THE PRACTICE OF HOSPITAL CASE MANAGEMENT: A WHITE PAPER

JUNE 2019

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HOSPITAL CASE MANAGEMENT:
Past, Present and Future

Message from the Chair, Task Force on the Practice of Hospital Case Management

Through its representation, advocacy and education functions, the Case Management Society of America (CMSA) has been an organizing force setting the practice direction for the discipline of case management. CMSA promotes practice that is evidence based and discourages the use of practices which, though popular or widely accepted, are either not beneficial or are contrary to the CMSA Standards of Practice for Case Management (SoP). While the increasing emphasis on care coordination by providers and payers has opened professional debate regarding the models being used in hospitals today, CMSA intends to clarify its position on hospital case management practice through this white paper initiative and urges hospital leaders to seek solutions that more effectively address the needs of our most vulnerable hospitalized patients.

It's no secret that the hospital industry in the midst of seismic changes. From the scale of mergers and acquisitions among hospital and non-hospital entities to the expansion of convenient centers for ambulatory services healthcare systems are under overwhelming pressure to improve patient outcomes and lower costs. Value-based inducements were introduced to incentivize hospital leaders to improve delivery of care processes and promote collaborative, interdisciplinary interactions. The traditional private medical practice is waning as medical group practices consolidate and medical homes are created. All these changes are taking place at the speed of light.

To adapt and survive in this new marketplace, hospital leaders are scrambling to take advantage of every bit of institutional talent to make changes that reflect the new reality. As a result, hospital case management in general, and care coordination specifically, have suddenly caught the attention of hospital executives.

According to the Agency for Healthcare Research and Quality (AHRQ), the main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value healthcare. Care coordination is not a synonym for transition planning but a process that "ensures that the patients' healthcare needs and preferences are known and communicated at the right time, to the right people, and that this information is used to guide the delivery of safe, appropriate and effective care (AHRQ 2014)." Any activity that bridges gaps between providers, care team participants, settings, and information important to the treatment plan and patient flow through the healthcare maze leads to improved care coordination. Furthermore, case management is designed to "assist patients and their

support system in managing their medical/social/mental health conditions more efficiently and effectively" (AHRQ.gov, 2014). In a 1998 study, case management was defined as a "means of coordinating services" by a single case manager who is expected to assess that person's needs, develop a care plan, arrange for suitable care to be provided, monitor the quality of the care provided, and maintain contact with the person (Marshall, 1998). Recognition of the confirmed connection between case management and care coordination energized the task force in its mission.

To address the queries and requests for information received by the Case Management Society of America (CMSA) from hospital case managers across the nation, a task force of notable experts in the field was assembled to explore the current models of hospital case management practice and weigh them against the goals and expectations of our rapidly evolving hospital environment. In the process, the task force intends to provide insights on the overarching theme of care coordination as promulgated by governmental and quasi-governmental entities, federal, state and private payers, and to recommend best practices wherever possible to help hospital leadership embark on the road to transformation.

CMSA established the Standards of Practice for Case Management (SOP) in 1995 and has revisited and updated the content four times to reflect the changing healthcare system and the changing role of the case manager. The most recent change in the SOP were made in 2016. CMSA emphasized the professional role of the case manager and the need to empower patients and their caregivers in important decisions regarding their care, to promote healthcare literacy and self-care, and to engage the patients' participation and their transitions from the hospital (CMSA, 2016).

Key provisions in the SoP include:

A. Identify & select patients who can most benefit from case management services.
B. Complete health, cognitive and social assessment.
C. Identify problems or opportunities that would benefit from case management interventions.
D. Collaborate with patient and stakeholders to develop individualized plan of care.
E. Facilitate, coordinate, monitor, and advocate to "minimize fragmentation in the services provided and prevent the risk for unsafe care and suboptimal outcomes"
F. Employ ongoing monitoring to measure client's responses.
G. Demonstrate the benefits of case management services (CMSA, 2016).

Using these standards, the task force endeavored to identify what, if any, constraints exist in the hospital environment that impede the application of these practice principles and what strategies can

be used to ensure that hospital case management practice models are in synch with the transformation taking place throughout the hospital industry.

I wish to thank the members of the task force for their contributions.

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Sponsored by CMSA, 2019

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SECTION 1: THE HEALTHCARE ENVIRONMENT

Value, the concept that has emerged as a guiding principle for transformation of the healthcare industry, is not just another buzzword. Though many hospitals are still struggling as they prepare for a totally new marketplace, the task force believes that this is the moment when hospital case management leaders and their executive sponsors should seize the opportunity for disruptive innovation and challenge the predominant hospital case management models.

Case managers have long understood the importance of fiscal responsibility while delivering value and quality based care. Case managers see networked partners working together in Accountable Care Organizations (ACO) to deliver better coordinated care; we see initiatives by hospital leaders to eliminate or reduce adverse events; we see the adoption of evidence-based care guidelines that produce the best outcomes for the most patients; and we see payers bundling payments that cover the patient's full continuum of care for selected chronic conditions.

Healthcare goals and priorities have shifted, if not challenged, the professional landscape of case management practice. 'Change is the only constant' reflects one of the most popular mantras across sectors, particularly in the healthcare industry. No one has had to weather more change than case management due to the constant change in the regulatory environment, resulting in much scrutiny of the case manager role. Each organization designs a unique model, with little consistency from one facility to the next. What started as a position steeped in care coordination, now evokes confusion for hospital consumers and healthcare stakeholders alike.

Hospitals have focused on reducing costs since the implementation of diagnostic related groups (DRGs) in the 1980s. The alignment of costs and care became a top priority for hospitals and innovative discharge planning and utilization review processes hit the ground running. All of them became focused on that magical length of stay to assure financial return on investment. It seemed that knowledge of the organization's payor case mix and operating margins became more valuable than knowledge of the target population's community resources. This was due to the declining reimbursement for acute care and the frequent changes of which codes with the corresponding procedures were deemed an inpatient procedure. The prominent DRGs were also watched as payer mix became an important topic. Reimbursement was a priority and reimbursement was not tied to value.

Amid an industry so focused on demonstrating successful outcomes, case managers face considerable stressors. Population complexity, reimbursement shifts, and regulatory requirements have brought increased pressures for the entire workforce. Having insufficient time for meaningful client interactions is a common complaint across every discipline involved in healthcare today. In fact, the assessment of a client and caregiver's intricate circumstances can take a backseat to other more pressing administrative goals. Hospital case managers often find themselves spending more time in long stay (LOS) huddles and related meetings justifying their discharge planning processes than engaging directly with clients.

The future of the modern acute care delivery system, together with the shift to population health initiatives, and the establishment of community-based partnerships that many acute care hospitals find essential to thrive in a value-based environment challenge this legacy mindset of the case manager being a discharge planner only.

> *As healthcare systems become responsible for large populations and tasked with preventing illness and avoiding hospitalization and getting paid for doing so, the highly effective case managers who are managing at risk populations will become the direct income source and occupied hospital beds will be viewed as an expense line.*
>
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Escalating costs, shifting payment methodologies and increasingly complex populations, are spawning new trends in care and reimbursement (for that care). A move outside of the acute care hospital to less costly settings and the community is underway. Healthcare spending in the United States (US) totaled $3.5 trillion in 2017, with roughly 32% of that amount, or $1.1 trillion spent on hospital services alone. Current hospital costs average approximately $3,949 per day, with each hospital stay averaging $15,734 (Fay, 2019). Avoidable healthcare expenses in the US, are estimated at $3.2 trillion, with continued growth estimated to be 5.5% by the year 2025 (Beaton, 2017). Both the Centers for Medicare and Medicaid Services (CMS) and the payor community have emphasized a needed shift from volume to value. Hospitals and healthcare systems are scrambling to meet the expectations those new challenges demand (Fay, 2019; VBP, 2019).

The development of value-based payment programs, from Accountable Care Organizations (ACOs) to Bundle Payments for Care Improvement (BPCI) and Quality Payment Programs (QPP), have forever altered how healthcare is rendered. Value will will bring new attention to population health initiatives and practitioners will shift focus to community-based care and wellness. The change will mandate the expertise of competent, credentialed hospital-based case managers who meet defined qualifications and who acknowledge that care coordination extends beyond the walls of a single setting.

Assuring financial sustainability, if not survivorship, has become a paramount priority for hospitals and healthcare organizations alike (Fink-Samnick, 2019a, pg. 169).

Chronic Illness

Patients living with chronic illnesses are among the costliest populations. They incur four times more in medical costs, spend twice as much out of pocket on healthcare despite their much lower incomes, and are three times more likely to be hospitalized. Additionally, about half of these clients are over 65 years old, and more than 25% of them have not completed high school (Khullar, 2017). In fact, 90% of the nation's $3.3 trillion spent in annual healthcare expenditures are for those persons with chronic health and mental health conditions (CDC, 2019). This is the population that has caught the attention of hospital leaders in the face of the continuing generation of readmission penalties and bundled payments, and has generated concern that fiscal imperatives often supersede attention to patient-centric care.

Integrated Care Management (ICM)

The identification of the high costs incurred by comorbid physical and behavioral healthcare, has led to a surge of attention to integrated behavioral health. Increased attention to the co-morbid health and behavioral health needs of populations prompted a more comprehensive approach to care. Proactive attention to both realms of pathophysiology and psychopathology lead to treatment plans that have greater potential to promote more positive client outcomes. Sixty-eight percent (68%) of adults with mental disorders have medical conditions, and twenty nine percent (29%) of adults with medical conditions have mental disorders (Fortney, et. al., 2015). Thirty-five percent (35%) of patients with a chronic illness have a mental illness (Epstein Becker Green, 2015). The co-occurring disease states create huge challenges for healthcare stakeholders, clients, and providers alike. Unmanaged patients with mental illnesses cost insurance payers more than double to manage chronic conditions (Epstein Becker Green, 2015). Patients assigned to a hospital case management team for coordination of care for medically complex diseases are ill-served if the case manager cannot also manage co-existing behavioral diagnoses. Hospital case management practice must be integrated and linked to the patients' past history of medical and behavioral health as well as their future risk (Fraser, Perez, & Latour, 2017).

The Social Determinants of Health

The Social Determinants of Health are a top priority for every healthcare organization and practice setting. Patients living in communities having the highest incidence of downstream factors impacting health outcomes (e.g. poverty, lack of education, housing and food insufficiency, unemployment, limited access to care) are at the greatest risk for poor health outcomes. Astronomical

costs mandate 100% screening of patients, particularly with $1.7 trillion spent on five percent (5%) of the population (Sullivan, 2017). As high as eighty percent (80%) of an individual's health is influenced by the non-clinical factors so heavily associated with the Social Determinants of Health (Driver, 2019). The readmissions challenge has hospitals, and anyone involved in the revenue cycle on heightened alert, case managers included. Over fifty percent (50%) of hospital readmissions are due to the social determinants. Patients experiencing transportation access, are at risk facing forty one percent (41%) more excess days in the hospital. Those persons with higher home instability risk are thirty two percent (32%) more likely to exceed the average hospitalization (Gooch, 2018).

Healthcare organizations must be purposeful in how they develop care teams and community partnerships that address the diverse needs of their populations. Hospital case management is well positioned to play a vital role in these efforts by ensuring that patient care is well-coordinated while in the hospital and across subsequent settings. With the majority of the largest insurance companies developing programming to attend to the costliest populations (e.g. chronic care, integrated care, social determinants), seamless, collaborative partnerships can be built among case managers across practice settings.

Bridging the gap between volume and value is incumbent on having a competent professional case management workforce who can coordinate care across the continuum and collaborate with care coordination colleagues from other provider or payer entities who are now attempting to see the hospitalized patients who are within their risk pools. Payer and provider case managers may have difficulty finding or contacting the hospital case manager so they intervene directly with the patients, bypassing the hospital case manager. How can this Holy Grail for hospital case managers be achieved? This white paper will detail how case management can demonstrate its true value proposition in the hospital setting.

SECTION 2: PRACTICE BACKGROUND

Case management concepts are recognized as a method of advocating, securing and coordinating services for patients needing assistance. In the 19th Century, the community 'case manager' served as the direct line of communication between the patient and the multiple public welfare agencies and charitable services. Social work can trace its origins to this movement when the first formal social work course was offered in 1898 at Columbia University, New York.

In the mid-1980s, the case management concept was embraced by the nursing leaders at New England Medical Center (NEMC) as an innovative nursing delivery model in response to the new

prospective payment system (PPS). To achieve the efficiency outcomes needed to thrive under this new payment model, 'a nurse case manager', working with a designated care team and using critical paths (key interventions that must occur in a deliberate and predictable manner to achieve the desired length of stay), sought to tighten the coordination of services to expedite delivery of care and eliminate redundant interventions.

While disruption and innovation in nursing models were taking place at NEMC in Boston, Carondolet-St Mary's in Arizona and Lee Memorial in New Jersey, many facilities could not sustain the economic impact of PPS' diagnostic reimbursement system (DRG) and by the early 1990s over 1000 facilities went bankrupt, closed, or converted to other service lines. Those that survived the financial freefall resulting from the shift from cost-based reimbursement to a prospective payment system sought out management engineers who were charged with quickly reducing expenses by eliminating, consolidating, or reorganizing hospital services. As a result, the management engineers or their hospital operating officer counterparts, embarked on a full-time equivalent (FTE) reduction and service consolidation campaign, the results of which are still with us today.

When the FTE reduction campaigns began, social workers made an effort to increase their value as a service line by taking on more discharge planning responsibilities. Despite their best efforts, however, their departments were eventually eliminated in many hospitals and the executive team chose one of two popular courses of actions. Many organizations simply eliminated all staff social workers but established contractual arrangements with them to consult with selected patients on an 'as needed' basis.

Other hospital leaders, or their management engineers, taking their cue from the articles and conferences highlighting the economic success of a new case management concept at NEMC, moved the remaining social worker resources into the utilization review department and "with a generous dose of fairy dust, utilization review nurses became case managers, and utilization review and social work departments became case management departments. We have been living with variations of that model ever since" (Daniels, 2009).

SECTION 3: THE CURRENT STATE OF HOSPITAL CASE MANAGEMENT

The result of the restructuring that took place after the DRG implementation, produced a hospital case management department consisting of varying hospital functions. They include, depending on the hospital size, access management, utilization review, clinical documentation improvement, social services, quality improvement, revenue cycle appeals, discharge planning and post-acute transitional

care. Out of these functions, the primary practice of hospital case management evolved into the activities and tasks related to discharge planning and confirming acute care medical necessity. Both are important services offered by the acute care facility. However, the task force is concerned that the intensity of the case managers' focus on these two essential activities, detracts from the case managers' practice standard obligation and the related opportunities which this era of value-based care demands. Today, more than ever, case management must be clinically and financially accountable.

Hospital nurses in the late 1970s and early 1980s practiced primary care nursing. Under this model, a professional nurse was responsible for the care of a group of patients during their entire hospital stay. At the time, nurses worked eight hour shifts five days a week and the primary nursing structure fostered a relationship-based model between the patient and their nurse. Embedded within that relationship, the primary care nurse monitored progression of care and was responsible for assessing the patient's post-acute needs to ensure that the gap between hospital and home was successfully bridged.

> *Given the complexity of healthcare and the social determinants affecting the ability of our patients to achieve their highest level of wellness, the role of care managers is even more critical.*
>
> Kristine Adams, MSN, CNP, Associate Chief Nurse Officer Care Management and Ambulatory Services. Cleveland Clinic

At the same time, most hospitals maintained a separate department of social workers who intervened, at the nurses' request, to help patients cope with healthcare needs. They also assisted patients and families who required special post-acute placement or just some extra guidance when they were discharged from the hospital with a complex set of needs. At the time, it was not unusual for public health departments and home care agencies to place liaisons in the acute care hospital to assist with what was considered complex discharge planning.

Eventually, primary care nursing gave way to the more efficient team nursing and the delegation of work by the professional nurse to Licensed Practical Nurses and non-licensed nurse associates. With the nursing shortages of the late 1980s, the traditional eight hour/five-day workweek across shifts, gave way to the 'Baylor' plan which offered professional nurses the option of working 24 or 32 hours over the weekend (usually two twelve or sixteen hour shifts on Saturday and Sunday), and being paid 40 hours of straight pay. Other variations of the twelve-hour shift were quickly adopted. As a result, the patient admitted by Professional Nurse Jones may never again be seen by that nurse as the continuity of nursing care weakened. The transfer of discharge planning, long the purview of professional nursing, to a small team of case managers responsible for the entire hospitalized population, arguably resulted in the increase in 'just-in-time' discharge plans. These plans were prepared in reaction to an unforeseen

physician discharge order, and resulted in readmissions, as there was minimal engagement between the case manager and the patients and families. The need to overcome the patient's knowledge deficits was not recognized. Patients were not provided a personal teaching plan about potential post-acute early warning indicators, their medication regimen, and to confirm post-acute follow-up appointments with clinics, specialty care centers, or primary care physicians. This shift in assigned responsibility is further exacerbated when that same case manager who is responsible for all the logistical tasks associated with executing the discharge plan remains responsible for the utilization review responsibilities.

The administrative pressure to investigate each new hospital arrival to confirm the medical necessity of the admission and continued stay, coupled with the expectation that the case managers remains current in their knowledge of rules and regulations and contractual obligations, continues to impact the case managers' effectiveness. Case managers are also expected to comply with the CMS rules to validate continued stays in the hospital and intervene when the criteria is not met. In interview after interview with hospital case managers, their narratives describing the tension arising from administrative admonitions to "facilitate discharges and open beds," and payer demands for daily chart reviews, which includes submitting documentation to confirm medical necessity, create an untenable situation where neither task is done optimally nor consistently. This typical scenario is often the reason why case managers spend the majority of their time in front of computers or on the phone with their payer counterparts. It also speaks to why they are often absent when the physicians, family or care-team members are discussing treatment plans, answering patient's concerns or questions, and exploring post-acute options.

Under these circumstances the hospital case manager's purpose and intent become grossly limited. Case management's capability to coordinate prescribed services along the progression of care, evaluate the appropriateness of those services through collaborative consultation with other members of the care team, or advocate on behalf of the patient and family to take actions that prevent clinical or financial harm all take a back seat to utilization review, clinical documentation integrity, and other priorities. Though none of these, that are the predominant activities of most hospital case management departments, have yielded the outcomes envisioned by the administrative team, they continue to dominate.

Because of the focus on task completion, many directors of hospital case management services advocate a geographic assignment to expedite functions. These assignments make it easier to schedule case managers and most case managers prefer to work on one unit as opposed to traversing the hospital. There is some evidence that the geographic assignment model does provide value when

hospitalists are regionalized, patients are grouped by specific clinical needs, and there is a designated care team assigned to the population. These accountable care units (ACU) are examples of value-based care where the entire team is accountable, and rewarded, for sharing relevant information, working together to streamline service delivery, and generating positive clinical and financial outcomes.

Case managers strive to develop relationships with their patients and their families. However, in in the majority of hospitals, patients are frequently moved from one geographic area to another and any relationship the patient and family may have formed with the first case manager is erased as the patient and family must acclimate to a new personality. The geographic assignment perpetuates a pattern of fragmentation often associated with increased resource utilization. Therefore, case manager leaders may sabotage the valued patient relationship for the comfort of providing their teams a permanent hospital unit. The hospital executive team may evaluate the value of case management resources based on productivity statistics, staffing ratios, and length of stay. Outcomes related to the case managers' influence on resource utilization (costs of care per patient), which is a key metric in bundled payments and Medicare's Value Based Payment system, or Patient Reported Outcome Measures (PROM), are rarely reported.

There are other important implications regarding the current state of practice that warrant attention and concern. Planning a patient's discharge, organizing the logistics of the plan, exercising the skill of implementation, and reviewing the patient's record to conduct a medical necessity review is often interpreted as care coordination by the staff and generally constitutes the extent of the case manager's knowledge of, and involvement in care coordination. They have little time to create a proactive plan of care, to reinforce self-management goals, to facilitate transitions within the hospital, to ensure safe medication management, to investigate available community resources or to meet with caregivers to share information, answer questions, and be available when needed.

Additionally, there are reports of wide-spread hospital case management vacancies and most probably arise from the tensions regarding the discharge planning focus. Hospital and corporate recruiters are constantly seeking new recruits to fill vacancies. Hospital executives often turn to costly agency services for temporary or traveler staff to fill vacant positions to perform the functional tasks that characterize these legacy models. Vacant positions and temporary personnel add additional burden to the remaining resources who eventually succumb to the pressure and resign, creating more vacancies. When candidates are recruited, more often than not, they do not receive and extensive case management orientations. They are thrown into the fray with 'down the line' orientation and little exposure to formal education programs on case management. Their tenure is generally short-lived.

Finally, the most egregious implication of this is that we are orienting a new group of hospital case managers who have little knowledge of the case management profession, its concepts or standards of practice, or its relationship to the industry-wide shift to value-based care and care coordination for high risk patients. These new RN recruits know that to promote good health patterns, patients often need guidance to synthesize all the information they've been given. They know that patients must be taught to understand that there is uncertainty in medicine and treatment plan choices are available. They also know that a case manager must be willing to be an assertive advocate on behalf of the patients and families. But they have little understanding of how these advocacy concerns are applicable to the case manager role. They become quickly disillusioned, leave the profession, and seek alternative venues where their colleagues are actually coordinating care among several providers.

The disruption taking place in the hospital industry has resulted in many pockets of innovation. With the implementation of the Affordable Care Act and Section 3021 creating The Center for Medicare and Medicaid Innovation (CMMI), we have seen a rapid introduction of new delivery of care and payment models. Both emphasize the critical component of care coordination. The recent development of post-acute networks has addressed many of the coordination gaps by extending continuity into the community and post-acute facilities with emerging new roles including Health Coaches, Community Health Workers, and Navigators. There are even reports of EMS Technicians serving as care coordinators for the well-known high-risk patients they regularly encounter during emergent situations. In addition, innovations in electronic technology have significantly improved timely communication with patients and families and among inpatient and outpatient care teams which results in better coordination and less redundancies.

> *"It is not uncommon that inpatients are found to have 6-8 co-morbid conditions making their treatment more complex and demanding. Hospitals and physicians must ensure that care is coordinated and integrated both within the inpatient and outpatient settings. Failure to do so increases the risk that treatment will be less effective and unnecessary readmissions more common."*
>
> Matthew J. Lambert III, MD, MBA, FACS.
> Member of the Board, Hospital Sisters Health System

Hospital case management leaders must lead. Working with their colleagues, they must initiate innovations to re-structure and redesign their workflow so that they become indispensable contributors to effective and efficient care management of high-risk patients. Until they do so, hospital case managers remain at risk for new tasks that will burden team members without full fidelity to any of them. New consumer expectations, new payment schemes, and new alliances demand a case management model that focuses on care coordination. Put another way, the case management department must modify its conceptual, structural, and operational framework to suit the new delivery

of care and payment models. By doing so, the case management program can demonstrate the real value of a modern case management department while attracting and retaining staff.

It is with this understanding of the current state of hospital case management the task force believes the time is ripe to establish parameters on the practice of hospital case management and its position in the larger picture of value-based care.

SECTION 4: THE DESIRED STATE

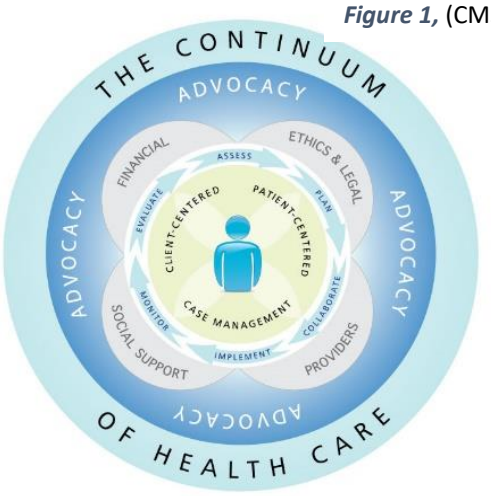
Healthcare is not just changing; it is perpetually and consistently undergoing major shifts on a routine basis in completely new ways. The Healthcare reform movement is one of the most significant financial, cultural, and technological challenges ever faced by the healthcare system. Yet, it also presents an opportunity to carefully consider the future of hospital case management practice and how practice strategies should be reconfigured for this new era.

Economically, the entire healthcare community is in turmoil with one foot in the fee-for-service market while the other adjusts to various value-based payment and care delivery models that discourage inpatient admissions in favor of community-based care. As the marketplace undergoes these transformations, so must the vision for a hospital case management program. Hospital leaders are steadily adjusting to marketplace pressures and recognize that changes in the manner in which patients are cared for within the hospital setting and its community partners, must correspond with changes in the scope of work for their case management professionals. As one evolves, so must the other.

Conceptual models are a representation of an idea, a process or a system. Healthcare models are helpful to promote a universal understanding of the idea or system being discussed and it offers a simplification of how things work. Today, there are as many models of hospital case management as there are hospitals and in this new marketplace, many hospitals are testing even more models.

CMSA's model, established in 2016, highlights the continuum of care conceptually; it puts the patient at the center, surrounded by the iterative case management process and the four domains of care coordination considerations: health needs, social needs, financial issues and ethical/legal matters. Overarching it all is the theme of advocacy encircled by the continuum of care. While this framework represents the vast majority of case management settings today, the question raised by the task force is whether this conceptual framework reflects the predominant practice of case management in the hospital? The consensus among the task force members is that it does not. Figure 1: The Continuum of Health Care and Professional Case Management, (CMSA, 2016).

Figure 1, (CMSA 2016)



A new value-based marketplace calls for a new vision of case management that eschews tasks and instead focuses on activities that promote a safe, coordinated journey across the continuum for the most vulnerable patients. Ticking off prescribed checkboxes is replaced by thoughtful engagement and purposeful planning by individual case managers based on the needs of their patients. Indeed, it could be argued that the generic principle of case management is to ensure coordination of a patient's care through the assignment of a case manager. Creating a vision of that coordinated journey is a practical approach that will serve as the impetus to align future initiatives, inspire participation, and generate new ideas. But, before executives will agree to invest time or resources to transform the hospital's case management program, they must be comfortable that the vision complements the organizational mission and reflects current and future environmental circumstances.

According to the Agency for Healthcare Research and Quality (AHRQ), there are 40 different definitions of care coordination found in the literature (AHRQ, 2014). Because no single definition of care coordination has surfaced, from the perspective of the hospital case manager it may be convenient to think of it as a *deliberate and longitudinal organization of safe, efficient and appropriate care and services for selected patients with multiple needs as they move through the care continuum from acute care to community settings.* This is a compilation description and requires the alignment of care and sharing information among disparate providers to optimize treatment plans, influence resource stewardship, and streamline transitions. It also presumes that the individual charged with coordinating

their patients' care across the continuum will be collaborating with members of the care team in the hospital and in the community to advocate for the Triple Aim: Improve the care of the patient; reduce the costs of care; and enrich the patient's experience of care (IHI, 2019).

Attributes of Care Coordination

The influential report from the Institute of Medicine (IOM), Crossing the Quality Chasm: A New Health System for the 21st Century (IOM, 2001), cited strong evidence that the healthcare system, as it stood at the time, harms patients too frequently and routinely fails to deliver benefit. The report recommended a redesign of the American healthcare system, providing overarching principles and specific directions for policymakers and leaders. These principles comprise a recommended framework for care provided within a high-quality system and are identified in Table 1.

Table 1. (IOM, 2001)

Safe	Planned and managed to prevent harm to patients due to medical or administrative errors.
Effective	Based on scientific knowledge, and executed well to maximize their benefit.
Timely	Patients receive needed care and consultative services without unnecessary delays.
Patient-centered	Responsive to patient and family needs and preferences.
Efficient	Limited to necessary referrals, and avoids duplication of services.
Equitable	The availability of a case manager and quality of transitions and referrals should not vary by the personal characteristics of patients.

These "six aims" should inform a vision of care coordination in every hospital and serve as a template for the transformation of the case manager role. Since care coordination seeks to synchronize the roles and contributions of everyone on the care team, including the patients themselves, the vision for the organization's care coordination program must also account for a structure which supports the seamless exchange and reconciliation of clinical information between hospital units, facilities, and members of the care team. Also, it must remodel the legacy role of the hospital case manager from discharge planner and/or utilization reviewer to care *coordinator*. This is

Healthcare is a team effort. Sometimes that effort is synchronous. Often, the effort is sequential. Each step in the patient journey presents an opportunity to manage transitions well and optimize outcomes for all. Industry evidence suggests that we don't manage these transitions as well as we could and our patient suffer with confusion, inefficiency, and at times poor outcomes. Improving our handoffs in each care transition is likely one of the most fruitful outcomes we can pursue. The impact of effective transitions on the patient experience, desired outcomes, total cost of care, and appropriate utilization is tremendous.

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perhaps the greatest challenge faced by case management leaders when re-shaping the concept of their department's overarching purpose.

Case Management provides critical services to help patients and their caregivers navigate, coordinate, and transition through their hospitalization and beyond. Case managers support an evidence-based approach to assist patients achieve their healthcare goals. These efforts promote better clinical and financial outcomes for individual patients and for the population in aggregate (Case Management Model Act, 2017).

The task force suggests consideration of the definition and attributes to create a vision for the new case management program. In addition, the structure and services outlined in CMSA's revised Case Management Model Act (Case Management Model Act, 2017) should be considered to identify the framework of a comprehensive hospital case management program. A vision paints a broad picture of the objectives and direction of the program to generate the creation of a practical hospital case management framework, the formulation of new goals, and the preparation of strategies to drive successful execution. A vision doesn't have to be a formal statement…it can be a portrait of "what might be" if you or a loved one were a patient in the hospital and anticipated follow-up care in the community. The discussion for a future vision of case management practice is the time to explore ideas, however unrealistic they may seem at the time. It is the time to consider so-called "wild ideas" and think about them as if they could happen. This is the time to encourage transformation participants to enter into conversations with an open mind and a willingness to challenge one's own long-standing position to advance mutual understanding.

Transformation Priorities

The task force suggests consideration of the following transformation priorities:

1. Redesign Scope of Services

For many years, hospital case management was a hospital department charged with managing several hospital functions. But that model no longer meets the challenges of the modern acute care delivery system, population health initiatives, nor the establishment of community-based partnerships that many acute care hospitals find essential to thrive in a value-based environment. New consumer expectations, new payment schemes, and new alliances demand a case management model that focuses on an enterprise-wide *program* of care coordination.

Care Coordination is an essential component of the standards of practice promulgated by the Case Management Society of America (CMSA, 2016), and is also cited by the National Quality Forum (NQF, 2010), the AHRQ (National Healthcare Quality and Disparities Report chart book 2016), the Institute for

Healthcare Improvement (Craig et al. 2011) and numerous articles as an essential "service delivery plan" (Bodenheimer 2008; NEJM Catalyst 2018). Care coordination is at the heart of any new hospital case management model and leaps the brick and mortar boundaries of the acute care facility into other care facilities, community-based settings, and the patient's home. This much broader vision can pose significant challenges when planning for the future. Not only does the hospital system require strength and cohesiveness within the walls of the facility, but also within the larger web of the surrounding community's infrastructure and support systems. Care coordination can no longer exist and function within a solitary hospital *department l*ocated in the bowels of the facility; it must become a core competency of every hospital organization and evolve into a *program* where every hospital care giver provides value that results in better outcomes at lower costs.

2. Establish clear roles and responsibilities

The Affordable Care Act has put a focus on the improvement of health outcomes, specifically calling out effective case management and care coordination as activities to achieve these outcomes. By moving the case manager's focus away from tasks and procedures as the focus of their scope of practice, opportunities will be created to meet the needs of the healthcare consumer and add to the value of case managers (Lucatorto, 2016).

Case management practice extends beyond the basic training of any single discipline within the healthcare field. Organizing for patient-centric care coordination suggests a program comprised of diverse individuals with the skill-sets, critical thinking skills, and enthusiasm to coordinate care for a selected group of patients in the hospital and across the continuum. Eligible individuals may come from many professional clinical disciplines and have strong communication and collaborative skills to engage the patient and members of the patient's care team.

The practice of case management is guided by CMSA standards but influenced by each individual hospital. Specific practice expectations vary by hospital and may even vary based on the case managers' professional disciplines within the same hospital. This is not an unusual occurrence. Unfortunately, there are many human resource leaders who fail to appreciate that the academic background of a nurse, social worker, physician, therapist, pharmacist, et al serves as the clinical

Pharmacists are essential partners in the work of care coordination. Patients must understand the medication they are receiving and also understand the value of adherence to the treatment plan prescribed for them. A risk that is consistent across all post-acute transitions, including the home is inappropriate medication use and reconciliation of the meds.

It's easy for patients to get their medications "fixed" while an inpatient or at an outpatient visit then go home where all the old prescriptions still exist. So, the value of a thorough home going medication program and advancing the effort of pharmacy at non-traditional points of transition is key.

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underpinning for adoption of the standards governing the practice of case management. While each discipline brings unique perspective and skill set to case management practice, case management standards of practice is the common denominator. The diversity of experience and their professional strengths are positive features of a complementary case management team charged with working with equally diverse populations. This is the rationale used by CMSA and the Commission for Case Management Certification (CCMC) which welcomes all disciplines as members of the case management guild.

The absence of role clarity, clearly specified role expectations across the hospital community, and the scope of employer-mandated practice expectations, continue to blur the role of the hospital case manager in hospitals across the country. This can be tested by asking several hospital and medical staff members to briefly describe the role of the case manager. In doing so, you will likely find there are wide variations in the answers provided. This lack of clarity diminishes the potential value of the case management team and compromises the hospital's care coordination capabilities. By assigning the role multiple tasks, both clinical and administrative, the vision, intent, and goals attached to a care coordination program will not be achieved. Joo & Huber (2018) describe the need for case managers to provide case management services while doing administrative work within the tight timeframe of shortened admissions as being a barrier to case management implementation.

The hospital case manager role should optimally parallel the standards of practice, the Triple Aim, and the Six Aims of the IOM. A framework like the IOM domains can be used to build job descriptions and make it easier for colleagues and consumers to grasp the meaning and relevance of the case manager role. Consider the acronym STEEEP: Safe, Timely, Effective, Efficient, Equitable and Patient Centric (Wold, 2016) in Table 2.

Table 2.

AIM	HOSPITAL CASE MANAGER (HCM) RESPONSIBILITY	GOALS TO CONSIDER
Safe	HCMs play an active role in ensuring that patient care is safe and appropriate.	Prevention of hospital acquired complications
Timely	HCMs are empowered to reach out to payers and care team providers to expedite prescribed interventions, negotiate practical care delivery alternatives, promote timely transition from one care setting to another, and make appropriate referrals to hospital service providers and community resources.	Reductions in delays and avoidable days
Effective	HCMs are knowledgeable about the goals of the medical treatment plan; promote the use of evidence-based guidelines, if available; identify variations that may jeopardize desired outcome and advocate to maximize the benefit of treatment.	Improvement in Patient Reported Outcome Metrics (PROM)
Efficient	HCMs serve as stewards of limited resources owned by the hospital in trust for the community it serves and advocate on	Reduce per capita costs for selected patient populations

	behalf of the patient and family to avoid wasteful, duplicative, redundant or potentially harmful interventions. They are empowered to intervene to prevent potential harm.	
Equitable	HCMs apply a consistent predictive methodology to identify patients who would benefit from the care coordination services.	Patients meeting criteria for inpatient care coordination are referred to Transitional Care team members for post-acute oversight.
Patient Centric	HCMs confer with members of the care team to confirm that the proposed treatment plan meets the preferences and expectations of the patient and family.	Patient's experience of care is enhanced through personal engagement during hospitalization and thereafter.

Overarching these responsibilities is advocacy; the ethical obligation of every case manager no matter the practice setting. It is probably the most important attribute in the hospital setting as the hospital is the highest cost and highest risk venue along the care continuum. It is also one of the most difficult concepts to espouse in the hospital setting given its history of cultural barriers. The established power relationships between physicians and care team members, limited administrative support, and narrow opportunities for communication often discourage case managers from acting in accordance with their knowledge and conscience. Nevertheless, to mitigate the inherent risk of an unnecessary hospital readmission, case managers serve as trouble-shooters for the patient's care team. Their knowledge and experience bring value as arbiters of safety and stewards of resources. "A patient who is treated efficiently with the right resources can achieve maximum medical improvement in a timely fashion" (Campagna & Stanton, 2010). Nevertheless, the cultural climate of the hospital will be a factor in transforming the case manager from a task-doer to an essential partner of the care team.

Changing the way case management is practiced in the hospitals is no easy task. However, hospital leaders in general, and hospital case management leaders specifically, must speed up their transformation plans if they are going to succeed in a value-based marketplace and reap the synergistic benefits of a care coordination approach.

> *"Case management has come of age, and just in the nick of time!! Now we need to manage it all, from site to site and of course all the way home. We have to connect these dots with all the technology we can bring to the table and enable case managers to make data the life blood of the system."*
>
> David Nash MD MBA
> Dean. Jefferson College of Pop Health

3. Develop an entrepreneurial structure to support care coordination goals

Just as form follows function, so too must structure follow strategy. Moving to a care coordination practice focus requires as much of a structural change as it does a cultural change. Success depends upon the executive team's appetite for disruption and innovation and the transformation's

team willingness to think broadly about the future. Early research on the return of investment for care coordination programs was not uniformly convincing and the anticipated savings did not initially appear. This continues to be a formidable barrier when proposing real process change to the executive team despite the fact that more recent studies have confirmed that well-designed, targeted care coordination for the most vulnerable patients reduces fragmentation and improves clinical and financial outcomes for the patients, providers, and payers (Frandsen, 2015; Buric, 2017; & Khullar, 2018).

Most importantly, investing in transformation does not require executives to hire new staff members. Instead, leaders will reallocate existing FTEs, provide additional training and education so professional staff can practice at the top of their license, modify the scope of the case managers' practice, introduce support staff as post-acute 'travel agents,' or case manager extenders and optimally use technology for swift communication with the hospital care team and externally with the consumer. Staffing ratios, one of the most frequent questions addressed to CMSA, become moot as care coordination outcomes and Patient Reported Outcome Measures (PROM) become the primary metrics of success.

4. Position case management with a transformative executive sponsor

Choice of the program's executive sponsor is often driven by the size of the organization and the degree of compartmentalized operations. It is also another question frequently posed to CMSA staff. In large organizations, there is evidence that senior executives are managing functions rather than departments. Hence, there is often a Vice President of Population Health, Integrated Care, Care Coordination, or a similar title, who is charged with overseeing the organization's care coordination strategy across the system settings; in the hospital, the hospital-sponsored Accountable Care Organization (ACO), outpatient-ambulatory clinics, and/or hospital-owned medical practices. In smaller organizations, the executive sponsor might be the Medical Director of the ACO, the Chief Medical Officer of the hospital, or another member of the executive team who can offer new information and new insights on the new marketplace.

Key to the decision is a commitment to ensure a seamless program across the campus and continuum. To fully ensure that the commitment to continuity is sustained, hospital departments, campus services, and post-acute partnerships must be surveyed to identify roles that provide piecemeal care coordination and may overlap or duplicate coordination activities. These positions or roles need to be integrated, blended or eliminated for consistency across the health system. When patients and families are unclear about what services are available and who is available to guide them, the value assigned to care coordination of medical and psychosocial needs may be lost. Indeed, there is evidence

that fragmented care coordination offered by multiple providers may result in diffused professional responsibility and patient dissatisfaction (Span, 2014).

5. Realign for greater effectiveness

Many hospitals have overburdened the hospital case managers' portfolio of tasks based on the often-heard premise that "they're in the chart anyway." However, transitioning into the realm of care coordination will require more conversations and problem-solving activities with the care team members; it will require a real-time partnership with the attending physician/hospitalist/consultants; it will require more focused engagement with the patient, family, the patient's nurse and community resources; and it will inevitably require lengthy negotiations with payer representatives. For these reasons, peripheral activities organized under the traditional case management department may be redirected to reduce the wide scope of services currently housed under the case management department umbrella. For example, utilization review, a largely financial activity, will be recognized as a unique specialty and may find its way to the revenue cycle side as would activities related to denials and appeals.

The impact of social determinants of health on the hospital's bottom line may signal that it's time to reestablish a distinct designation for counseling services, which had occupied a separate identity prior to the financial free-fall mentioned previously when several hospital departments were consolidated to reduce expenses. As payers and providers are now engaged in activities to identify and address social needs, the task force suggests that a dedicated team of social work and psychosocial counseling professionals positioned to address the obstacles that may prolong hospital lengths of stay, increase avoidable inpatient admissions, increase readmissions, and inhibit self-care competency is a value-added service (Osborne et al, 2018). High-risk patients have greater unmet behavioral health and social issues than do other adults and require greater support to help manage their complex medical and nonmedical requirements (Ryan et al., 2016). Working in partnership with the case manager, social workers and counseling professionals are experts in preparing and empowering patients and family members to engage effectively in their health and healthcare activities (Steketee, et al, 2017).

6. Fine tune case manager workflow

Through the initial patient assessment process, electronic predictive analytics or risk assessment tools, patients are identified who present with challenging medical or psychosocial issues. In the majority of cases, these are the patients who also have the most challenging transition planning needs. According to MedPac (Medicare Payment Advisory Committee) outlier cases range from 0.3 to 25.0 percent of hospitalized patients (Lisk, 2016). They constitute the high-risk population and would most

likely benefit from the attention of a case manager to collaborate with the patient's care team to coordinate the treatment plan, advocate for the patient, and work with the family to educate and engage, and make community-based referrals that best meet the complex transition needs of these high-risk patients. Identification of these patients triggers the workflow of the hospital case manager which then follows the case management process as outlined in the SoP (CMSA, 2016).

Professional nursing, in conjunction with members of the patient's care team, has been traditionally responsible for leading discharge efforts for the patients under their care. That planning begins upon admission. "Registered nurses are at the frontline of the hospital admission process where initial patient assessment data are gathered and utilized to drive the collaborative medical and nursing care efforts. This assessment data identifies treatment plans, safety risks, and provides the foundation for discharge planning" (Handy, 2016). Through a series of pressures over the years, nurses have by and large abdicated their role as the primary discharge planner and the hospital case manager has filled the void. Regardless of the past pressures, the fact is that hospital case managers have largely assumed that role as evidenced by the plethora of literature on case managers and transitions of care (Hunter, 2013; Swope, 2015; & Holland, 2017). To be successful at coordinating care for the most vulnerable hospitalized patients selected through the analytic process, case managers must be freed from hospital-wide discharge planning responsibilities.

7. Separate professional transition responsibilities from associated logistics

As the marketplace exerts greater oversight of post-acute resource utilization, the activities related to the logistics of making a plan come to life have grown more complex and time-consuming but rarely requires a professional license. This awareness has sparked the explosion of support teams to manage the logistics associated with discharge plans, which, from time memorial, has been a professional responsibility. These post-acute organizing teams take many forms, but all are charged with coordinating the administrative and clerical requirements of the plan and keeping the care team apprised of the progress. Most importantly, they are the 'go-to' people for the nursing staff to organize the logistics of a transition plan for a patient not being followed by a case manager. As these teams mature, they often take on expanded roles to provide other community-based information services.

8. Resolve opposing views of case management

There are many authoritative voices in the case management community who are opposed to restructuring traditional hospital case management services. Many claim that separating utilization review, social work/psychosocial counseling and other activities currently positioned under the hospital

case management department umbrella from the care coordination activities of the future, may impact communication priorities. They express a valid concern.

Until the executive team and influential medical and departmental leaders promote a cultural shift that focuses on safety, quality and cost effectiveness or adopts a care delivery structure that creates a cohesive care team that consistently works together, communication gaps between these activities may occur. Hospitals are traditionally structured in siloes and sharing information across providers is an age-old challenge. But that should not detract from the goal of offering patient-centric care coordination to the neediest patients so that they can move through the continuum of care with a guide to educate, inform, and optimize self-care and well-being.

SECTION 5: EXECUTIVE SUMMARY

Case management is "A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes" (CMSA, 2016).

As hospitals adapt to the new marketplace, they are looking for a case management strategy that addresses managing the high-risk and at risk-patient populations and the barriers to health such as social determinants which contribute to misuse and over-use of hospital resources. To accomplish this goal, it is essential to break away from a tendency to place efficiency over effectiveness. It is axiomatic that the realities of value-based care are equally driven by the need to contain costs (efficiency) and improve quality (effectiveness). When considering the evolution of case management departments and the expectation of longitudinal care coordination continuity, merging several activities into a single role dilutes the anticipated impact and benefits each could bring to the table. For value, leaders must realign their priorities and re-engineer their case management models.

Case managers must be agents of change and drive the processes and policies that leverage the structure, the role and the practice workflow to promote achievement of the Triple Aim (IHI, 2019). The case manager role must be developed to support new continuum strategies and generate outcomes that will outperform competitors (efficiency) and contribute to the well-being of the community served (effectiveness).

The task force believes that the strategy for hospital case management practice is built around three core principles. It starts first with a shared vision of patient-centric care and an enterprise-wide commitment to quality and safety. The second is evidence of an enduring mutual interest which, in

organizational terms, means that executive leadership supports the intent and the goals of a care coordination program across the continuum as it parallels the organization's preparations for a value-based environment. The third, and often the trickiest, is alignment around shared values and a shared spirit of cooperation, teamwork and respect. Those three principles – shared vision, enduring mutual interest, and shared values – form the foundation for transformation.

There are many steps that can be taken independently within the hospital's case management department but they offer limited opportunities to affect the quality, safety and outcomes needed to manage the expectation of an enterprise-wide care coordination program. Gains are possible, of course, but the cost of achieving them is very high and the complexity of a new, internally-driven new case management model may conflict with the hospital's goals for the future.

For value, executive staff together with medical staff and case management leaders must get together to realign their priorities and transform their case management models. Hospital case manager roles must be developed which will excel; not to simply get things done quicker, but to generate process and patient reported outcome metrics that will outperform competitors (efficiency) and contribute to the well-being of the community served (effectiveness).

SECTION 6: SUMMARY 0F KEY ACTION POINTS

For Hospital Executives:

- Affirm commitment to value-based care.
- Create organizational wide awareness of the importance of a care coordination competency.
- Evaluate your hospital's or health system's care coordination capabilities across the continuum.
- Align regulatory and contractual medical necessity obligations with revenue cycle activities.
- Define interoperability and deliver EMR development projects to connect providers.
- Focus on eliminating the manual entry of data by recruiting artificial intelligence, natural language processing and other emerging technologies.
- Establish a nimbleness to expedite delivery of care and care transitions.
- Junk the fax machine and embrace electronic communication to share documents with payers and providers.
- Invest in resource utilization monitoring through a revitalized utilization management committee.
- Invest in community-based transitional care as a component of a robust continuum of care strategy.

For Directors of Case Management:

- Develop job descriptions with broad eligibility to create diverse case management team.
- Identify non-value-added tasks and negotiate with executive and colleagues to realign them.
- Invest in contemporary care coordination education to orient current and future case managers.
- Clarify the meaning of care coordination….develop the 15 second "elevator speech."
- Reallocate FTEs so that professionals work at the top of their license with non-professional support.
- Develop parameters and electronic capability to identify high risk patients.
- Create HIPAA compliant electronic opportunities for patients to interact with their assigned case managers.

***For Medical Staff Leaders*:**

- Explore opportunities to use digital health to engage patients.
- Create common standards for evidence based medical practice.
- Support electronic medical decision-making.
- Bridge the disconnect between hospital medical staff and community providers to keep them apprised of patient developments including admissions, ED visits, discharges, and medications.
- Enlist colleagues to design clinical workflows that take advantage of interprofessional rounds.
- Tailor the size and process of morning hand-off rounds to keep all members of the care team current.
- Make analytics available to the medical staff through the utilization management committee.

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