care necessary for their optimal level of recovery. Nonetheless, it is incumbent on the HCMs to be well versed in the medical, functional, and financial criteria needed for transferring a patient to acute rehabilitation, or to any other post–acute level of care.

The authors must change the construct and put patients at the center of care delivery in the hospital and beyond. The HCMs need to understand the patient's journey and perspective and cease operating in a discharge planning silo gathering the information they need and driving care through the HCM lens rather than the patient's lens (Stinebuck & Ferguson, 2021).

HCM and Compliance

Hospital case manager, in many hospitals, is separate from the utilization management (UM) work resulting in the formation of two distinct teams. This separation was supported by the CMSA task force and is still the authors' strong recommendation. However, as with any change, there are unintended consequences. The HCM is rightly focused on patient-centered care coordination; however, unless the HCM leader is astute, the HCM can lose expertise in regulatory and compliance mandates and loss of knowledge about medical documentation integrity, post–acute care criteria, and financial imperatives. The loss of the working partnership with the physician advisor may also occur.

The HCM leaders, in conjunction with UM, must guide their teams to understand hospital contracts with health care plans, and with Centers for Medicare & Medicaid Services, to include a myriad of payment models, such as the Accountable Care Organizations, Bundled Payments, and the recent COVID-19 waivers. Strong partnerships with the interdisciplinary

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team and the hospital physician advisor are essential to meet the new clinical and financial objectives of the payer and provider contracts.

Most patients are in the hospital for a very short time and this is to their benefit. Shorter inpatient stays decrease their risk of acquiring a hospital nosocomial infection, experiencing an adverse drug event, or developing a pressure ulcer. Readmission rates increase from 9% to 28.1% when length of stay (LOS) increases from 1 day to 15 or more days. The hospital also benefits from a decreased LOS through increased inpatient capacity to meet growing need and demand, decreased complication rates, and improvement in the hospital's financial health (American Hospital Association, 2019). The imperative for patients staying in acute care for only the time required poses a challenge for smooth care coordination. The need to coordinate the care of patients quickly requires HCMs to possess stellar interpersonal skills and excel in communication techniques. Hospital case managers have the patient for a limited time and they must work quickly and effectively. This is true relationship-based care.

Length of stay and readmissions are quality measures, demonstrating effective care coordination. In order for HCMs to have a clinical yardstick for diagnosis-driven LOS, they need to have a rudimentary understanding of the clinical criteria used by the UM teams at the hospital and the health plans.

Patient status is another concept not well understood by newer HCM. Although many observation patients are placed in rapid observation units and they do not require the attention of HCM, there are often exceptions. Observation patients placed on medical/surgical nursing units due to deficits in their social, cognitive, psychological, and/or physical function can be absorbed into the general nursing unit population without awareness by the team of the patient's observation status. This leads to the inability in some cases for the patient to access their skilled nursing benefit, and they can experience higher copays for the bed as well as their medication and other ancillary services. As patient advocates, HCMs must inform their patients of how observation status affects them and work with selected patients to coordinate their care quickly and safely from hospital to an appropriate level of care.

Hospitals and HCMs are required to comply with the Centers for Medicare & Medicaid Services Condition of Participation (CoP) for Discharge Planning. The heart of the CoP addresses the importance of including the patient in the care coordination planning and including their goals and their treatment preferences in the discharge planning process. This plan ensures a seamless coordination process from hospital to post–acute care. Within the plan, the factors leading to preventable hospital readmissions must be mitigated (Federal Register, 2019).

Hospital case managers must understand the basic underlying principles within the compliance and financial mandates that HCMs are required to follow. The mission and values of the hospital system in conjunction with the CMSA Standards of Practice provide the framework from which they should operate. The HCMs must have a strong foundation of case management principles, standards, and practice. This is necessary for them to understand, communicate, and implement the newer payment models and the COVID-19 waivers. These are the competencies that are required to provide care coordination for our hospitalized patients.

Hospital Case Management: Going Forward

The impact of the COVID-19 pandemic is all encompassing and cannot be discounted. As the pandemic continues in various waves and surges, the potential for health care burnout increases exponentially. The aptly named "Great Resignation of 2021" is demonstrating disturbing trends that could impact the state of hospital case management.

Robinson (2021) reports that health care industry resignation rates rose by 3.61% between March 2020 and March 2021 and the trend continues. There is significant concern that burnout among health care employees, demand for increased job mobility, and pressure on hourly pay will continue to increase turnover rates and add further risks to health care. Resignations are rising most frequently among midcareer workers. "Employees ages 30–35 (21.5%), 35–40 (19.6%) and 40–45 (25.1%) saw large increases in resignations, signaling that workers who are more established in their careers have continued to shift jobs" (Robinson, 2021).

Critical staffing issues across all disciplines have opened the opportunity to work in a similar position for

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a contract agency for significantly more pay, creating staffing issues across the continuum of care. For example, during the early days of the pandemic in Chicago, the state government worked to create "alternative care sites" for COVID-19 patients who were unable to return to their prior domicile posthospitalization. Ten-week contracts were offered at a rate in which the hospitals could not compete, beginning an exodus from the hospitals at a time that the facilities certainly could not withstand staffing turnover. The "Great Resignation" has continued. The turnover of staff "chasing the money" is how one case management director colloquially termed the phenomenon.

Remote work, once eschewed, is now preferred and there is reluctance to return to pre-COVID work environments. "Work from home" opportunities are actively sought out as being more attractive for work/life balance and perceived lower stress. Add into this mix the fact that the average age of those practicing case management is 50–55 years and succession planning becomes a major priority for the profession. Who will be there to take up the mantle and how do HCMs ensure that they are well prepared to take on the baton of leading case management into the future?

Promotion of Professional CM Practice

"Millenials" are currently the largest segment of the US workforce, comprising approximately 50% of the nation's employees. In addition, Generation Z (Gen Z) job seekers will account for 20% of the workforce within the next few years. Compared with baby boomers and Gen X workers, Millenials and Gen Z come to the workplace with differences in their expectations and desires in the workplace. Health care in general and case management in particular need to address the needs of the next generation of case managers if HCM leaders are to be successful in succession planning.

Topics including transparency around pay, making a long-term investment in workforce, and aligning employee goals to the facility and making them easily understood are the top three desires of this group. Open communication is key to success. Being able to demonstrate that the employee is valued by the employer through creation of development pathways, promotion of work/life balance, and providing a personal experience through frequent manager/employee check-ins are some key strategies to engage the workforce of tomorrow (Ceridian, 2019).

Title Protection and the Case Management Model Act

As the "Great Resignation" continues, there is an increased risk for unprepared individuals to be shuffled across disciplines to fill the gaps left in critical areas. Defining the term "case manager" is vital to the ongoing promotion and protection of the profession of case management. Imagine calling your local auto dealership or bank with a question or issue to resolve and being told that your "case manager" will be calling you back to assist you. This is happening every day. The title of "case manager" is being used in every industry without definition or design.

Title protection, according to Muller (2016), is the "limitation on who can say I am a doctor, I am a nurse or I am a social worker." Title protection addresses that the person identifying themselves as that specific profession or discipline has the required licensure and training to practice as such and through that protects the public from risk from unqualified individuals practicing in the profession or discipline.

One way to protect the practice of case management is to look to the Case Management Model Act (CM Model Act), adopted by the CMSA (2017). This Act defines the practice of case management, advocates for title protection, and outlines the scope and role of case management in promotion of clinical outcomes, value-based purchasing, quality improvement, and advancing integration in health care across the care continuum. Section III addresses the professional case manager qualifications in detail, as well as defining the role of the Case Management Extender. Section VIII outlines the need for a training/orientation program before a case manager can assume assigned roles and responsibilities. These are vital pieces to protect and promote the practice of professional case management. Too often, as a past CMSA president, Nancy Skinner says, people are "poofed" into the role of a case manager, meaning that they are hired or transferred into the department and given the title of "case manager" without appropriate or adequate training. This practice puts the profession and the public at risk.

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The Importance of Positivity

Hospital case manager leaders have the "Great Resignation," lack of title protection, and fragmented training. Why would anyone want to become a professional case manager and how do those of us in case management already stay positive about our profession's future? As professional case managers, we act as advocates for our patients. Hospital case managers need to become better advocates for ourselves and our profession. The task force emphasized the value of HCM leaders defining the case management profession for hospital executive leadership and describing why hospitals cannot function without professional case managers. Hospital case manager leaders should reflect on HCM history, evolution, and growth, in preparation for this important presentation. The following points can guide this exercise:

1. Understand why the role of case manager is so important to health care. Case managers are at the center of a complex world of improving health, managing costs, and improving patient experience. Truly, HCMs are the masters of patient-centered care. Social determinants of health have become recent buzzwords to the rest of health care; case managers have identified and addressed these for years. Master collaborators and coordinators, unparalleled critical thinking skills, and the ability to think outside the box for a resolution, case managers meet people where they are, empowering and motivating patients to help them meet their goals.
2. Explore your "why." Why are you in case management? What brought you here? Would you recommend case management to a non–case manager? Why or why not? If yes, discuss the opportunity with them. If no, why not and what can be done to change that "no" to a "yes"?
3. The power of numbers: A favorite quote from Margaret Mead is "Never doubt that a small group of thoughtful, committed citizens can changed the world. Indeed, it the only thing that ever has." Professional associations are vital to the success of any profession as a springboard for advocacy and gathering place to affect change.
4. Get involved. Not happy with the status quo or changes proposed that will affect your practice? Your choices are to suffer in silence or do something about it. It could be a little as calling or writing your supervisor, newspapers, or elected officials about your concerns. You control how much you do, but do something. That one action can stimulate positive feelings of actions in yourself and others around you.
5. The power of positivity cannot be underestimated. It is hard to stay positive with all the challenges HCMs face daily. Lisa Bonsall, MSN, RN, CRNP (Fryling-Resare & Bonsall, 2020), senior clinical editor for NursingCenter Blog, created a top 10 list of ways to stay positive during trying times. Seven of the 10 takeaways relevant to HCMs are as follows:
    a. Find inspiration: Why did you become a (discipline) and find a way to get excited about it again.
    b. Go to the right sources. Use reputable sources for your information.
    c. Practice gratitude. Start each day on a positive note; identify three things you are thankful for.
    d. Surround yourself with positive people. Avoid negativity as much as possible.
    e. Practice self-care. Do something that brings you joy or try something new that is not related to your profession. Work/life balance is important.
    f. Smile, even behind your mask. Smiles can also be communicated through your eyes and it can be just the thing for you and those around you.
    g. Stay connected. Say hello to those you pass in the halls, send a quick n¡ote or email, text, or call.

Hospital case management practice is evolving and continues to evolve. Change is the single constant in health care. This review of the CMSA Hospital Case Management Whitepaper demonstrates that in just three short years, the landscape of health care can change dramatically. Who would have thought of HCMs working remotely pre-COVID or the explosion of telehealth services in such a short time, much less a global pandemic? The profession of case management must always be ready to move with the times, even on short notice, and HCMs continue to be the master collaborators and coordinators: the key to patient-centered care.

References

American Hospital Association. (2019). *Medicare inpatient length of stay: A relevant value metric*. https://www.aha.org/case-studies/2016-09-16-medicare-inpatient-length-stay-relevant-value-metric

Case Management Society of America. (2017). *Case Management Model Act*. www/.cmsa.org

Ceridian. (2019). *Six strategies to retain millennial and Gen Z employees*. www.ceridian.com/blog

Federal Register. Department of Health & Human Services CMS. (2019). Vol. 84. No. 189. *Rules and regulations*. https://www.govinfo.gov/help/fr#:~:text=To%20find%20a%20more%20recent,Office%20of%20the%20Federal%20Register

Fryling-Resare, K., & Bonsall, L. (2020). *10 ways to stay positive during tough times*. Nursing Center Blog. www.nursingcenter.com/blog

McLaughlin-Davis, M. (2019). The practice of hospital case management: A White Paper: Hospital case management: Past, present and future. *Professional Case Management*, *24*(6), 280–296. https://doi.org/10.1097/NCM.0000000000000391

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Muller, L. S. (2016). Title protection for professional case managers: What's in a name? *Professional Case Management Journal*, *21*(5), 252–256. https://doi.org/10.1097/NCM.0000000000000178

Robbins, D., Dunn, P., & Orsini, R. (2020). Science and data-driven choice: Shaping empowerment during Covid-19 and beyond. *CMSA Today*, *8*, 15–17, 30.

Robinson, B. (2021). *"The Great Resignation" migration and what this means for your career*. www.Forbes.com/blog

Stinebuck, M., & Ferguson, T. (2021). The patient journey through the continuum of care. *CMSA Today*, *6*, 20–21.

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