CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

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Need for case managers is rising with recent boom in ACOs

CMs are the "hub" of patient care

Accountable care organization (ACO) and medical home models for Medicare and other patients have expanded in recent years due to financial incentives provided by the Affordable Care Act, and the result is a spike in demand for health professionals who can do care or case management type of work.

The Centers for Medicare & Medicaid Services (CMS) added 89 new ACOs in January 2015, for a total — including the pioneer ACOs — of 424 ACOs, serving 7.8 million beneficiaries.

ACOs are designed to improve care coordination and integration for Medicare beneficiaries. Many also have expanded to privately insured populations. An ACO is a collaboration between doctors, hospitals, and other healthcare providers. The purpose is to provide high-quality care meeting specified Medicare quality targets, and to share in any savings they can generate for Medicare, according to CMS.

"We're at an interesting point

EXECUTIVE SUMMARY

Due to the Affordable Care Act, the accountable care organization (ACO) model has grown in recent years, providing more opportunities for case management and greater demand for CM experts.

- Case or care managers assist in provider, payer, and other settings with helping patients avoid unnecessary hospital and emergency room care.
- Case managers who can speak Spanish are in great demand in some areas of the country.
- ACOs are changing the face of what case management does by providing a financial framework for creative solutions to patient barriers to better health.

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in healthcare, where a lot of the financial incentives really are aligned to help us be creative and do things that are the right things to do, but previously we weren't rewarded for doing those things," says **Ann Kirby**, MSN, MPA, BSN, regional director of care management for Oregon at Providence Health & Services in Portland. Providence has a connected care contract, which places a heavy emphasis on team-based care, coordination, and online records and scheduling.

ACOs are changing the face of what case management does, says **Morey Menacker**, DO, president of Hackensack Alliance ACO in Hackensack, NJ.

"I think costs and quality go hand-in-hand," Menacker adds. "There are different reasons why people form ACOs, but if you're truly trying to change the care mechanism then what you need to have is someone who is the point person behind the patient's whole healthcare experience."

Increased demand for case/care managers has led to staffing problems for ACOs, says **Chris Senz**, chief operating officer at Tuality Health Alliance in Hillsboro, OR.

"It's a nightmare, finding case managers," Senz says. "There are not enough case managers."

It's even more challenging to meet the demand for bilingual case managers, she notes.

"We live in a county with a very large Latino population — 53%," Senz says. "And we've had a position open for a Spanish-speaking nurse."

It might be that all case managers need to learn Spanish, she adds.

Rather than English as a second language classes, CMs could use Spanish as a second language classes, she says.

"We partner with universities for nursing students and nursing programs to help them attract people of different cultures, to help them build a pipeline," Senz says.

As Providence Health & Services grows, there likely will be additional staffing challenges, Kirby notes.

"So far, we have been able to recruit people from other types of nursing roles or recruit people from different communities into care management roles," Kirby explains. "I am guessing we'll experience a shortage of people with care management experience, and we'll have to do more intensive training and education to get people up to speed on the care management role."

Finding experienced case managers (CMs) who are flexible in how they define case management is another challenge. A long-time CM might have a mindset and culture that is counter to what ACOs are trying to accomplish, Senz adds.

"A lot of case managers come out of a traditional healthcare/providing direct treatment environment, thinking, 'How do we get them to the skilled nursing facility?'" she explains.

ACOs need case managers who can think outside the provider box, willing to develop common sense solutions that are unrelated to healthcare interventions and care.

Funding decision flexibility gives CMs room for creativity in problem-solving. Examples include providing air conditioning units to congestive heart failure patients who live in homes that become swelteringly hot in summer months, and providing hand-held shower wands to obese patients who might otherwise end up with wounds that require hospitalization, Senz suggests.

"I think it's fun to see that creativity at work and to see case managers thinking about the whole

person's care — a total care model," Senz says.

ACOs and patient-centered medical home (PCMH) models are focused on moving beyond traditional fee-for-service healthcare through creative solutions, notes **Anna Meara**, RN, MBA, associate vice president of Network Care Management at Montefiore Health System in Bronx, NY.

"We take collaboration with other healthcare providers to another level," Meara says. "We've built a robust infrastructure at Montefiore that includes 600 people across our network."

The organization manages a population of the highest risk and high utilization, she adds.

"We have a structured way of data mining to benefit people who would benefit from care management," she says. "We also track discharges from all of our own hospitals and do utilization management."

In the Montefiore system, a team of primary care physician sites and case managers direct the care of several hundred thousand people.

Case managers in emergency departments make referrals, and other case management takes place in primary care offices where teams identify patients who would benefit from medical home services, Meara explains.

"Once we identify people through outreach, we explain care management and do a comprehensive bio-psychosocial assessment to explain medical needs, medications, and to find out about other things in their lives, including their housing situation, child care issues, transportation issues, depression screening, fall risk screening, and palliative care screening," Meara says. "We look at every aspect — a holistic approach."

Case managers oversee patients' care plans and are the primary point of contact. But they can pull in experts on a regular basis, Meara adds.

"If someone is suffering from depression, we can call in expertise in that area."

There are multiple roadblocks to creative solutions, but ACOs give CMs a route to bypass them.

For instance, the old medical model, which is still the Medicare model, requires patients to have a three-day inpatient stay before they're eligible for coverage at a skilled nursing facility, Kirby notes.

> "I THINK IT'S FUN TO SEE THAT CREATIVITY AT WORK AND TO SEE CASE MANAGERS THINKING ABOUT THE WHOLE PERSON'S CARE..."

"Once, maybe having people stay in a hospital for three days made sense," she says. "But now in our [ACO] plan we can place someone in the skilled nursing facility whenever it makes sense for that patient."

ACOs allow for flexibility when dealing with a population's health, she adds.

"A big part of this is the case manager," Kirby explains.

"When you work with a population that ranges from extremely healthy and young to disabled, older, frail, and with cognitive issues, it's not the care manager who is providing services," she adds. "But the care manager is the one who is identifying people who need help and who might reach out to the person to set up a series of services."

The case/care manager is the hub, the person who works at the point of transition and assists when patients are at a vulnerable point in their health, Kirby says.

CMs can provide risk assessment by telephone. While the goal is to identify problems that could lead to unnecessary hospital visits, the CM also can regularly call patients who have chronic diseases but are otherwise low risk, to help them manage their illnesses, Kirby suggests.

Case/care managers across settings need to coordinate and collaborate for an ACO model to work. Improved communication is important, Kirby says.

"We also need to determine who is the lead care manager," she adds. "This can be something as simple as saying who is in charge."

People in healthcare think of ACOs as a model for practicing population health, but it's more than that, Menacker notes.

"What we're trying to do is classify our program as a global healthcare experience as opposed to population health, because we're not just looking at groups of people," he explains. "We're looking at individuals, and we realize we need to partner with the individual throughout the person's life and in all interactions with healthcare professionals."

This philosophy leads to sensible solutions, Kirby notes.

"An example is how in the fee-for-service system, Medicare does not pay for a certified nursing assistant. Medicare will pay for skilled services, but this creates a care gap for frail, elderly people who need home service," Kirby says.

An ACO can choose to pay for the

certified nursing assistant position, which might keep some elderly people out of the hospital and in their homes for longer than they would be, she adds.

ACO CMs pay particular attention to individuals with multiple hospital visits for avoidable problems. For example, a Providence Health ACO care manager identified that one patient had visited three different emergency departments in one day. Further checking revealed that the same patient had made 29 ED visits within the previous 12 months. These findings resulted in the CM connecting with the patient's primary care physician to talk about the patient and develop a solution, she says.

Improving patients' health through the ACO model also means directly asking patients and their families what they want as part of their care plan, Kirby says.

"A lot of times what is left out of patient care is asking patients and families, 'What do you want? What is your plan of care? How can we help you be healthier?'" she adds. ■

Strategies for flexible case management in the ACO model

CM involves "everyone in the practice"

Accountable care organizations (ACOs) make it possible for case/care managers to help patients improve their health through creative and flexible solutions, particularly during transitions, experts say.

CMs work in hospital and clinic settings, collaborating to ensure everyone knows what is going on with patients, says **Ann Kirby**, MSN, MPA, BSN, regional director of care management for Oregon at Providence Health & Services in Portland.

Their real role is understanding what's going on with the patient and knowing what changes need to happen, she says.

"The inpatient person is the collaborator at a critical point in the patient's health, but is not the long-term link," Kirby explains.

CMs in the clinic meet with patients in their homes to see what they need to stay healthy. For instance, if a patient is unable to get to the clinic for an appointment or is lacking regular meals, the CM can find community resources and solutions to these problems, she adds.

"This intervention care manager can provide a nice way to connect with folks we have not been able to care for before," Kirby says. "There also are care managers who can go into the home and work with the family, identifying their needs."

Some organizations are finding less direct ways of monitoring their population's health. For instance, a community clinic's front-line staff might pick up on cues that something is wrong, suggests **Chris Senz**, chief operating officer at Tuality Health Alliance in Hillsboro, OR. Tuality Health Alliance is a physician-hospital-community organization, which includes some practices that are patient-centered medical homes. The Alliance enters into agreements with ACOs.

"One of the first things we embrace is the case management model in a practice," Senz says. When a patient who typically is low risk comes in for a sprained ankle, the front office staff might get into a discussion with the patient and learn that she had recently lost her sister and inherited her sister's cats, despite having an allergy to cats and not owning a vacuum cleaner, Senz explains.

The staff can tell the office's CM about the encounter, and the CM can stop by to talk with the patient before discharge, asking how the patient is doing and whether she is managing her allergies, Senz suggests.

In a ranking of the patient's risk, the normal low level of one has risen to a three or four because of out-of-control allergies, Senz says.

"That level of case management in a medical home happens with everyone in the practice — everyone who has interaction with patients," she adds. "We've reduced the cost of care for that patient because we've identified her problems before she even knows she has them."

Catching an allergy problem early also provides opportunities for creative solutions. For instance, the organization could buy the woman a vacuum through flexible funds for nonbillable services, Senz says.

Once the patient is able to vacuum up cat hair and dander, her allergy could be controlled well enough to avoid her having to seek nebulizer treatment or a hospitalization for breathing difficulties.

"In a traditional case management

model, case managers are nurses who may have arranged transportation or coordinated with home health or talked with hospital case managers to get a patient into a skilled nursing facility," Senz notes. "Under an ACO model, there are a lot of things that happen outside of healthcare that affect healthcare costs, and case management is becoming more creative, using more social workers, educators, and lots of different people."

Another strategy is to encourage case/care managers to get out from behind a desk and to meet patients where they are.

"When a patient is in the ER, the care manager will meet with the patient and say, 'Gosh, I've noticed you've been here 15 times in the last three months. What's going on?'" Senz says.

Helping high-risk patients improve their health is sometimes the second, third, or fourth step after removing major obstacles in their path.

For example, Senz recalls the case of an extremely obese, middle-aged woman who was mostly bedridden. She would benefit from bariatric surgery, but was not a candidate for this solution until she lost 75 pounds.

The case manager could have arranged for the woman to receive nutrition counseling, but that would have been of little use because it was obvious to providers that the woman couldn't cook for herself. "So how is she continuing to hook onto this weight? It wasn't her — it was her caregivers," Senz says.

Although nutrition counseling for caregivers is not billable, they used flexible funds to find a solution.

So they sent a nutrition counselor to the patient's caregivers and had them stop her daily 14-egg omelet breakfast and whole chicken dinner. The nutritionist accompanied the family to the grocery store and helped them shop for healthier food. As a result, the patient lost 75 pounds and qualified for bariatric surgery, which will help her lose another 300 pounds, Senz adds.

"The woman lives in poverty, and her caregivers were not very well educated, so they just did what she told them to do," Senz explains. "Once we got creative with care management, it worked."

In another example of using flexible funds, Senz recalls the case of a teenage boy who had cerebral palsy and was wheelchair-bound. He'd outgrown his wheelchair and was developing sores and injuries as his mobility decreased. "He didn't want to be in his wheelchair because it was painful, so he spent more time in bed," Senz says.

This problem resulted in increased hospitalizations and inpatient expenses. However, the boy's insurance payer would only provide a new wheelchair every five years and he would have to wait at least another year to receive one. The traditional healthcare solution would be to treat his symptoms through home health or skilled nursing services.

"I said, 'What if we paid for the chair now? What would happen?" Senz recalls. With the patient's care manager on board, the ACO bought the boy a new wheelchair out of a budget set up for that sort of nontraditional solution.

With a wheelchair that fit him, the teenager could get out more and even take some work training to be independent, Senz says.

Having the ability to treat the patient holistically has resulted in reducing unnecessary emergency department visits, Senz says.

In addition to providing care management services, they offer patients flexible appointment scheduling, open access to providers, screening patients in the ED to discourage emergency visits for non-emergency issues, and phone-Internet conversations with doctors — all of which help reduce ED visits, she adds.

"People go into health professions because they want to help people, and it's exciting to see our creativity come to the forefront," Senz says. "People understand now that 10% of health is what the health system does for you, and 90% isn't about healthcare." ■

EXECUTIVE SUMMARY

Flexibility is crucial to an accountable care organization model. In order to prevent unnecessary hospitalizations and emergency room visits, case managers working with ACOs need to find creative solutions to the type of lifestyle barriers and funding obstacles that hamper health improvements.

- Case/care managers can meet with patients in their homes and provide education to caregivers and families as needed.
- Front office staff can be enlisted to assist in case management and identifying patient issues.
- Often, rehospitalizations can be avoided when the ACO simply buys a solution that is not otherwise covered in medical treatment, such as a vacuum cleaner for a patient with allergies.

Case study in how CMs can help make ACOs successful

CM role is front and center

The accountable care organization model works well with ensuring patient adherence to treatment, as well as preventing unnecessary emergency department visits and hospitalizations, according to an ACO president.

"ACO is a hot topic, but it's all about the way you practice medicine," says **Morey Menacker**, DO, president of Hackensack Alliance ACO in New Jersey. The Hackensack Alliance ACO, with 575 care providers, was launched in 2011 and began commercial contracting in 2014.

"We look at the ACO as a clinical laboratory," he adds. "We identify doctors who are motivated to change practice, and we try out new programs."

The ACO decided to use the medical home model and had all primary care physicians become patient-centered medical home (PCMH) certified. Also, all medical practices switched to electronic health records so they could be better integrated with the hospital and more easily share data, he says.

The third piece to the ACO model was to change the healthcare philosophy of intermittent and emergent care to an ongoing, coordinated care philosophy. "We trained nurses in case management and embedded them in practices to interact on a regular basis with our high-risk patients," Menacker says.

"Case managers basically make sure people are cared for on an ongoing basis," he adds.

"One of the things that sets us apart from a lot of other programs is we also are looking at the post-acute period, and not just the hospitalization period," he says. "We identified in New Jersey that the percentage of patients who are discharged from the hospital to a subacute facility is twice the national average."

After analyzing data, they identified a group of patients who could benefit from going directly home or shortening their stay in a subacute facility. "This was beneficial from a cost and quality standpoint," Menacker says.

Case managers from the hospital setting and from the payer/provider setting work together to identify the newly admitted patients who would be optimal candidates for being discharged directly to their homes, he explains.

Case managers also work with high-risk patients to improve their quality of care and outcomes, and when they find a strategy that is successful, it can be rolled out to the entire ACO network of 85,000 patients, Menacker says.

For example, one pilot program involved giving hospital patients a three-month supply of medications before they were discharged, he explains.

The program began at discharge planning and involved the discharge nurse, a pharmacist, and a case manager making rounds on the floors and reviewing the plan with patients, he adds.

They tell patients at discharge to throw out the medications they have at home because their new prescriptions will be the medications they are taking home with them, Menacker says.

"After three months, the patient can continue [the new prescriptions] by getting pills from the hospital pharmacy or transferring prescriptions to a pharmacy of choice," he adds.

This program was enormously successful from a compliance standpoint, and so it has been expanded to all ACO patients, he adds.

EXECUTIVE SUMMARY

According to one accountable care organization, the key to success is to change the healthcare philosophy of intermittent and emergent care to an ongoing, coordinated care philosophy.

- A New Jersey ACO embedded trained case managers in provider practices so they could interact with high-risk patients on a regular basis.
- The ACO made it a goal to reduce the number of patients discharged from the hospital to a subacute facility, which in the state has been twice the national average.
- Giving patients a three-month supply of medications at discharge greatly improved medication adherence.

"Imagine an 85-year-old being discharged and someone fills out a prescription for seven different medications," Menacker says. "The patient will end up duplicating medications or waiting a week to fill the prescription and end up back in the hospital."

By giving patients a three-month supply, the ACO absorbs that cost, but improves compliance immediately.

Another program involved congestive heart failure (CHF) patients who had significant readmissions. "We supplied them with electronic tablets that had a medication calendar, reminding patients to take their medication. The program told them which pill to take," Menacker says. "Then patients had to tap the tablet when they took out the medication. If they didn't tap the tablet, then a message was automatically sent to the case manager, who would call immediately to find out what the problem was."

The tablets also recorded patients' daily vital signs, and each person was weighed on scales that recorded his or her weight.

Case managers received the data so they could intervene if a CHF patient's weight went up or if something else was out of the ordinary.

The program resulted in a 75% decrease in hospitalizations, Menacker says.

In one example of anecdotal success, one patient who received the tablet had been hospitalized six times the previous year, but then went 18 months without one hospitalization after participation in the program, Menacker says.

"This elucidates how case management can work in a proactive manner, as opposed to being reactive and only dealing with patients after they have been hospitalized," he adds.

The ACO works through a partnership of provider and payer. Together, the two groups can collect the best analytics and create a system in which case managers work for both groups — no matter which signs their paycheck, Menacker says.

For instance, the Hackensack Alliance ACO recently expanded to provide coordinated care to 10,000 Aetna members. Aetna will supply the case managers, but the CMs will work for the ACO, following the ACO's guidelines and reporting for the case management program, he explains.

"They're going to be taking care of our Aetna patients, but utilizing the skills we've identified, maximizing quality, and minimizing costs," he adds.

"This is a partnership between the hospital's case management program and the ACO's care coordination program, and it benefits everyone," Menacker adds. "Our long-term plan is to eventually make case management population-based as opposed to hospital-based and location-based." ■

Mount Sinai leverages smartphone technology to boost ED care coordination

New initiatives are just getting started

Using telemedicine in the care and treatment of stroke patients is widely used and accepted at this point; the approach facilitates quick access to expert consultations when time to treatment is a critical factor. However, some medical centers are finding that there are other ways to take advantage of telemedicine in the emergency setting, and they're testing out methods to most effectively leverage its ability to connect with patients from a remote location.

For example, as part of its Geriatric Emergency Department Innovations in Care Program (GEDIWISE), Mount Sinai Hospital in New York City is using smartphone technology to conduct face-to-face follow-up communications with senior patients after their ED visits. Further, they have just begun to experiment with a new program that is sending some ED patients who meet inpatient criteria home, where they will receive hospital-level care and monitoring through a mobile acute care team (MACT).

In both instances, investigators are attempting to show that these new approaches can help to avert readmissions and trim costs, and that patients can come out ahead on both outcomes and satisfaction.

Smartphones facilitate face-to-face connections

The idea of using telemedicine to advance the emergency care of senior patients is just the latest step in Mount Sinai's GEDIWISE program, which is funded by a Health

Care Innovation Award from the Centers for Medicare & Medicaid Services (CMS). "This is a federal grant we received in 2012 to open our geriatric ED, staff it, and build in some workforce innovations, informatics innovations, and structural enhancements to better serve elderly patients in the ED," explains **Nicholas Genes**, MD, PhD, an assistant professor in the Department of Emergency Medicine at the Icahn School of Medicine at Mount Sinai.

The telemedicine component is an enhancement of a practice already in place in which nurses schedule follow-up calls with senior patients while they are still in the ED. The calls are used to confirm that the patients got their prescriptions filled, they are on track to proceed with any scheduled follow-up visits with their physicians, and that circumstances haven't changed, explains Genes. "We really don't want these patients to end up back in the ED," he says. "That would be bad for the patients and it would just be bad care."

While these calls have been taking place for years, Mount Sinai is now incorporating smartphone technology so that the nurses can actually engage with the patients face-to-face, much like the way people interact on video chat services, explains Genes. However, he notes that this approach utilizes an application that is compliant with the Health Insurance Portability and Accountability ACT (HIPAA) to protect privacy.

"We ask patients if they have a smartphone and if they are comfortable using it. And with them we install the [application] while they are still in the ED prior to discharge," explains Genes. At this point, the nurse will schedule a follow-up call with the patient, and at the appointed time the face-to-face visit will take place, he says.

Visual clues add value

How much value does seeing the patient bring to a typical follow-up call? Genes admits he was skeptical at first, but even after just a couple of weeks, the nurses making these calls say that actually seeing the patient gives them a better view of how the person is doing.

> "THEY LIKE THE FACE-TO-FACE INTERACTION; THEY FEEL IT IS MORE PERSONAL... WE HAVE GOTTEN REALLY POSITIVE FEEDBACK."

"I think you are more able to gauge the person's overall temperament and how they are really feeling," says **Cindy Amoako**, RN, a GEDIWISE nurse clinical coordinator who has made several of these face-to-face calls. "You get to see their facial interaction; you have that eye-to-eye contact, so it is really more intimate, and it allows a bit more assessment."

Amoako adds that you can also get a sense of the patient's overall surroundings, which can provide additional clues on how the patient is faring at home. For instance, Amoako recalls speaking to one patient who had been to the ED recently for a fall. "I was making sure his pain was okay, trying to gauge his reaction … and I could tell by his facial expression that he was much better than when I saw him in the ED."

Amoako was also able to verify that the patient was not forgetting to use his walker, an important point because that was why he fell in the first place, she says. "I asked him if he was using his walker. He said 'yes' and then pointed to it in the room."

The face-to-face calls provide both the nurse and the patient an opportunity to verify that the right medications are being taken as directed. "If I can see the medication bottle right in front of me, that is definitely an advantage over just talking about it over the phone where the patient might be confused or not able to read what is on the bottle," says Amoako.

Another plus is that the patients who have participated in the face-to-face calls thus far give the approach high marks. "They like the face-to-face interaction; they feel it is more personal," says Amoako. "We have gotten really positive feedback."

All of the geriatric patients receive a call the day after their ED visit, but from that point on the call schedule is individualized. "Some people need more extensive follow-up if they are more complicated or if they are less compliant," says Amoako. "We call some people up to two weeks after their initial ED visit."

Genes acknowledges that a lot of people were skeptical that geriatric patients would have smartphones or would be comfortable using the technology. "That is true in some instances, and so we just use the traditional phone calls in those cases, but in the handful of patients we have done the video telemedicine calls with so far, I think we are

perhaps surprising some of these critics," he says.

Mount Sinai has three interrelated goals in mind for its telemedicine push: to improve care, reduce costs, and promote coordination, notes Genes. But he acknowledges that measurement of these factors is not a simple matter. "We have to wait for the Medicare claims data which takes many months, so we have some proxy measures, and revisits [to the ED] is one of them."

Mobile teams deliver acute care

Genes notes that Mount Sinai is, in fact, being very ambitious with both telemedicine and coordinating care throughout the health system's accountable care organization (ACO). These efforts extend to one of the medical center's newest initiatives — an approach focused on caring for some ED patients who meet inpatient criteria in the home setting rather than the hospital.

"Basically, if a patient needs admission from the ED to the hospital and they are medically stable, they can get admitted to their own home, and the MACT [mobile acute care team] will go to their home and see them there," notes Genes, explaining that program incorporates both in-person home visits and tele-health communications.

Funding for this program also comes from CMS, but eligible patients over the age of 18 who present to the ED can participate, explains **Linda DeCherrie**, MD, an associate professor of geriatrics and palliative medicine at Mount Sinai. "The emergency physician has determined that they need hospitalization, and we are bringing them home instead and providing services that are pretty equivalent to hospitalization, with a physician coming daily to their home and a nurse going twice a day."

Depending on individual needs, these patients may require physical therapists, social workers, IV medicines, and other types of care. "All of these services are provided in the home," notes DeCherrie. However, she explains that the program is currently limited to a set of conditions that clinical leaders have determined can be treated safely within the program's parameters.

These include community-acquired pneumonia, cellulitis, congestive heart failure, high and low blood sugars for diabetes, deep vein thrombosis (DVT), and chronic obstructive pulmonary disease (COPD), although DeCherrie notes that more conditions may be added later on. "We have created criteria where we know we can get all the things we need into the home within four hours [such as] nebulizer treatment, IV antibiotics, or oxygen," says DeCherrie.

To handle any emergency situations that arise with these patients, the program is relying on community paramedics. "We are having ambulances with paramedics go out to the patient but ideally not to transport them to the ED," says DeCherrie.

As part of this process, physicians use smartphones to see what is going on during the paramedic's visit, and communicate any instructions through this two-way video conferencing method, explains DeCherrie.

While entry into the MACT program always begins with a visit to the ED and an emergency provider's decision that the patient requires hospital-level care, most of the physicians providing care as part of the MACT program are internists or geriatricians, explains DeCherrie. "There was a lot of discussion about who would be the right providers — both physicians and nurses," she says. "And we really needed people who are very comfortable in the home."

Consequently, the MACT program has been able to draw on Mount Sinai's large health call program which takes care of as many as 1,200 patients who are homebound in Manhattan. "Emergency physicians are extremely important [to the program]. They need to make the decision to admit," she says. However, after that point, the MACT program takes over, utilizing the skills of physicians who are already accustomed to operating in the home environment, adds DeCherrie.

Nurse, physician buy-in takes time

Bringing both emergency physicians and nurses on board with this type of disposition took some time, acknowledges DeCherrie. For instance, getting nursing approval to send a patient home with an IV in place was one issue, and some physicians initially resisted the idea of sending home patients who met inpatient criteria. "They really needed to understand the services of our program, how it is based, and what we are able to do for patients," she says. "We also had to work with case managers so that they would understand our program."

One key concept that everyone needed to understand was that the program is not advanced home care, says DeCherrie. "We need to make sure that these patients

truly need an admission," she says. "So once a patient is determined to need admission and [he or she] is administratively assigned to a medicine team in the hospital, we will at that point intervene."

Typically, a MACT provider will physically come to the ED to discuss the patient's condition with both the patient and the emergency provider to make sure that the MACT provider fully understands what is going on, and that the patient is safe to go home, explains DeCherrie, noting that the patient must also be comfortable with the arrangement.

The MACT works frequently with patients who have been in observation for 24 hours, and are then deemed to require admission, so the emergency physicians who work in observation are perhaps most acquainted with the program at this point, although the program is still quite new. "We had our first patient in November [2014]," notes DeCherrie. "We are still in our pilot phase, but we are planning to have about 1,100 patients in three years."

Also on the schedule is a planned expansion of the MACT program to a second ED in September 2015. And it is possible that MACT program administrators may at some point consider accepting patients from settings other than the ED. However, for the time being, the ED is the only entry point, says DeCherrie.

Administrators eye program expansion

While there are other hospital-at-home programs around the country, Mount Sinai is among the first to attempt the approach in a fee-for-service environment. "The programs that [already] exist are in VA [Veterans Administration] hospitals, and they exist in some closed health systems where the insurance company owns the hospital and employs the physicians and the nurses with a much cleaner package," explains DeCherrie.

These other programs have already demonstrated that the approach is safe and that it can save money under those conditions, explains DeCherrie. "What is different here is we are doing it in fee-for-service Medicare where we have multiple vendors and multiple parties involved," she says. "From Medicare's point of view, this [effort] is really to show that this [type of program] can be done with the same outcomes, and that it can also save money."

"FROM MEDICARE'S POINT OF VIEW, THIS [EFFORT] IS REALLY TO SHOW THAT THIS [TYPE OF PROGRAM] CAN BE DONE WITH THE SAME OUTCOMES, AND THAT IT CAN ALSO SAVE MONEY."

What's more, investigators are hoping to demonstrate that, given an option, patients would prefer to be cared for in their homes rather than in the hospital. "We also think there will be fewer complications, fewer falls, less delirium, and fewer superbugs when patients are cared for in their homes," adds DeCherrie.

Further, while the earlier programs have produced good outcomes, they have been done on a smaller scale, notes DeCherrie. "We are really going to do a much larger investigation of all of this," she says.

Getting the program up and running has involved multiple challenges, says DeCherrie. "It probably took us 14 to 16 months to see our first patient," she says, noting that there are multiple parties involved with the service. Program administrators also had to decide how to create an electronic medical record (EMR) for these patients, how patients would be categorized in the EMR, and how nurses would carry out medication reconciliation when they are not physically administering every medicine.

"A person's initial response to this is often concern, liability, and they don't get it, but almost everyone, once you talk about it, is very excited about this prospect," says DeCherrie. "The Mount Sinai ED is always full … and the whole hospital is always full, so taking a patient out of the system is not a problem at Mount Sinai because there is always another patient waiting for the bed."

Further, health system administrators have been very supportive of the program because they see this as the future, says DeCherrie. "Yes, there will always be a need for an operating room, and there will always be a need for the ED and the ICUs and general medicine floors," she says. "But I think there is a level of patients we can really do this for, and this could potentially be expanded once we have all the protocols and procedures in place." ■

EHR failures create havoc for hospitals

Outage led to ED closing, other issues

The wide adoption of electronic health records (EHRs) and other electronic systems inevitably means that healthcare facilities will have to cope with outages. Several facilities recently have experienced how much the failure of one of those systems can cripple a hospital.

Registered nurses at Antelope Valley Hospital in Lancaster, CA, have asked the Los Angeles County Department of Public Health (DPH) to investigate the failure of an electronic health records system at their hospital, which they say led to the closure of the hospital emergency department and multiple other problems that put patients at risk.

In a message to the Los Angeles DPH office, Antelope Valley nurse Maria Altamirano, RN, reported that "our entire electronic and data system failed." She was speaking on behalf of other nurses who are members of the California Nurses Association/National Nurses United.

Antelope Valley Hospital issued a statement confirming that the hospital experienced a "rare information system outage" but said the issue was quickly identified and did not compromise patient safety. The emergency department continued to treat patients during the outage, the hospital stated.

The nurses' union contends that the outage created problems with properly dispensing medications; verifying physician orders; reviewing patient labs, MRIs, and other diagnostic procedures; and led to an inability for clinicians to review patient records.

Boston Children's Hospital's system also experienced an outage recently that affected lab orders, pharmacy work, and electronic prescription writing. Digital imaging, patient registration, and scheduling continued to run, according to a hospital statement.

"The outage was quickly identified, and the staff quickly shifted to patient care services that don't rely on electronic systems, such as face-to-face communications, direct hand-offs, read backs and running pharmacy notes from floor to pharmacy," according to the hospital statement.

The *Boston Globe* reported that the outage was caused by a hardware issue related to storage. Rob Graham, a spokesman for the hospital, told the *Globe* that less than five elective medical admissions were postponed, and all surgeries continued as planned. The incident was the longest outage the hospital has experienced with that health record system, he said.

In August 2013, an EHR system at several Bay Area hospitals operated by Sutter Health went completely dark for hours, which required nurses and doctors to effectively work without any access to patient information, including what medications patients were on or needed, patient history information that informs treatment options, and all other information required for safe patient care delivery.

Rideout Memorial Hospital in Marysville, CA, also reported a system blackout recently that was traced to a burned-out heating unit at an off-site data center. Patient records were not available, and email was not functional during the shutdown. ■

CNE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.

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CNE QUESTIONS

1. Through the beginning of 2015, CMS has approved how many ACOs, serving what size population?

A. Nearly 300 ACOs, serving 4.2 million beneficiaries
B. 424 ACOs, serving 7.8 million beneficiaries
C. 525 ACOs, serving 10.2 million beneficiaries
D. 89 ACOs, serving 1.7 million beneficiaries

2. What is one of the problems that has arisen since the Affordable Care Act encouraged the expansion of ACOs, according to CM experts?

A. There are not enough jobs for case managers
B. Patients are bouncing in and out of emergency rooms more frequently than before
C. There is a greater need for case managers, and the supply is not keeping up with the demand
D. Doctors are quitting the profession because of ACO reimbursement fees

3. Which of the following is a good example of flexible funding in ACOs, according to Chris Senz?

A. A teenage patient who has outgrown a wheelchair but isn't eligible for a new one for a year or longer can be given one by the ACO
B. An extremely obese patient who is bedridden needs to lose weight before becoming eligible for bariatric surgery; the patient's caregivers can work with a nutritionist
C. A woman with cat allergies inherited her sister's cats, but can't control hair/dander in her home because she lacks a vacuum cleaner, so the ACO purchases her a vacuum
D. All of the above

4. An accountable care organization can quickly improve medication adherence by making which change, according to Morey Menacker?

A. By giving patients medication apps for their smartphones
B. By giving high-risk patients a three-month supply of medications to take home with them at discharge from a hospital stay
C. By requiring patients to take a three-hour educational class on medication adherence
D. None of the above