

Exploring the Effect of At-Risk Case Management Compensation on Hospital Pay-for-Performance Outcomes: Tools for Change

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ABSTRACT

Purpose/Objectives: Acute care nurse case managers are charged with compliance oversight, managing throughput, and ensuring safe care transitions. Leveraging the roles of nurse case managers and social workers during care transitions translates into improved fiscal performance under the Affordable Care Act. This article aims to equip leaders in the field of case management with tools to facilitate the alignment of case management systems with hospital pay-for-performance measures. A quality improvement project was implemented at a hospital in south Alabama to examine the question: for acute care case managers, what is the effect of key performance indicators using an at-risk compensation model in comparison to past nonincentive models on hospital readmissions, lengths of stay, and patient satisfaction surrounding the discharge process.

Primary Practice Setting(s): Inpatient acute care hospital.

Findings/Conclusions: The implementation of an at-risk compensation model using key performance indicators, Lean Six Sigma methodology, and Creative Health Care Management's Relationship-Based Care framework demonstrated reduced length of stay, hospital readmissions, and improved patient experiences.

Implications for Case Management: Regulatory changes and new models of reimbursement in the acute care environment have created the perfect storm for case management leaders. Hospital fiscal performance is dependent on effective case management processes and the ability to optimize scarce resources. The quality improvement project aimed to further align case management systems and structures with hospital pay-for-performance measures. Tools for change were presented to assist leaders with the change acceleration process.

Key words: care coordination, case management process improvement, key performance metrics, pay for performance, relationship-based care

REINVENTING CASE MANAGEMENT: TOOLS FOR CHANGE

The Institute of Medicine (2001) has prompted health care leaders to reshape delivery systems to produce better patient outcomes. Dramatic changes in hospital reimbursement by both public and private payers have caused hospital executives to evaluate traditional organizational systems and structures, including case management. Value-based purchasing under the Affordable Care Act has turned the inpatient payment system upside down as leaders attempt to balance fee-for-service payment with hospital pay for performance. For case managers, changes in Conditions of Participation surrounding discharge planning guidelines and interpretations of inpatient services have added a new level of complexity to the role of acute care case management (Centers for Medicare

& Medicaid Services [CMS], 2013). Collectively, these forces have set the stage for change.

Case managers play a pivotal role in the acute care environment by contributing to the revenue

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in the critical task of organizational
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cycle, patient experience, and organizational outcomes. Nurse case managers and social workers possess first-hand knowledge of care transition barriers and the issues impacting the health of communities. As hospital payment systems shift from volume to value, clinical integration becomes increasingly important. Case managers are change agents in the critical task of organizational transformation.

This article aims to equip leaders in the field of case management with tools to facilitate the alignment of case management systems with hospital pay-for-performance measures. A quality improvement project was implemented at a hospital in south Alabama to examine the question: for acute care case managers, what is the effect of key performance indicators using an at-risk compensation model in comparison to past nonincentive models on hospital readmissions, lengths of stay, and patient satisfaction surrounding the discharge process.

CHANGING LANDSCAPE

The inception of the Affordable Care Act has placed a spotlight on the role of the acute care case manager. The goal of hospital case management is to achieve “optimal health, access to care and appropriate utilization of resources, balanced with the patient’s right to self-determination” (American Case Management Association, 2013, p. 2). Acute care nurse case managers are charged with compliance oversight, managing throughput, and ensuring safe care transitions. Case managers function as an extension of the hospital’s revenue cycle and possess the ability to adapt workflow according to payer requirements. Most hospitals are challenged by complex payer rules ranging from per diem, diagnosis related group-based payments, pay for performance, and most recently accountable care reimbursement. Value-based purchasing represents another layer of complexity requiring strong case management departments.

The evolution of new at-risk payment hospitals requires leaders to be savvy in building effective teams to support the future care delivery model of population health management. Each year hospital leaders are charged with doing more with less. Hospital fiscal performance is dependent on effective case management processes and the ability to optimize scarce resources. The weight of value-based

purchasing measures continues to increase, moving payers from a fee-for-service delivery system to one that is based on patient outcomes. Where value-based purchasing allows hospitals to earn dollars based on quality, readmissions create financial losses in the form of Medicare reimbursement. By 2015, hospitals demonstrating excessive readmissions within 30 days of hospital discharge will experience reductions in Medicare reimbursement with a maximum penalty of 3% (CMS, 2012). Leveraging the roles of nurse case managers and social workers translates into improved fiscal performance under health care reform. Consequently, it is crucial for hospital executives to explore new mechanisms for engaging staff and accelerating the change process.

STAKEHOLDER SUPPORT

The change process requires organizational support and the involvement of key stakeholders (Rich & Porter-O’Grady, 2011). Case management and discharge planning involve stakeholders across the continuum including patients, physicians, nurses, ancillary staff, nurse case managers, social workers, post-acute care providers, and executive leaders. Stakeholder involvement is an important consideration during the change process and can impact quality improvement outcomes and sustainability (Harris, Roussel, Walters, & Dearman, 2011). For a hospital in south Alabama, the chief financial officer was an important stakeholder in the development of a new incentive-based compensation model for case managers. Using hospital financial targets,

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key performance metrics were developed to align the case management department with the hospital's fiscal performance. In addition, the reporting structure for the director of case management shifted to the chief financial officer.

CALL TO ACTION: PERSON-CENTERED CASE MANAGEMENT

The American Academy on Nursing Policy has encouraged leaders to explore mechanisms to promote patient engagement and activation in self-care (Pelltier & Stichler, 2013). Qualitative studies support the importance of having open conversations with patients and families to develop care that is in line with patient and family preferences (Powers, Norton, Schmitt, Quill, & Metzger, 2011). Recent revisions in the conditions of participation for discharge planning call for developing discharge plans in accordance with patient preferences and patient capabilities (Department of Health and Human Services, 2013). Changes in CMS regulations demands increased interaction beyond providing facility patient choice lists to patients and families (Birmingham, 2009).

While developing discharge plans according to patient and family preferences may seem intuitive to case managers, balancing priorities remains a challenge. In 2013, changes in CMS regulations regarding discharge planning and level of care interpretations created a heightened awareness for highly skilled case managers. Leaders have been challenged with continuously revisiting their care management models to deliver the highest quality of services under lean circumstances.

RELATIONSHIP-BASED CARE FRAMEWORK: PERSON-CENTERED CASE MANAGEMENT

In response to changes in health care reform and value-based purchasing measures, case management departments continue to evolve into models emphasizing care coordination. In recent years, complex regulatory rules governing level of care determinations along with pressures from managed care organizations have resulted in utilization review functions becoming the dominant function of nurse case managers. Consequently, face-to-face time with patients has become increasingly difficult. The shift to population health management calls for relationships between patients and case managers. Creative Health Care Management's (2004a) Relationship-Based Care (RBC) Model is an excellent conduit for building on the human elements of patient-centered case management.

Relationship-Based Care was utilized in the quality improvement project to engage nurse case man-

agers in the transition from a utilization function to a role encompassing utilization, discharge planning, and care coordination (Koloroutis, 2004). The framework not only reduces preventable readmissions but ultimately improves better patient outcomes (Cropley, 2012; Koloroutis, 2004; Ledesma, 2011; Schneider & Fake, 2010; Wooley et al., 2012). As accountable care organizations evolve, new payment modes will drive the need for changes in case management roles to support patient- and family-driven care. Organizational support are key, as leaders work to reshape roles, pilot new case management models, and redesign care navigation beyond the inpatient setting.

Relationship-Based Care serves as a practical guide for transforming hospital systems into patient-centric environments. RBC fosters caring and collaborative relationships between patients and nurses and has been utilized by chief nursing officers internationally as a means of impacting patient experiences (Koloroutis, 2004). The framework encompasses care of self, care of the team, and care of the patient. Leadership, teamwork, professional nursing practice, and the promotion of a caring and healing environment are key elements in the RBC model (see Figure 1) (Koloroutis, 2004). These elements are consistent with the standards of practice for nurse case managers and are critical concepts in the development of case management teams (American Case Management Association, 2013).

The RBC framework compliments the work of Jean Watson (Goldin & Kautz, 2010). The cultural transformation is achieved through RBC implementation of Watson's theory. Watson's theory includes caritas statements. These statements foster relationships between case managers and patients such as (a) being authentically present, (b) developing and sustaining helping and trusting relationships, (c) engaging in genuine teaching and learning, and (d) creating a healing environment at multiple levels (Goldin &

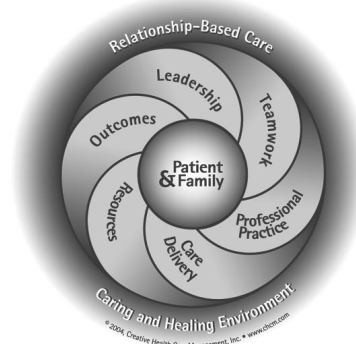


FIGURE 1
Creative Health Care Management's Relationship-based care Model. Used with permission from *Relationship-Based care: A Model for Transforming Practice*. Copyright 2004, Creative Health Care Management, Inc.

Kautz, 2010). Caritas principles emphasize caring in person-centered care transitions. Research has shown implementation of RBC improves associate satisfaction and boosts patient satisfaction scores (Berry et al., 2013). Exposing case managers to the caritas themes supports the overarching goals of improving patient experience, reducing readmissions, and reducing lengths of stay. The application of Creative Health Care Management's framework transforms barriers encountered by patients from the point of admission to hospital discharge. The RBC Model sets the stage for collaborative relationships between the nurse case manager and the patient, promoting patient-driven choices and optimal healing.

TRANSDISCIPLINARY EVIDENCE-BASED PRACTICE MODEL

The majority of decisions impacting quality take place on the front lines (Porter-O'Grady & Malloch, 2010). The people closest to the process must be involved in quality improvement activities. Discharge planning and care coordination require continuous cross-continuum collaboration among nurses, social workers, case managers, physicians, and post-acute care providers. Evidence-based practice (EBP) models are an effective mechanism for gaining buy-in and driving organizational change (Schaffer, Sandau, & Diedrick, 2012).

The Transdisciplinary Model of EBP provided guidance to case management process improvement (see Figure 2) (Satterfield et al., 2009). Previous evidence-based medicine models lacked attention to patient preferences, whereas the Transdisciplinary Model places shared decision making at the center (Hall & Roussell, 2014). The model is a natural fit

for quality improvement efforts involving care transitions, as close collaboration is essential among nurses, case managers, and medical social workers. Case management standards of practice have also moved toward a transdisciplinary approach, describing care coordination as a process and not a function owned by any particular discipline (Treiger & Fink-Samnack, 2013).

A NEW ERA IN HEALTH CARE

In the 21st century, health care organizations are characterized as highly complex, involving multiple layers of systems and subsystems, continuously interacting with one another (Nelson et al., 2008; Wheatley, 1993). Change is no longer viewed as something that can be controlled but is inevitable (Wheatley, 1993). Effective leaders demonstrate adaptation to change through acceptance, respect for autonomy, and innovation (Plsek & Greenhalgh, 2001). When faced in the midst of chaos, leaders respond by equipping their team with information rather than using the "knowledge is power" approach (Wheatley, 1993). As external changes occur in the health care environment, equipping frontline staff with knowledge is an important part of the cultural transformation process.

To succeed in the 21st century, nurse leaders must seek to understand rather than control (Wheatley, 1993). Transformation of complex systems requires leaders to move from traditional linear approaches to solving challenges using tools from other industries (Plsek & Greenhalgh, 2001). The Deming Wheel is imbedded in almost all quality improvement initiatives and continues to influence the manner in which nurse leaders solve complex problems (The W. Edwards Deming Institute, 2013). This philosophy

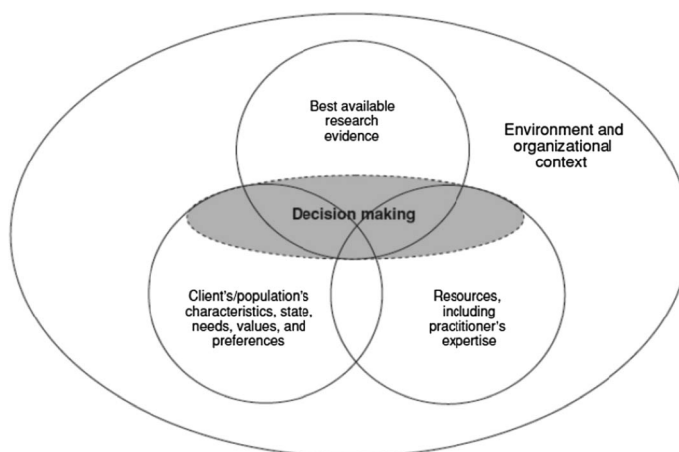


FIGURE 2

Transdisciplinary evidence-based practice. Used with permission from "Toward a transdisciplinary model of evidence-based practice," by J. M. Satterfield, B. Spring, C. Brownson, E. J. Mullen, R. P. Newhouse, B. B. Walker, & E. P. Whitlock, 2009, *The Millbank Quarterly*, Vol. 87(2), pp. 368–390.



FIGURE 3
Deming wheel. Courtesy of The W. Edwards Deming Institute®. Reproduced with permission.

recognizes the relationships among systems, individual views of the world, variation of processes, and human behaviors. Quality improvement efforts follow a continuous process beginning with the Plan, Do, Study, and Act framework. Equipping the team with an understanding of the Deming Wheel assists the team with adapting to change and provides empowerment among staff to create better processes for patients and staff (see Figure 3).

QUALITY IMPROVEMENT

Patient and family engagement is a national priority for eliminating health disparities (National Quality Forum, 2013). Reinventing case management requires the application of quality improvement methodologies gleaned from engineering and business industries. The transformation of traditional fee-for-service hospital case management practices to population

health management is consistent with the Institute of Medicine's (2001) quality domains. For a hospital in south Alabama, caring for the underserved, developing patient-centered care transitions, and focusing on high reliability in care processes were in alignment with the mission and vision of the organization.

Consistent with goals of the Institute of Medicine (2001), quality case management services must be safe, efficient, timely, effective, equitable, and patient-centric. Achievement of the six quality domains requires continuous efforts to improve care processes. Leaders and quality improvement participants must view organizations as complex, dynamic, and adaptive microsystems (Sturmberg & Martin, 2012). After careful examination of improvement opportunities, and the involvement of stakeholders, incremental changes were implemented using the Plan, Do, Study, Act framework.

Effectiveness of case management process changes is monitored using run charts reflecting readmission rates, patient satisfaction scores, and lengths of stay. However, it is important for data to be communicated in a manner that is meaningful and of value to front-line staff. The Lean Six Sigma quality improvement methodology emphasizes the voice of the customer and places a strong focus on standardization of workflow processes (DeKoning, Verver, Van den Heuvel, Bisgaard, & Does, 2006). Lean also emphasizes active participation of the people closest to the process. The methodology provides a voice for associates, and the framework facilitates problem solving while eliminating the emotional aspect of highly charged process issues. Quality improvement tools such as the fishbone

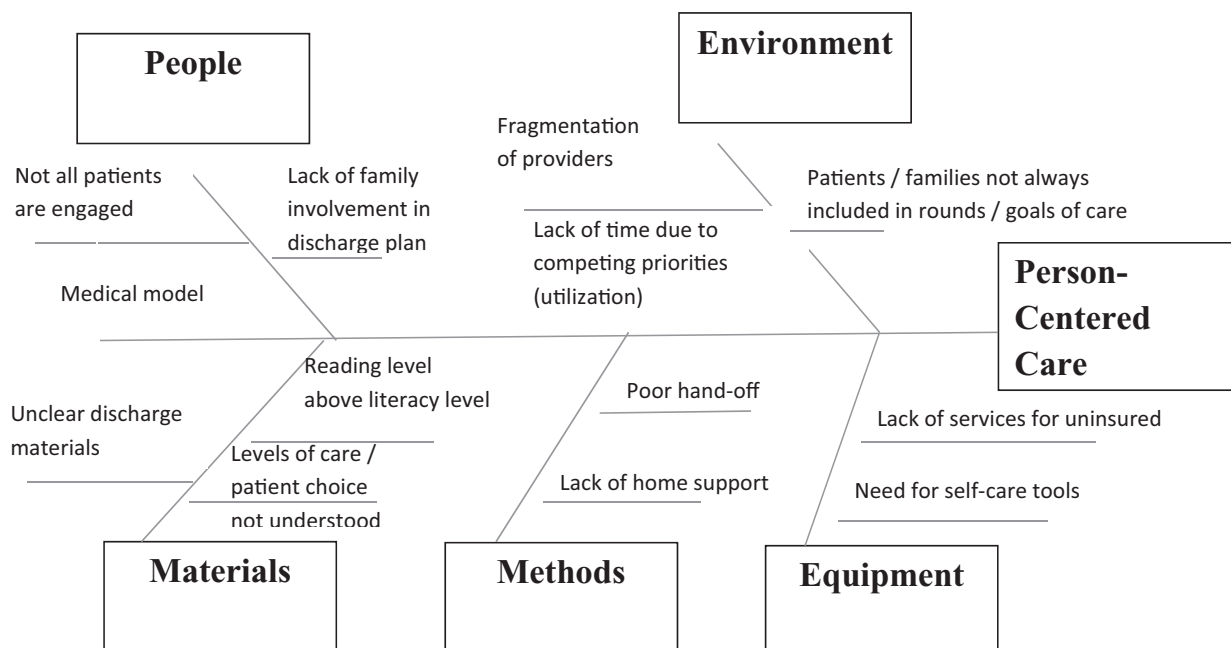


FIGURE 4
Fishbone diagram for barriers to person-centered care delivery.

diagram (see Figure 4) assist case management leaders and frontline staff with the process of assessing complex problems within microsystems. The fishbone diagram is frequently utilized by clinical leaders to examine drivers of preventable readmissions, payer denials, or barriers to patient satisfaction.

INCENTIVES FOR CHANGE: AN AT-RISK COMPENSATION APPROACH

Project implementation occurred in a 349-bed community hospital located in southern Alabama, a faith-based organization and part of the largest nonprofit health care system in the country. Approvals were obtained from the internal institutional review board at the hospital level and from the University of South Alabama. The project timeline spanned over 5 months following a systematic needs assessment and literature review surrounding evidence-based case management interventions and an exploration of the use of at-risk compensation models for acute care case managers.

Tools

Key performance indicators were selected in collaboration with the hospital's chief financial officer according to budgetary benchmarks (see Figure 5). Metrics were selected by industry standards and hospital financial targets. Run charts provided visualization for the team to monitor progress related to hospital performance outcomes impacted by case managers such as discharge questions in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, readmission rates, and hospital lengths of stay (Cesta, 2011). Although individual metrics were captured per patient population (nursing unit), at-risk compensation targets were based on overall hospital performance.

Tools were accessed through Creative Health Care Management, a resource available to organizations implementing the Relationship-Based Care framework. The *Commitment to My Co-workers Cards* (Creative

| Pay for Performance (P4P) | Level 1 P4P | Level 2 P4P | Level 3 P4P |
|--|--|--------------------------------|----------------------------------|
| Medicare ALOS | 1% reduction in length of stay | 2% reduction in length of stay | 2.5% reduction in length of stay |
| Managed Medicare ALOS | 1% reduction in length of stay | 2% reduction in length of stay | 2.5% reduction in length of stay |
| Patient Satisfaction Discharge Question (HCAHPS) | Improved but less than the 75th percentile | At the 75th percentile | Greater than the 75th percentile |
| Value Based Purchasing Readmission Rate | 15.0% – 16.2% | 13% – 14% | 12% or less |

FIGURE 5

At-risk compensation key performance metrics.

Discipline: Social Worker _____ Registered Case Manager _____

Read each statement below and rate it on a scale of 1 to 7 based on how often it is true for you (column 1) and for your team as a whole, (column 2):

1=Almost never

2=Rarely

3=Once in a while

4=Frequently

5=Quite often

6=Usually

7=Almost always

Self Team

- A. I believe that it is less important that I “like” my colleagues and more important for us to be committed to the same purpose and goals. (Rate the same question but answer by replacing “I” with “My team”.)
- B. I accept responsibility for establishing and maintaining healthy interpersonal relationships with my work team members.
- C. I speak directly and promptly with the person involved in a conflict or problem.
- D. I trust my coworkers to do the job they are required and prepared to do.
- E. I address the situation directly and constructively whenever I see a problem in the quality of work.
- F. I respect my colleagues without consideration to titles, education, or job position.
- G. I require my colleagues to treat me with respect.
- H. I address any behavior I perceive as disrespectful or abusive to others or to myself.
- I. I avoid engaging in the “3 Bs”: bickering, backbiting, and blaming.
- J. I practice the “3 Cs” in my colleague relationships: caring, committing, and collaborating.
- K. I affirm and recognize my colleagues for quality work.
- L. I avoid complaining about my colleagues; if I have a complaint I address it with the person.
- M. I avoid gossip.
- N. If I hear someone complaining about another, I will as that person to speak directly to that person.
- O. I accept others and myself as imperfect... a work (masterpiece) in progress!

TOTAL SCORE

I believe our team excels at _____

I would like to see us build on our already excellent ability to _____

I think we need to strengthen in the area(s) of _____

I think we can accomplish this by _____

FIGURE 6

Commitment to My Co-workers Healthy Team Assessment Survey (Koloroutis, 2004).

Health Care Management, 2004b) and *The Ultimate Guide to Competency Assessment in Health Care* were incorporated in the project plan (Wright, 2005). Case management staff participated in the *Commitment to My Co-workers Healthy Team Assessment Survey* at the start of the project and upon completion (Creative Health Care Management, 2004b) (see Figure 6).

Interventions

Key performance indicators and an incentive-based compensation plan were key components of the project. While no specific studies were found pertaining to case managers, research demonstrates that financial incentives have the potential to impact performance outcomes (Kurtzman et al., 2011; Love, Revere, & Black, 2008; Riley, James, Rolband, & Norton, 2009; Valez-Gonzalez, Pradhan, & Weech-Maldonado,

2011; Wieck, Dols, & Northam, 2009). A meta-analysis reported that workplace incentives increased performances by at least 22%, regardless of the work setting (Condly, Clark, & Stolovitch, 2003).

The project intervention included the development of key performance indicators for nurse case managers and social workers with specific targets for length of stay, 30-day readmissions, and patient experience data (see Figure 5). Based on hospital budget targets, metrics were created for three levels of performance. Achievement of Level 1 for hospital outcomes resulted in a financial incentive at the individual staff level. Level 3 represented the highest level of at-risk compensation based on the end of fiscal year performance. From a budget perspective, incentives were funded through the achievement of targets approved by the hospital's chief financial officer. The budget for the at-risk compensation pilot was funded by hospital outcomes impacted by the work of frontline case managers.

The RBC framework and the Transdisciplinary EBP Model provided guidance for addressing opportunities identified during the needs assessment. Areas for improvement included person-centered care, staff development, increased care coordination, and interventions to improve value-based purchasing measures. A kickoff meeting with case management associates explained project goals, the new at-risk compensation model, description of RBC, and an invitation to participate in shaping person-centered care. Research findings were shared with staff regarding outcomes of RBC in other contexts, particularly findings surrounding patient satisfaction and preventable readmissions (Berry et al., 2013; Cropley, 2012; Ledesma, 2011; Schneider & Fake, 2010; Wooley et al., 2012). Process improvement activities focused on informed discharge and staff discussions with patients and families about goals of care (Bauer, Fitzgerald, Haesler, & Manfrin, 2009; Ellis-Hill et al., 2009; Powers et al., 2011).

Outcome Measurement

Outcome data were collected using monthly dashboards for length of stay trends, hospital readmission rates, and HCAHPS scores. These measures

were imbedded in the new key performance indicator dashboards for the department. Data were reported according to the hospital's fiscal calendar from July 1, 2013, to June 30, 2014. Process measures were tracked using a project timeline (Gantt chart) and updated regularly. Selected statistical data reflect publically reported data and hospital value-based purchasing measures. During the planning phase, the proposed project was presented to the hospital's Administrative Council. If shown to be effective, the pilot could be expanded to other roles.

ADAPTING SYSTEMS AND STRUCTURES

Since hospitals represent highly complex adaptive systems, the process for studying root cause analysis surrounding patient outcomes is highly complex (Nelson et al., 2008). An analysis of strengths, weaknesses, opportunities, and threats revealed important considerations at the micro, meso, and macro systems level (see Figure 6) (Harris et al., 2011). The presence of a strong palliative program represented a strength that could be leveraged, as nurse case managers became more involved in goals of care discussions. However, lack of experience among staff in areas of care coordination, motivational interviewing, patient activation, and screening for readmission risks presented system weaknesses. High turnover and fragmentation of the discharge planning process and care coordination created opportunities to reinvent the role of the nurse case manager and social worker. In tandem with the development of key performance metrics, new job descriptions were created. The role of the nurse case manager recently shifted from utilization and clinical resource management to a role encompassing utilization management, care coordination, and care transitions. The role of the social worker also changed from performing the role of discharge planning to responsibilities involving complex care transitions, communicating with child and adult protective services, coordination of mental health services, and psychological assessments for patients transitioning to skilled nursing facilities (see Figure 7).

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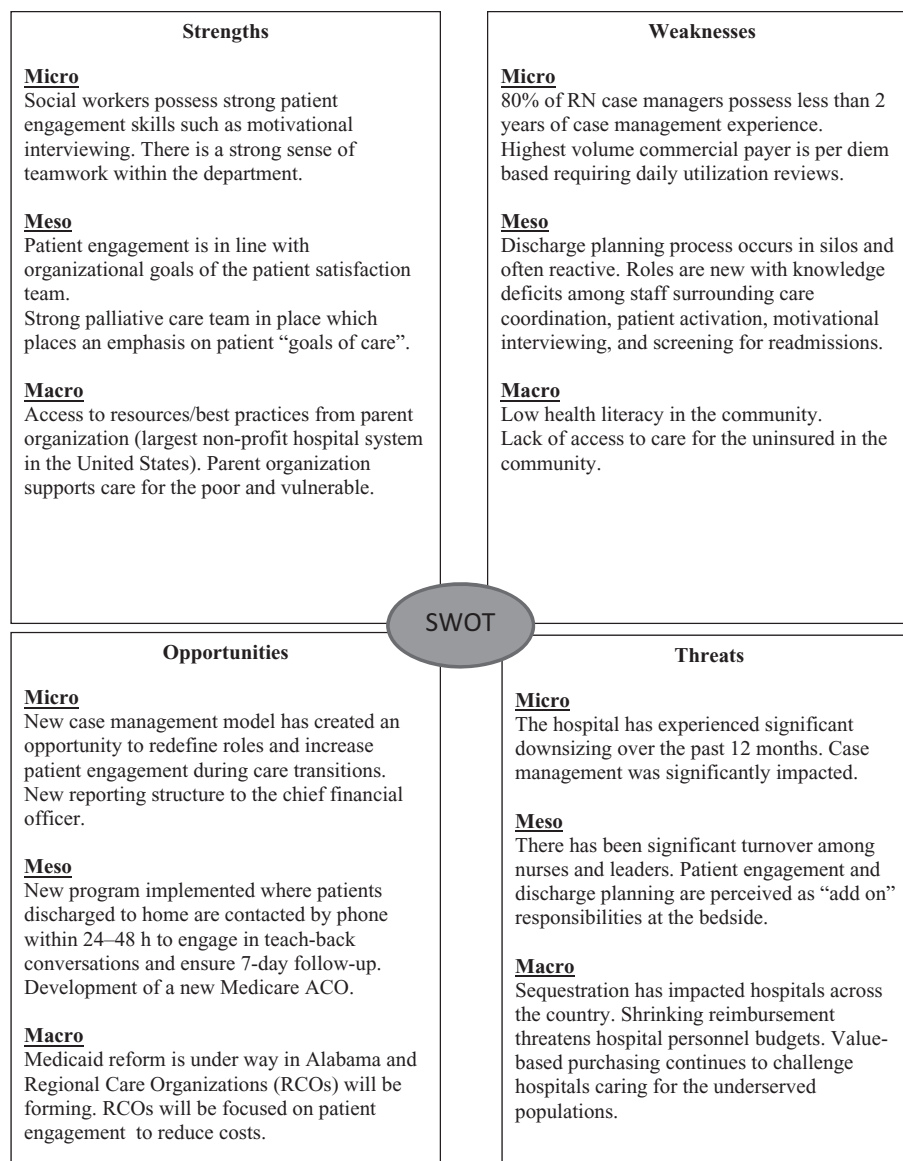


FIGURE 7
Hospital strengths, weaknesses, opportunities, and threats (SWOT) analysis.

IMPLICATIONS FOR THE FUTURE OF CASE MANAGEMENT

The outcomes measured in the project are consistent with the Institute of Medicine’s (2001) quality domains of efficiency, safety, and patient-centeredness. The American Academy on Nursing Policy has also called leaders to explore mechanisms to promote patient engagement and better patient outcomes (Peltier & Stichler, 2013). There is minimal research on the effectiveness of case management models and key performance measures in relation to organizational performance. Historically, the role of the nurse case manager has been focused on utilization management tasks associated with fee-for-service

hospital reimbursement. Changes in hospital reimbursement have heightened awareness of the critical link between effective care management and hospital pay-for-performance and patient outcomes. Sequestration and tighter hospital budgets call for case

Changes in hospital reimbursement have heightened awareness of the critical link between effective care management and hospital pay for performance and patient outcomes.

Health care reform has prompted a cultural shift where patients are considered to be equal participants in their plan of care. The recommendation for initiating discharge planning on day 1 is not a new concept to case managers. What has changed is the emphasis on patient and family patient engagement during care transitions and the discharge planning process. The HCAHPS survey asks patients about specific questions concerning the discharge process and whether the hospital took patient and family preferences into consideration. If patients are to experience successful care transitions, playing an active role in the discharge plan is paramount.

management leaders to demonstrate value and return on investment for each full-time equivalent position. Changing reimbursement has created the perfect storm for leaders operating with limited resources, yet responsible for meeting compliance rules, value-based purchasing measures, and new payment models. This quality improvement project aimed to further align case management systems and structures with hospital pay-for-performance measures. Not only is this work important to the field of case management, knowledge gained from the project may prompt health care leaders to consider similar approaches for other roles in the acute care setting.

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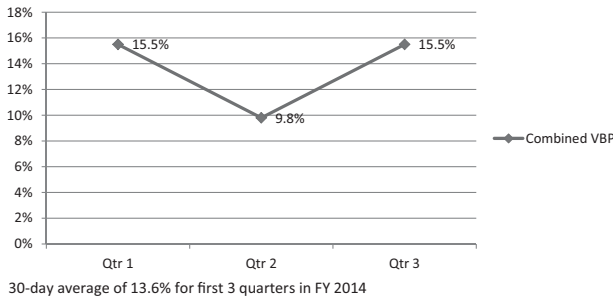
The phenomenon of patient-driven care transitions is significant to patient safety and preventing hospital readmissions (Greenwald, Denham, & Jack, 2007). Higher patient satisfaction rates correlate with lower 30-day readmission rates and better outcomes (Boulding, Glickman, Manary, Schulman, & Staelin, 2011). Case managers must ensure that patients and families understand post-acute care options and are actively involved in decisions early in the stay. Care coordination efforts should focus on the goal of rendering care at the right time and in the right place. The introduction of an accountable care organization at the project location created another reason for stepping up the refinement of roles to support person-centered care.

The application of RBC framework created an opportunity to demonstrate the impact of RBC in a new setting. Most studies regarding the implementation of RBC have involved bedside nurses (Cropley, 2012; Ledesma, 2011; Schneider & Fake, 2010). The RBC framework is highly applicable to case management for a number of reasons. In recent times, nurse case managers have been forced to focus a great deal of attention on compliance activities pertaining to utilization review and documentation requirements. Consequently, face-to-face time with patients continues to be a challenge. Through the application of RBC principles and Lean Six Sigma tools, case management leaders can articulate the benefits of adjusting case management models to support person-centered case management. Increased time with patients should result in higher patient satisfaction, improved care coordination, throughput, and the avoidance of preventable readmissions (Cropley, 2012).

RESULTS

Outcomes for the quality improvement project included patient satisfaction scores specifically related to patient involvement in the discharge process, readmission rates, and length-of-stay data. Outcome data were most favorable for length of stay, demonstrating a 4.7% reduction in the average length of stay for traditional Medicare patients, and a 2.6% reduction in length of stay for managed Medicare patients (see Figure 8). The value-based purchasing readmission rate of 13.6% was better than the expected readmission rate of 16% (see Figure 8). However, challenges reported by frontline case managers for the managed Medicare population included lack of approval from insurance companies for post-acute care services such as short-term skilled nursing rehabilitation, acute rehabilitation, and long-term acute care services. At the time of completion of the project, additional quality improvement efforts were under way in partnership with the state quality improvement organization to determine

Value Based Purchasing 30-Day Readmission Rate



Medicare Length of Stay Trends: FY 2014

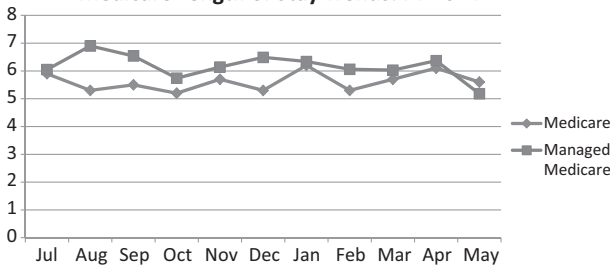


FIGURE 8
Length of stay and readmission data.

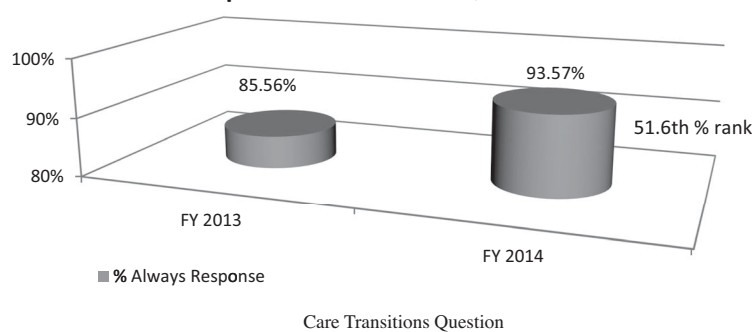
root cause analysis for readmissions at the community level.

Patient satisfaction scores improved regarding the perception of staff taking patient preferences into account when developing discharge plans (see Figure 9). While the HCAHPS question regarding help at home following discharge improved, the results did not meet the 75th percentile goal in comparison with national benchmarks (see Figure 9). Although 94% of patients responded “always” when asked about how often staff inquired about whether patients required help at home following discharge, the score only ranked in the 52nd percentile in comparison with other hospitals.

The at-risk compensation pilot required the achievement of at least Level 1 achievement in all categories. At the point of project completion, the projected outcome ranged between Level 1 and Level 2 achievement. While length-of-stay outcomes exceeded Level 3 achievement, patient satisfaction scores and 30-day readmission rates reduced the overall performance rating. Final determination will

Question asked to patients during the survey: “During this hospital stay, did doctors, nurses, and other staff talk with you about whether you would have the help needed when you left the hospital?”

Help At Home HCAHPS Question



Question asked to patients during survey: “During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left. Would you say never, sometimes, usually, or always?”

Care Transitions HCAHPS: Patient Preferences

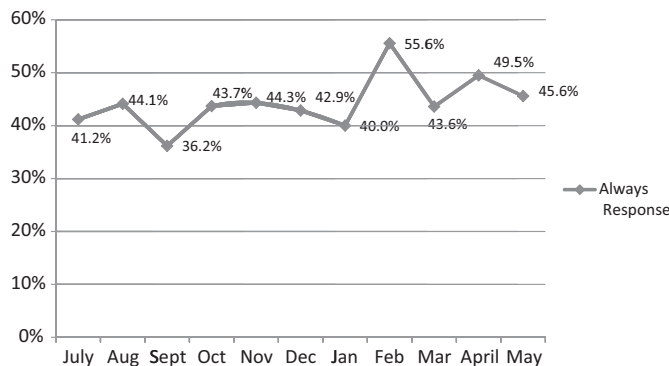


FIGURE 9
Patient satisfaction data.

| Pay for Performance (P4P) | Level 1 P4P | Level 2 P4P | Level 3 P4P |
|--|---|--------------------------------|------------------------------------|
| Medicare ALOS | 1% reduction in length of stay | 2% reduction in length of stay | 2.5% reduction in length of stay ★ |
| Managed Medicare ALOS | 1% reduction in length of stay | 2% reduction in length of stay | 2.5% reduction in length of stay ★ |
| Patient Satisfaction Discharge Question (HCAHPS) | Improved, but less than the 75th percentile ★ | At the 75th percentile | Greater than the 75th percentile |
| Value Based Purchasing Readmission Rate | 15.0%–16.2% | 13%–14% ★ | 12% or less |

FIGURE 10

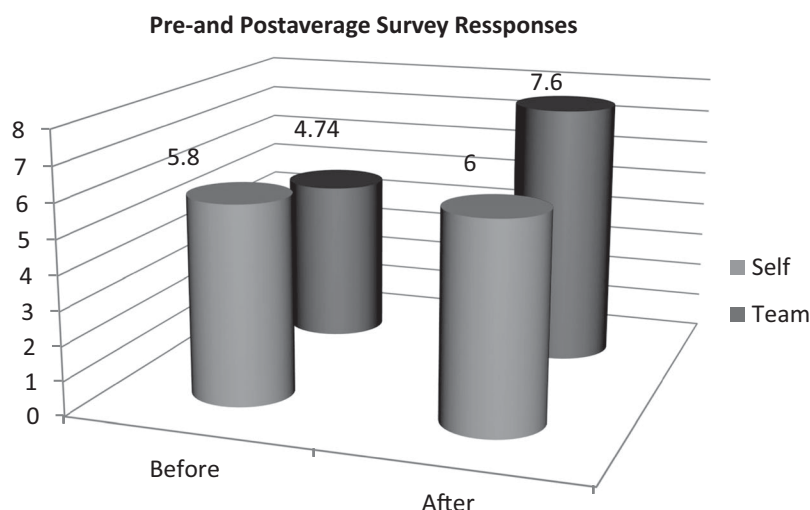
Key performance indicator score card results.

be made at the end of the fiscal year and will be based on hospital performance. Preliminary results were shared with case management staff at the conclusion of the project (see Figure 10).

The quality improvement project also involved a healthy team assessment using the *Commitment to My Co-Workers Healthy Team Assessment Survey* (2004b). The survey was administered at the beginning of the project and at the end. Results demonstrated improved scores for associate perceptions of team commitment at both the individual (self) and team levels. Scores improved significantly in the area of perceived team commitment. Qualitative feedback revealed strengths in areas of team work, efficiencies, and delivering care to underserved populations. As increased attention was placed on patient–staff face-to-face time, associates reported high caseloads and as a barrier to comprehensive discharge planning. Qualitative surveys also pointed to the need for increased cross department collaboration.

FUTURE INVESTIGATION

There is a need for future investigation regarding the longitudinal effect of compensation not only on



Healthy Team Survey Qualitative Survey Questions
Associate Feedback

| Survey Question | Survey Responses / Themes |
|---|---|
| I believe our team exceeds at... | Working as a team Efficiency relating to work load Assisting the poor and vulnerable (patient needs) Creativity in problem solving |
| I would like to see us build on our already excellent ability to... | Enhance resources for uninsured and underserved patient populations Peer communication Prioritization of responsibilities relating to discharge planning Improve communication and coordination across departments |
| I think we need to strengthen in the area(s) of... | Keep each other accountable Time management Interaction with families and patients about discharge planning |
| I think we can accomplish this by ... | Effective communication and prioritizing activities Improving caseloads / ratios Develop materials for patients |

FIGURE 11

Commitment to My Co-workers Healthy Team Assessment Survey (Koloroutis, 2004).

hospital performance outcomes, but on case manager job satisfaction and turnover. Case management leaders should be cautious in the framing of incentive programs and the unintended consequence on team behavior. The quality improvement project included tracking of individual units or pods for the purpose of serving as decision support tools. However, final measurement for at-risk compensation was based on the whole. In other words, there was only one report card for the entire department. This concept promoted peer accountability and fostered team building to achieve common goals. There was a conscious decision not to utilize unit-based final score cards due to the natural progression of patients from the critical care units to certain areas that experience longer lengths of stay. In fiscal year 2015, the vision for at-risk compensation is to incorporate a department score card using similar key performance indicators coupled with a new professional development component. Professional development will be measured by achievement of case management certification, participation in quality improvement projects, and conducting peer inservices. Future quality improvement measurement will include an associate survey as well as the impact on staff turnover.

CONCLUSION

The difference between an effective and ineffective case management department can translate into the viability of a hospital's existence. The Affordable Care Act has forced leaders to consider ways to optimize case management roles. The Transdisciplinary Evidence-Based Practice Model facilitated collaboration among nurse case managers and social workers and assisted in keeping the patient as the central focus of process changes. The RBC framework engaged staff in the nurse-patient relationship and will continue to optimize patient outcomes as the department prepares for the next stage of population health management.

The application of an at-risk compensation model for case managers provided an opportunity to accelerate the change process for achieving financial targets through the alignment of case management outcomes with hospital pay-for-performance measures under value-based purchasing. Lean Six Sigma tools provided a vehicle for addressing complex problems to improve workflow and patient experience. In addition to the nurse case manager and social worker roles, the at-risk compensation model was applied to other support roles within the department and showed to be an effective tool for driving outcomes.

In today's challenging environment of scarce resources and increasing demands, health care leaders should consider creative mechanisms for improving

person-centered care. Results of the quality improvement project suggest that the plan could easily be replicated in other settings and departments. The project also demonstrated the significance of an effective case management department in relation to hospital fiscal performance.

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