CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

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Text Messages Transform Case Management for At-risk Patients

Messages are inspirational and instructional

Healthcare organizations continuously deal with patient populations that need ongoing management or guidance. In-person visits and phone calls can be prohibitively expensive when the population is in the tens or hundreds of thousands. One organization found a solution: using targeted text messages to engage people personally, but much less labor intensively.

Sharp Rees-Stealy Medical Centers in San Diego have found case management with text messaging is a success.

"Of our patients living with diabetes, we have seen a drop in HgA1C for patients in a texting program of 0.679, which shows an improvement in 70.8% of those enrolled," says **Janet Appel**, RN, MSN, CCM, director of informatics and population health at Sharp Rees-Stealy Medical Centers.

The diabetes program also has increased its unique patients serviced from 5,127 to 6,965 through texting, Appel says.

"We've also seen a decrease in hospital readmissions for the post-discharge texting program," she adds.

The texting tool has helped the case management program grow faster than it would have without it. And while it's not for everyone, many people, including seniors, do like it, Appel says.

Texting also has saved the case management program in costs of heart

THE CASE MANAGEMENT DIABETES PROGRAM HAS INCREASED ITS UNIQUE PATIENTS SERVICED FROM 5,127 TO 6,965 THROUGH TEXTING.

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disease and diabetes populations, although there is no way of putting an actual dollar amount to that part of the overall savings. "We can't say texting saves millions of dollars, but we can say that because of our diabetes program, we save millions of dollars," Appel explains.

Appel and a colleague devised the texting idea while attending a conference. "We were at a population health conference in Philadelphia four or five years ago, and the whole conference was about outreach and engaging populations as they grow," Appel recalls. "We met this new company that was using mobile technology to connect with patients."

This strategy appeared to be an engagement solution that could work with a large case management population.

"We were very much interested in assisting and engaging people," says **Christine Tedeschi**, MS, RN, CDE, CCM, manager of ambulatory disease management programs at Sharp Rees-Stealy Medical Centers.

At the same time, Appel and Tedeschi were given the task of engaging 5% of the health system's population in some kind of case management program. There were 180,000 total patients at that time, so 5% would be 9,000 patients, Tedeschi says.

The actual percentage of people enrolled in case management has not yet reached the target, although the population continues to grow and is just shy of 4%.

"We've been able to engage several thousand people over the years, using the technology," Appel says. "We see a 30% increase in patients we can care for because of the mobile technology."

The program has grown from 30 to 37 case managers. Nurse and social worker case managers lead the multidisciplinary teams, which also include community health workers, medical assistants, and project managers.

"We have limited resources, as everyone does, and limited money to spend," Appel says. "We were looking at how to expand the care we give using technology, and both Chris and I liked the mobile technology solution. That's how the whole thing started."

Each case manager can increase his or her caseload by about 30% with the texting program, Appel says.

The program works by delivering patients interactive messages for up to 26 weeks. Each message is designed to help the person adapt successfully to lifestyle changes and self-care behaviors.

"Instead of case managers

EXECUTIVE SUMMARY

Case management texting can be an effective and affordable way to engage with high-risk patients and encourage them to follow health regimens.

- Sharp Rees-Stealy Medical Centers in San Diego saw a 70.8% improvement in HgA1C levels for diabetes patients in the case management program.
- The total number of unique patients receiving service in the diabetes program rose by more than 1,800.
- The texting program also has saved costs for the heart disease and diabetes populations.

outreaching and talking to patients, these scheduled interactive messages are delivered through technology, and patients can interact by text or calling us," Appel says. "So, we can address their needs without using staff to personally outreach to every person who is using the program."

When patients receive a text message, they can respond through a centralized messaging center at which staff review all incoming messages and route them to RN case managers, Tedeschi explains.

For example, a patient with diabetes who is having a problem with low blood sugar can send a note or question via text. The patient receives an immediate response from either the RN case manager or another licensed professional, she says.

"We have a medical assistant monitoring the dashboard of all texting going back and forth," Appel says. "She reads the text and either answers it herself when it's something like, 'What time is my doctor's visit tomorrow?' or she can provide the question to a nurse."

The supportive text messages are evidence-based, following nationally recognized criteria for the condition being addressed, Tedeschi says.

"For instance, one of the messages that comes through for general health is that high blood pressure increases the risk of having a stroke and you can reduce risk by being active and healthy eating," she explains. "Then, at the end, it says, 'Easy, right?' with a smiley face. It's very personal and engaging."

Text messages also are motivational and inspirational. "For the diabetes program, one message is, 'Put your sneakers by the door before you go to sleep, so you are ready for your morning walk,'" Appel says.

Patients receive tips and specific curriculum information on how to improve their health, including strategies for selecting healthier foods at the grocery store, Tedeschi notes.

The text message medical information sticks to simple strategies, such as "Think FAST" to identify strokes.

"Think FAST is F for face drooping; A — arm weakness; S — speech difficulty, and T— time to call 911," Appel says. "The message says, 'Help save a friend's life or your own. Learn to recognize the warning signs of a stroke.'"

In addition to these kinds of simple messages, the technology delivers quizzes to patients and specific medical instructions and reminders to improve treatment adherence.

"Patients have the opportunity to set up text reminders for medication, blood glucose testing, taking their blood pressure, or doing other activities," Tedeschi says. "They can set up text reminders when they register for the program." The case management program also sends out reminders about blood draws and doctor appointments.

So far, the program has been popular with enrolled patients, Appel says.

"People like the flexibility of being able to choose the text messages they receive and the curriculum they're receiving," she says. "We have testimonials from patients and for our staff and staff members who love the idea of being able to communicate directly with patients through a text message, because that's so timely." ■

Case Management Is Essential in Handling Catastrophic Injuries

Workers' compensation relies on it

Case managers are essential in helping patients who suffered a catastrophic injury, such as an amputation, head injury, or spine damage.

"I would say that in almost every case out there, insurance companies covering catastrophic injuries will have a case manager on these cases," says **Kathleen Fraser**, MSN, MHA, RN-BC, CCM, CRRN, executive director for the Case Management Society of America (CMSA) of Little Rock, AR. Fraser has spoken about catastrophic workers' comp at national case management conferences.

Patients with catastrophic injuries see a multitude of physicians, specialists, and rehab therapists. Keeping up with these appointments can be overwhelming for patients and their families or caregivers, Fraser notes.

"So, you have a case manager on these claims to really keep the patient from falling through the cracks and to make sure they get all the appropriate care they need," she says. "If the patient needs a specialist

for assistance, the case manager can make certain the patient gets to that specialist immediately."

Typically, case managers who work with catastrophic injury cases also work for the insurance carrier for the patient's employer, or they work for an independent case management company that contracts with the insurance carrier, she says.

"The goal is to help patients achieve their maximum medical improvement and to obtain their maximum quality of life," Fraser says. "And if they can return to their previous employment, this is ideal."

In some cases, the injured worker will need assistance from a vocational case manager to help find a new career because it's not possible to resume the old job. An example might be a roofer who loses one or both legs.

"If the person is quadriplegic or ventilator-dependent, then the patient most likely will not go back to any type of work," Fraser says.

In those cases, the goal is to ensure the patients receive long-term care that could involve home health, lifetime planners, and other types of care and assistance.

"In a large amount of catastrophic cases, the person can return to some type of meaningful employment," Fraser says. *(See case study of catastrophic injury patient, page 89.)*

The case manager's role is to keep communication lines open with physicians, insurance companies, specialists, and therapists.

"Whatever the orders are, we need to make sure all of the doctors are on the same page," Fraser says.

The following is how case management of a catastrophic injury might work:

• Case management is among the first involved. When an employee has a catastrophic injury on the job, workers' compensation will pay 100% of the patient's care and treatment. There are no copays or deductibles, as there are with private insurance, Fraser notes.

And case managers are called in from the start, usually within 24 hours of the injury. "When I was a catastrophic case manager, the person might be on route to the hospital, and I was called," Fraser recalls. "Case managers obtain information from step one, and they make sure patients get everything they need at every phase."

The catastrophic case manager will work with the hospital case manager and meet with the patient to provide contact information.

"Patients might be at a point where they don't remember any of it, so the case manager sets up a relationship with a family member or caregiver so they have that contact and can give them the security of knowing there is someone helping them," Fraser says.

Families will worry about the various procedures, physician orders, and the bills. Catastrophic case managers can help them understand these better, and that early contact to build rapport is crucial. "We have to develop that relationship," she says.

• The catastrophic case manager assists with transitions. Once a patient has been treated for the catastrophic injury and the hospital is ready to discharge him or her to a skilled nursing facility, rehabilitation hospital, or elsewhere, the catastrophic case manager works with the hospital case manager on the discharge.

"We address whatever challenges that patient may have to help remove any barriers that would stop the person from getting necessary help," Fraser says.

For example, a patient who is in a wheelchair might be discharged home, but will need physical therapy. Entering the house will be difficult because of stairs at every entrance. And the person might need medical devices, a hospital bed, and other assistive devices or technology. The patient might not even have someone to drive him or her to a rehab center each day. These are the types of barriers the catastrophic case manager can address, Fraser says.

"The case manager can ask the physician if the person can be put in a rehabilitation hospital first, instead of being discharged home," she says. "Or, the case manager could suggest giving the patient home health physical therapy instead of having the patient go to the rehab center."

The case manager also can ensure the patient's home has the necessary equipment and address any other barriers.

EXECUTIVE SUMMARY

Case managers assigned to patients who have suffered catastrophic injuries can make a huge difference in patients' outcomes and ability to return to work.

- Patients with catastrophic injuries see multiple specialists and need case managers to help them navigate confusing and complex health instructions and appointments.
- The catastrophic case manager is involved in the case within the first 24 hours of the injury.
- It's the catastrophic case manager's job to keep communication lines open between the patient, family, providers, and others involved in the case.

"Patients assume they can't get to their therapy, but the case manager can call the physician and say, 'We have XYZ as a problem, and this is what I'm suggesting,' or, 'How do you want to handle this?'" Fraser explains.

Without a case manager's intervention, the patient and family might skip therapy, not realizing they could receive help with transportation or have a therapist come to the home. The physician might assume that all is well and not find out until weeks later that there was a problem. Then, the patient ends up rehospitalized or needs wound therapy, Fraser says.

• **Keep communication lines open.** Catastrophic case managers will talk to therapists and make sure the patient is progressing. They also will meet with patients at therapy sessions to see what they have to go through. This helps when the case manager is talking to the therapist later, and the patient can see the case manager knows what he or she is talking about, Fraser says.

"Case managers can see whether patients are making progress or at a point where they're plateauing, and they can communicate this to the adjuster who does the utilization review," Fraser says.

The case manager's observations can determine what happens next. "Are they going to request another four weeks of therapy, or keep the same amount, or is it working?" she says.

Without a case manager's contact with patients and ability to ensure patients are receiving the care they need, patients and families might begin to blame insurers for missed physical therapy appointments or other lapses that lead to insurance denials, Fraser says.

"Maybe the progress notes fax didn't go through or they forgot to fax, or maybe the progress notes didn't explain the progress they were making, and case managers can help with that," she says.

Insurers need information to review and might have to deny a request without that information, she adds.

• **Help patients until they reach the MMI.** When catastrophic injury patients no longer are progressing under therapy and treatment, they have hit their maximum medical improvement (MMI).

"There's nothing else medically the case manager can do for the patient," Fraser says. "They know they have them settled into what will be their life."

The insurance company still will be involved, but the catastrophic case manager will close files.

The patient's case could be handed off to vocational case managers, who will ensure the patient receives vocational training to return to work, or retraining to find another job.

"Patients might need medical devices that will help them on their jobs, so vocational case managers can help get them set up and follow through with them," Fraser says.

Catastrophic injury patients often are very motivated to improve and return to employment — more so than some people who have had minor work injuries, she notes.

"They were always so much more proactive about working to get back to work," Fraser says. ■

Worker at Candle Factory Loses Hand, but Returns to Work With Case Management Help

A good example of a catastrophic injury patient was a man who worked as a mechanic for a candle company. He had been at his job for years and was working the night shift just to help train a new mechanic, recalls **Kathleen Fraser**, MSN, MHA, RN-BC, CCM, CRRN, executive director for the Case Management Society of America (CMSA) of Little Rock, AR.

The experienced mechanic and the new employee received a call about machinery that had stopped working. The experienced worker checked it out and explained everything he was doing to the new worker.

"The mechanic unplugged the big candle cutter, explaining what he was doing to the new employee, who might not have been listening," Fraser says.

"The new young employee thought he was helping and said, 'Look, I think this is the problem,' and he plugged in the machine just as the mechanic stuck his arm in there to feel for a clog," she explains. "The machine turned on and cut his dominant right hand off at a slant, leaving a thumb dangling."

The man was bleeding and injured so severely, they flew him to a regional hospital, where surgeons quickly worked to save his life. But there was an additional problem that made the medical team and the catastrophic case manager's work more challenging: The man was a Jehovah's Witness, and he refused blood transfusions, despite the risk this action posed for his survival and recovery.

"He had bled out badly and was anemic, and the surgery had problems," Fraser says. "It got worse and worse because he was so in need of blood products."

Surgeons tried to reattach the man's appendage, and it would have had a greater success if he had allowed blood transfusions, she says.

"But none of his fingers could be saved, and all he had left was a thumb," Fraser says. "That type of injury normally would stop someone from returning to work, but this man had such a great work ethic and a good view on life."

With help from Fraser, who was his catastrophic case manager, the patient went through all of his medical treatment, and Fraser helped him stay in contact with his employer so he wouldn't lose his job.

"The healing process was taking longer than it usually would," she says. "We had a vocational case manager get involved earlier in the case than was usual, and we worked together to find all of the devices he could use."

The man didn't want a prosthetic hand, but they found him a prosthetic he could accept so it would enable him to return to work.

Fraser also educated the patient about how much more difficult it would be for him to improve his health if he was refusing transfusions and continuing to smoke, which affected his circulatory system.

"I was able to get smoking cessation treatment approved, along with patches, and I even worked with his wife, who didn't want to stop smoking," Fraser says. "When I closed the case, neither of them was smoking — they were amazing."

The man did return to work as a mechanic and was able to stay there — and probably will stay through retirement, she notes.

"Yet, if he hadn't had a case manager and with all of his issues, he never would have made it back to work," Fraser says. ■

Technology Increasingly Helps Case Managers Engage With Patients

Tech also adds efficiency to process

Whether the nation's healthcare industry changes in coming years, technological advances will be a constant.

Technology, including electronic health records and smart devices, will help organizations become more efficient and respond to market-based and regulatory solutions, such as Merit-based Incentive Payment System for Medicare, says **Ron Sterling**, CPA, MBA, of Sterling Solutions in Silver Spring, MD, a national independent consultant on EHRs and medical billing solutions.

Merit-based incentive programs aim to track specific patient outcomes and monitor health changes consistently — even outside of the clinical environment, he says.

Care coordination and case management are about increasing engagement with patients.

"What you're trying to do is increase the number of touches we have with patients to improve their care," Sterling says. "We do that in many different avenues."

One of the newer avenues is through technology. Case management can monitor patients objectively through the use of Bluetooth-enabled devices and equipment that can engage with patients and monitor their health.

Even subjective information could be transmitted in real time. A patient could answer questions via smartphone about pain that is occurring at that moment. The patient could respond electronically to questions about whether they've walked around the block that day, Sterling says.

So much real-time information could be collected that the chief danger would be that case managers receive too much data.

EXECUTIVE SUMMARY

Technology helps case management programs improve efficiency and become faster at reacting to patient problems or anticipating issues before they occur.

- Bluetooth-enabled devices can be used for patient engagement.
- Sometimes, there can be too much information collected, so case managers need to prioritize where to place their attention.
- Case managers easily can spot red flags through data collection of the patient's day-to-day health actions.

"The problem is we're talking about a constant stream of information from patients that could inundate a case manager with gobs of information, making it difficult to discern what is significant," Sterling says.

The answer is to focus on priority health concerns.

For example, an obese patient needs to lose weight. The case manager is helping the patient monitor his or her weight, but there hasn't been a weight reading in a couple of days. The patient's scale automatically sends readings when the patient weighs himself or herself, Sterling says.

In this case, the case manager should make it a priority to monitor the patient's weight and consider it a red flag if the patient hasn't weighed himself or herself for a couple of days.

"We can use technology to help us stay in touch with patients, which doesn't necessarily mean a phone call or home visit, but receiving information that gives us an early warning sign," Sterling says.

Even having scales with Bluetooth technology can provide powerful incentives to patients who need to monitor their weight. "If I call a patient this morning and say, 'What do you weigh?' it might not be as valuable as the patient weighing himself on a scale and capturing the information electronically," Sterling explains.

Technology can help case managers set daily or weekly priorities. If there is a patient who has a pill box that sends electronic information to the case manager's dashboard, he or she will note that the patient did not take medications that day and call the patient, he says.

Without the technology providing an immediate alert, the case manager might not call the patient for a week or a month, and find out a little late that the patient is having trouble.

These immediate warning signs can keep patients out of the ED, he adds.

Healthcare efficiencies occur with technological monitoring. By gathering patient blood pressure, weight, and other information remotely, case manager time can be preserved for when patients have problems and need someone to call them or visit them, Sterling suggests.

"We can use case managers to provide the human touch if they're seeing problems," he says.

As technology improves and the costs of implementing these advances decreases, case managers will see more in use. For instance, it might even be possible to provide wound care via technology with the use of high resolution, daily video images transmitted to wound experts for monitoring, Sterling says.

"If the wound healing is not going in the right direction, we could intervene right away rather than spending more on the expensive process of having a nurse visit the patient three times a week," he says.

As more people need care for chronic illnesses, case managers likely will find that technology is helping them do their jobs.

"The bottom line is if I only have so many resources and so much money, what is the best way to allocate those resources and allocate the money?" Sterling says. ■

Health Promotion Advocate Extends Benefits Offered to Adolescents, Young Adults

With all they have on their plates, emergency personnel generally are not enthusiastic about taking on new preventive health initiatives, but a unique program that aims to identify and respond to risky and unsafe behaviors in adolescents and young adults who present to the ED has won over both providers and staff at Boston Medical Center (BMC).

At the heart of the approach is the creation of a new health promotion advocate (HPA) role, a position designed to encompass both clinical medicine and public health in the emergency setting. Individuals serving as HPAs are trained to connect with young patients, identify risks as well as needs, and to use motivational interviewing techniques to nudge patients away from risky or unsafe behaviors. Also important, HPAs are armed with an impressive array of resources they can provide to young patients, ranging from substance abuse treatment and mental healthcare to housing, food assistance, or even help in obtaining a general education diploma.

While it is difficult to document preventive outcomes, one new study shows that the approach is effective at identifying and connecting young patients with needed care, much of it focused on substance abuse. Between 2009 and 2013, investigators reported that HPAs screened 2,149 pediatric patients 14-21 years of age, and referred 834 of these individuals for services to address identified health risks. Of 785 patients in this group

who screened positive for at-risk substance abuse, 636 received a brief intervention, and 546 were connected to specialized substance abuse treatment.[1]

The conclusion of the study was that HPAs who work as part of the pediatric emergency medicine team can extend the benefits offered in the ED beyond treatment of the presenting complaint.

Earlier studies have shown that the HPA model can be leveraged with other interventions to positively affect drug and alcohol use behaviors and increase access to primary care.[2-4] Although the results are modest, emergency providers at BMC approve of the HPA role, noting that it gives them a shot at connecting high-risk patients with the kind of interventions that can positively affect their overall healthcare trajectories. Further, they believe it's an approach that may make sense for other EDs, especially those that serve high-risk populations.

Focus on Health, Safety Needs

The HPA role grew out of similar work that was happening with adult populations at BMC through a Substance Abuse and Mental Health Services Administration-funded program called Project ASSERT (Alcohol & Substance Abuse Services, Education, and Referral to Treatment), explains **David Dorfman**, MD, chief of the division of pediatric emergency medicine at BMC.

"We started to then apply some of these approaches to patients in the pediatric ED, realizing that we were seeing adolescents and young adults with drug-related issues," he says. "Then, once we had the resource [of an HPA] through our research efforts, we then decided it was working well, and people appreciated it."

Another motivating factor for adoption of the HPA role in the pediatric ED was the fact that social workers there already had their hands full.

"Most of their issues were about neglect and abuse, and [these matters] were taking up most of their time," Dorfman says. "We felt that we were missing a large group in our population that we could help with other kinds of social and lifestyle issues, and that we could be doing more for these patients."

"WE FELT THAT WE WERE MISSING A LARGE GROUP IN OUR POPULATION THAT WE COULD HELP WITH OTHER KINDS OF SOCIAL AND LIFESTYLE ISSUES, AND THAT WE COULD BE DOING MORE FOR THESE PATIENTS."

The model used in Project ASSERT was adapted and refined to fit the needs of adolescents and young adults by **Edward Bernstein**, MD, an emergency medicine physician and the director of Project ASSERT at BMC.

"It's not just about alcohol and drugs. These patients have an array of issues ... and that came through in our research," he says. "We had high rates of PTSD, depression, anxiety, and [there were] children with special needs."

Bernstein developed a health and safety survey for the HPAs to use that encompasses everything from safe sex and drug and alcohol use to smoking, behavioral health, and access to primary care.

"Basically, [the HPAs] go room to room without any profiling and they just introduce themselves as health promotion advocates," he explains. "They ask if the patient has a few minutes to chat and find out how things are going for [the patient] ... and what sort of needs they have."

HPAs may be able to provide resources to patients, and they may work with patients to develop a plan. "It is like a friendly conversation, and nobody has really turned them down," Bernstein offers. "If parents are in the room, [the HPA] might ask them to step out after informing them what is in the survey."

The overarching goal of the program is to interrupt the problematic health trajectory that lies ahead for many of the young patients who present to the pediatric ED — problems that clinicians already can see in the adult population, Bernstein says.

"We definitely wanted something that was trauma-informed, respectful, and that young people could relate to ... so we [integrated into the role] the peer model of community in-reach, motivational interviewing, and screening and intervention," he says.

New data on the approach collected between January 2015 and November 2016 found that more than one-third of patients approached by HPAs lacked access to primary care, and so these patients were referred to an adolescent clinic, Bernstein explains.

"The big issue was safe sex practices if the patients were sexually

active; 65% of those surveyed were sexually active, and 43% didn't use any birth control or contraception," he says. These patients received safe sex education and were offered condoms.

Bernstein adds that 65% of patients surveyed used drugs or alcohol in an unsafe way, with more than half using marijuana and alcohol. Many of these patients received alcohol and drug education along with a brief motivational interview. Patients identified with severe problems in this area were linked with either an inpatient or outpatient program.

"We have a lot of internal resources at BMC. It is sort of a hub for addiction and at-risk alcohol and drug use," he says. "We provide these services, and we also have community linkages to a lot of other resources."

Initially, the pediatric ED-based HPAs tended to work with the social worker, identifying patients potentially in need of screening through electronic flags, but the approach has evolved to where HPAs round on all patients. "You can walk around and very easily pop your head in each room and round with the nurses as well as always be an active presence on the unit," explains **Karin Rallo**, RN, the nurse manager in the ED at BMC. "It is much less restrictive to be on the unit rounding than it is to be in the office going through medical histories."

Further, Rallo stresses that active rounding is imperative given that many patient needs are not captured on medical charts. For example, patients often need food or housing, or there may be problems at home that interfere with their ability to access care or to get to school. It may take only five minutes to effectively intervene, she observes. "In some cases, people have complex needs that take longer, but other people have needs that are very simple," she says, noting that HPAs can direct patients to nearby food banks when basic necessities are an issue.

Rallo stresses that the patient population at BMC is very challenging demographically. "One of the primary complaints in the pediatric ED here is homelessness, so there is a lot of room to help," she says. Further, she notes that the HPA program has grown to where the nurses, physicians, and HPAs collaborate well together.

> "IT IS REALLY ABOUT APPROACHING AS MANY PATIENTS AS WE CAN AND COACHING THE HPAS TO BE AS PROACTIVE AS POSSIBLE."

"We have huddles in the pediatric ED three times a day, and the health promotion advocates are at those huddles," she says. "Not only are they roaming around the unit and surveying who we have here for patients, but they are also at the huddles to hear pressing issues that we may be having as far as flow issues, bed capacity, and things like that. And their ears are already turning from that perspective to assess what they can do to help patients."

For example, Rallo notes that when the ED is backed up with patients, it may mean that the HPAs have more time to spend with patients, and they may be interacting with people in the waiting room. When a medical or social work-related need is identified through the health and safety conversation, the HPAs are trained to work with the nurse and the primary emergency physician to arrange for appropriate referrals.

Dorfman notes that there has been no problem fitting the HPA role into the workflow of the ED. "Even if the place is busy, most ED visits are long, with a lot of downtime between tests," he explains. "When there is a break between nursing or physician interventions and the patient is in the room alone, [the HPAs] will go in and introduce themselves, explain what they are there for, and start a conversation with the patient."

If the nurse comes back with an IV, the HPA will step outside until the procedure is completed, says Dorfman, noting that there is never any disruption to the care process. "The people who [serve as HPAs] have been well-integrated into the role, and the nurses and the physicians really appreciate having them there," he says. "The advantage is that this is an extra person, and the physicians and nurses understand that [the HPA role] is important."

In cases in which a patient is in a lot of pain or distress, the HPA will defer interacting with this person until later in the visit when he or she is more comfortable, Dorfman explains. "Obviously, there are some patients who are in and out and never get approached by the HPA," he says. "It is really about approaching as many patients as we can and coaching the HPAs to be as proactive as possible."

Bernstein stresses that there is no required trigger to prompt an HPA to interact with a patient. "We are not profiling. We are not waiting until someone has a serious problem to talk to them," he says. "This is primary prevention."

However, any social or other issues that are uncovered by the HPA are documented in the medical record. "There is a page that addresses all these needs, whether it is food security, housing security, or whatever the need may be," Bernstein explains. "All these needs are identified and that record goes with the patients to primary care."

Nurture HPA Candidates

By training, the HPAs come from myriad health backgrounds, Bernstein explains. "The last several [HPAs] had public health backgrounds because this is really trying to integrate public health into clinical practice, so those folks did very well in the role because they were health educators," he explains. "We educated them at our institute for motivational interviewing and screening."

Alternatively, one HPA had a license in drug and alcohol counseling as well as a mental health background in a community-based program. "The HPAs need to have some background in adolescents, good communications skills, and they need to be able to be flexible to fit in with the busy ED and not be intimidated," Bernstein offers. "They can't be sitting in a corner waiting to be called. They have to be really good at mixing [with different types of people], respecting diversity, and communicating well with people of all backgrounds."

The HPA program is fortunate to have a ready supply of interns available through the Boston University School of Public Health. The interns work under a supervising HPA, learn about the role, and help the HPA round on patients and provide services. They also can help bridge gaps when the HPA position is open.

While the HPAs have diverse educational backgrounds, they must be able to approach patients in a friendly, supportive, nonjudgmental manner, Bernstein observes. "That is what our training is about, along with how to use the health and safety survey, how to get the most out of it, how to build resources, and then make the referrals," he says.

Identify Resources

With any prevention effort, it is difficult to document benefits or to show a direct link to a particular intervention. Further, it would take years of very expensive research to determine whether an HPA-driven intervention produced the intended effect of curbing unsafe or unhealthy behaviors. However, Bernstein observes that BMC has developed a mission geared toward addressing the social determinants of health, and the HPA approach fits this mission well.

"The reality is we have our fingers on the pulse of a person when we check him or her out in the ED, but we also have our fingers on the pulse of the community, and we get to see patterns," Bernstein says. "That is how we developed some of our programs. We get to identify things that pass the threshold of a normal visit."

Program administrators emphasize that a lot of the difficulties young people face do not arise from medical problems, but rather inadequate housing or education, food insecurity, or other social issues. Many young people cope with their problems through drinking or drug use.

Bernstein recalls the case of one young woman who was in the ED because of her marijuana use. "In questioning her and trying to find out what was going on, she said her mother had been overdosing on heroin, and so we were able to provide her with a naloxone rescue kit," he says. "We actually found out through follow-up that she had actually used it and saved her mother's life."

Bernstein stresses that the idea behind the HPA program is not to wait for that moment when a person has a sexually transmitted disease or another bad outcome.

"We want to avoid that, but it is a teachable moment when people are a little bit more open to hearing what you have to say," he explains. "For those people who are seriously impaired by risky behaviors, we definitely want to connect them with things that are much more permanent, so the treatment system is there for them."

One outcome that should not be overlooked is the effect the HPA program has had on practitioners, Dorfman says.

"It has had a very positive effect on nursing and the physicians," he says. "It lessens your sense of hopelessness sometimes about your patients."

However, integral to this provider satisfaction is the array of resources that the emergency staff have at their disposal.

"When we identify someone [with a drug or alcohol use problem], we can at least offer them the chance of a real referral to outpatient management, and that has been a great thing," Dorfman says. "And that is mostly about opioids."

Key to the success of the HPA program is collaboration and knowing who the patient population is, Rallo notes.

"There is really no substitution for hands-on rounding in the department. You have to have an active presence to know what is going on," she says.

For instance, if there is a new drug

in the community that is affecting kids, everyone in the ED must be up to speed on this development, Rallo notes.

"The dynamic changes from day to day, and it can change from season to season, so really making sure everyone is on the right page is important," she says. "Nurses will often let the health promotion advocate know that there is a concern if the HPA hasn't had a chance to round on a patient yet or if he or she has been tied up with somebody else," Rallo says.

Conversely, HPAs will let nurses know about new resources they have identified and how they can be accessed during times when the HPAs are not on campus, Rallo advises.

"Collaboration is key ... and not being afraid to poke your head in [a room] and actually talk to a family," she says.

Bernstein stresses that starting something like the HPA program begins with a culture in the ED that embraces patients with drug or alcohol use problems on an equal footing with patients who present with other medical problems.

"Our diabetics don't always eat the right foods or exercise or show up at their appointments. They often come into the ED out of control, and we don't beat up on them," he says. "I think there needs to be more of a sense of responsibility that our mission is beyond treating and streeting." ■

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Health System Included PHI in Press Release, OCR Says

Memorial Hermann Health System (MHHS) in Houston has agreed to pay $2.4 million to the U.S. Department of Health and Human Services (HHS) and adopt a comprehensive corrective action plan to settle potential HIPAA violations related to claims it included a patient's protected health information (PHI) in a press release.

In September 2015, a patient at one of MHHS's clinics presented an allegedly fraudulent identification card to office staff, OCR reports. The staff immediately alerted appropriate authorities of the incident, and the patient was arrested. This disclosure of PHI to law enforcement was permitted under the HIPAA rules, OCR notes, but MHHS subsequently published a press release concerning the incident that included the patient's PHI.

MHHS senior management approved the impermissible disclosure of the patient's PHI by adding the patient's name in the title of the press release, OCR reports. In addition, MHHS failed to timely document the sanctioning of its workforce members for impermissibly disclosing the patient's information, OCR Director **Roger Severino** said in a statement announcing the settlement.

"Senior management should have known that disclosing a patient's name on the title of a press release was a clear HIPAA privacy violation that would induce a swift OCR response," Severino says. "This case reminds us that organizations can readily cooperate with law enforcement without violating HIPAA, but that they must nevertheless continue to protect patient privacy when making statements to the public and elsewhere."

In addition to a $2.4 million monetary settlement, a corrective action plan requires MHHS to update its policies and procedures on safeguarding PHI from impermissible uses and disclosures and to train its workforce members. The corrective action plan also requires all MHHS facilities to attest to their understanding of permissible uses and disclosures of PHI, including disclosures to the media. ■

CASE MANAGEMENT ADVISOR™

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CE QUESTIONS

1. **A text message-based case management program can send patients messages that assist with their health. Such messages might include which of the following?**

   a. Educational strategies and inspirational slogans
   b. Text reminders about doctors' appointments and blood draws
   c. Quizzes that instruct about medical conditions
   d. All of the above

2. **When Sharp Rees-Stealy Medical Centers began a text message-based case management program, the organization achieved which of the following results among patients with diabetes?**

   a. A 40.2% improvement in patients' HgA1C
   b. A 55% improvement in patients' HgA1C
   c. A 70.8% improvement in patients' HgA1C
   d. No improvement in HgA1C

3. **What is the chief goal for patients seen by a catastrophic case manager?**

   a. To help patients achieve their maximum medical improvement and quality of life
   b. To reduce the long-term costs of the patient's care
   c. To get the patient back to the job where the injury occurred
   d. None of the above

4. **Which of the following is a benefit of using medical devices that are connected electronically with a case management program?**

   a. Patients can pay for the devices out of pocket, saving the healthcare organization money.
   b. Technology used in the patient's home is more accurate than hospital medical technology.
   c. Use of technology can extend case manager's reach and make it possible to spot early warning signs that a patient is not following a medical regimen.
   d. All of the above

CE 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.