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INSIDE

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Formerly AHC Media

APRIL 2018 Vol. 29, No. 4; p. 37-48

Complex Care Teams Can Take Case Management to New Levels

The A-Team for difficult cases

A German expat was in the Connecticut hospital for four months. She had lived and worked in the United States for her entire adult life, but never became a U.S. citizen. So, at a critical time in her life when she suddenly was too ill and frail to work, she had no means to pay for her own care. She was not eligible for Medicare or Social Security, and was unable to cover the costs of care at home or in a nursing home.

"We repatriated her back to Germany, which was her only option, because once there she was eligible for entitlements and care," says **Michelle Wallace**, BSN, RN, ACM, complex case coordinator in complex case management practice (CCMP) at Hartford Hospital in Hartford, CT.

"WE TOOK OUR KNOWLEDGE AND RESEARCH INTO RISK TOOLS, AND CAME UP WITH OUR OWN RISK STRATIFICATION TRIAGE TOOL."

For the German patient, CCMP worked with a social worker and the German consulate in Boston to help her obtain a passport and find a nursing home where she could stay when she arrived in Germany, Wallace says.

"That took hours and hours of time each day, calling the consulate and trying to move her case along," she recalls.

CCMP assists with the transition of the toughest cases, providing continuity for those who have little to no support when everything goes wrong.

Patients who require long lengths of stay (LOS) often have needs that far outweigh the resources available in most case management programs. At Hartford Hospital, the four-year-old complex case management practice handles most of these cases.

Financial Disclosure: Author **Melinda Young**, Editor **Jill Drachenberg**, Editor **Jesse Saffron,** Editorial Group Manager **Terrey L. Hatcher,** and Nurse Planner **Margaret Leonard** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

CASE MANAGEMENT ADVISOR™

Case Management Advisor™,
ISSN 1053-5500, is published monthly by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Cary, NC, and at additional mailing offices.

POSTMASTER: Send address changes to:
Case Management Advisor
Relias Learning
111 Corning Road, Suite 250
Cary, NC 27518

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Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

SUBSCRIPTION PRICES:
Print: U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $419. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours or CMCC clock hours, $369. Outside U.S., add $30 per year, total prepaid in U.S. funds.

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GST Registration Number: R128870672.

ACCREDITATION: Relias Learning, LLC, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.25] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hour(s).

TARGET AUDIENCE: This educational activity is intended for nurses and nurse practitioners who work in case management environments.

This activity is valid 36 months from the date of publication.

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From October 2016 through September 2017, the program saved 454 hospital days, avoided an estimated 100 readmissions, and prevented 27 ED visits.

"Initially, two part-time staff — a social worker and case coordinator — were charged with transitioning patients with an extremely long length of stay," Wallace says.

The healthcare system and Hartford Hospital adapted to meet the needs of its patients.

Consultants to the team include a behavioral healthcare coordinator, a dialysis case coordinator, a heart failure case coordinator, and others.

"They are disease-specific and collaborate with hospitalwide case management," says **Jasmine Rivera**, BSN, RN, ACM, BC, complex case coordinator at Hartford Hospital.

"They're available to CCMP for expert consultation," Rivera says.

"We are a unique team of people who cross various departments, and the organization has allowed us to work together," says **Debra B. Hernandez**, MSN, APRN, BC, complex care advanced practice nurse at Hartford Hospital.

They started to work together in 2015, and it took three months to recognize the value of the team partners.

"Michelle was working on long LOS patients with a social worker, Jasmine was in the ER trying to transition patients home rather than having them admitted to the hospital, and I was working in the department of medicine, helping with throughput issues: medical, psychosocial, or financial," Hernandez says.

"We identified that we shared a lot of the same patients," Wallace adds. "We started to informally meet and collaborate."

The team has a multidisciplinary approach and broad expertise. For instance, Hernandez collected data and understood issues related to medical complexity. Rivera's experience in the ED gave her a clear understanding of readmissions and their causes. Wallace knew more about complex dispositions and payer issues.

Together, they identified goals and developed a risk stratification tool to triage referrals, Rivera says.

"We took our knowledge and research into risk tools, and came up with our own risk stratification triage tool that we've been using for two years," Hernandez adds.

CCMP continues to study and tweak the tool, expecting to eventually copyright and publish it.

The complex case management

EXECUTIVE SUMMARY

Patients with unusually difficult obstacles to transitions can end up with long lengths of stay or too many ED visits and rehospitalizations. A complex care team is one way to solve this problem.

- A complex care team can help patients with financial, cultural, medical, and other obstacles.
- The team works with physicians, specialists, and other providers and organizations to ensure as smooth a transition as possible.
- Within a year, the program saved 454 hospital days and helped patients avoid an estimated 100 readmissions.

team collaborates with any multidisciplinary team members, including providers, caregivers, post-acute care facilities, home care agencies, neighbors, emergency medical services, pharmacies, transportation entities, and state agencies.

"It takes a village and extends throughout the continuum of care," Wallace says.

For example, CCMP helped a dying patient on a ventilator in ICU transition to his home to fulfill his wish of dying in his own bed.

"We participated in the difficult discussion with the patient, his family, and ICU provider," Wallace says. "Then we collaborated with the palliative medicine team to ensure his symptoms were being aggressively treated."

Working with the home hospice team, they planned what his care would be once he was home. Communication with the EMS team was essential as they performed the necessary transition from mechanical ventilation to a tracheostomy mask, Wallace notes.

"The patient lived several days at his home with his family at his side," she says. ■

Here's How Complex Case Management Can Work

Decrease ED visits, LOS, readmissions

Hartford Hospital in Hartford, CT, has a complex case management practice (CCMP) that works with medically and/or especially complex patients, who often experience the longest lengths of stay.

The following are some of the team's successful strategies:

• **Make referrals and triage.** The team uses a risk stratification tool to triage patients who will benefit most from complex case management.

"Once we receive a referral in triage, we complete a risk assessment and then reach out to the entire team to let them know whether or not we will be following," says **Jasmine Rivera**, BSN, RN, ACM, BC, complex case coordinator at Hartford Hospital.

The team makes recommendations based on the patient's risks and establishes plans to achieve safe transition.

"Usually when we triage a patient, we determine which one of us will take the primary lead on the case, and that person assists the care team with throughput," Rivera says.

• **Address barriers to care.** Based on a patient's transition barriers, including financial, caregiver, and medical complexity, the team will identify and obtain resources to minimize the barrier. For example, if the barrier is financial, the team will look into helping the patient apply for secondary insurance coverage, such as Medicaid, says **Michelle Wallace**, BSN, RN, ACM, complex case coordinator in CCMP at Hartford Hospital.

If social barriers such as housing issues, financial limitations, lack of decision-maker, or legal concerns are identified, the team partners with a social worker.

"If the barrier involves the patient's lack of ability to make medical decisions, our partnership with social work may include coordinating a family meeting, petitioning for a conservator, or completing a healthcare representative proxy," Wallace explains.

• **Improve handoffs.** "We have various ways to hand off patients to the next level," says **Debra B. Hernandez**, MSN, APRN, BC, complex care advanced practice nurse at Hartford Hospital.

Written discharge summaries and interagency referral forms are standard documents provided to post-acute facilities, agencies, and providers.

"If the patient is going someplace within our health system, we have an email process of handover," she says. "If we're sending the patient to a skilled nursing facility or back to the community, we speak with the primary care provider as part of the handover."

Written discharge summaries accompany patients to the next transition.

"Also, we have created partnerships with clinics and community health services in our city, and the same handoff is provided," Hernandez says.

Sometimes the patient's case is very complex and a home health or hospice professional will visit the patient in the hospital to help facilitate the handover, she adds.

The complex care team stays involved with these patients until their cases are resolved, Rivera notes.

"If we're involved, we stay involved until a successful transition has occurred and the patient and family no longer need our services," Rivera says. "We don't hand off to the team and walk away. We visit those patients in their homes or nursing facilities and communicate with staff caring for the patient, including nurses, providers, nursing home coordinators, and administrators."

CCMP stays involved throughout the care continuum. "We talk about care of the patient and try to come up with the best plan," Hernandez says. "We might talk about medication reconciliation and explain anything where there could be confusion."

An example might be if the patient tells the provider that he or she doesn't take a particular medication, although it was a prescription initiated in the hospital, she explains.

"We dig into the reason why the patient is not taking the medication, and help resolve it," she explains. "If we in the hospital and in the community can reinforce their treatment plans, then patients have a better likelihood of adhering to treatment."

The complex care team continues to work toward its goal of preventing readmissions and meeting patients' needs by remaining involved with the patient in the community, she adds.

"We call this intensive case management in the community," Wallace says. "We may prevent an admission, readmission, and emergency department visit."

• **Use readmission prevention strategies.** The complex care team's work prevented an estimated 100 admissions — including 30-day readmissions — between October 2016 and September 2017. Also, an estimated 27 ED visits were avoided.

The team focuses on keeping nonhospitalized patients out of the hospital and preventing newly discharged patients from returning to the hospital within 30 days, Hernandez says.

"For multiple-readmit patients, we do a root cause analysis," she explains. "We analyze why that patient is being readmitted."

Often, the problem is related to the patient not taking medication. Sometimes it's for financial reasons. Housing might be an issue, or patients might need behavioral health strategies. Medical issues also could be related to failed treatment or technology.

"For example, maybe a patient's feeding tube is leaking," Wallace says. "So we arrange for the patient to come in as an outpatient to have the tube changed, preventing a visit to the ED or an admission."

In one case, a patient suffered liver cirrhosis, which led to multiple hospital admissions. The complex case management team worked with a skilled nursing facility to transition the patient from home to the SNF. Once there, the patient's hospitalizations greatly declined, Hernandez recalls.

• **Meet community partners**. "The team initially started meeting with individual community partners to explain our role, introduce ourselves, and to define our process of providing a more detailed handover if we are working with one of their patients," Wallace says.

For partners within the health system, the complex care team will send email handovers. For other organizations, they will call or email to see if they're interested in working with the team. This first introduction might occur when the team already is following a patient in the organization's care.

"If a patient is here in the hospital, then it's a great opportunity for us to reach out and call a clinic that's not in our healthcare system," Hernandez says. "Everybody has the same goal of keeping patients out of the hospital, and you can connect on that goal."

• **Identify patient problems.** There was one patient repeatedly seen in the ED. The patient's chief complaints were chest pain and body pain. The complex case management team found that at each visit, the patient would receive IV narcotics for the pain, and then would go into respiratory failure. This pattern was the problem, so the team created an ED treatment plan that included limiting the patient's narcotics and alternative pain management, says Hernandez.

The patient was opioid dependent, so treatment also included helping the patient taper off the drug after discharge.

EXECUTIVE SUMMARY

A case management complex care team handles a health system's most challenging patients by working toward a number of goals, including using a risk stratification tool to triage patients who could benefit the most.

- The complex care team checks with community organizations and providers to find resources that might help patients.
- One goal is to improve handoffs and communication between the complex care team and community providers and organizations.
- The team employs specific strategies to prevent readmissions, ED visits, and long lengths of stay.

"The patient wasn't happy with the change at first, but ultimately accepted it," she says. "The family appreciated it."

This type of solution would have been far more challenging without the community collaboration, she notes. Patients with opioid problems require coordination between hospitals and community providers.

"We have to reach out to the primary care provider and home care agencies to get them to support the solution on a day-to-day basis," Hernandez says. "You might need to put a lockbox for medication in the house to make it successful."

A home health nurse would have the only key to the lockbox. The nurse would pour the medication into cups for the patient to take at specific times every day. This way, the patient cannot take additional doses of opioids. Another lockbox uses a timer that triggers it to open with the dose at specific times.

• Target length of stay (LOS). "The other thing we're doing at our institution is reducing length of stay," Hernandez says. "As a complex care team, we work with patients who have difficult dispositions on a one-on-one basis, and we work with hospital leadership on strategies to help them as a population."

This is time-consuming and detail-oriented work, but is rewarding work that has the potential of reducing the length of hospital stay for complex patients, she adds.

It can also be costly, although still less expensive than an unnecessarily long LOS.

For instance, there might be a hospitalized patient who lacks entitlements and social supports, yet requires rehabilitation. The CCMP might present the patient's case to the health system administration after CCMP identifies potential transition options, such as providing rehabilitation while hospitalized or in a rehab facility, Wallace explains.

> "WE FIRST MEET THE NEEDS OF THE PATIENT, AND THEN, WITH THE SUPPORT OF ADMINISTRATION AND THE MULTIDISCIPLINARY TEAM, WE REDUCE LENGTH OF STAY AND PREVENT READMISSIONS."

"It can be costly, although still less expensive than an unnecessary and extended length of stay," Wallace says.

Other strategies might be to provide extensive family or caregiver education, home health nursing care, and in-home medical equipment.

Often, problems affecting LOS are related to social determinants of health. A current CCMP case is a patient who had a stroke. The patient is undocumented and does not have any financial or insurance resources. The patient also lacks a decision-maker and social support, Wallace states.

"To date, we have a court-appointed conservator and are pursuing a passport for the patient and a transition back to Poland," she says.

"We look nationally for resources for people, and we look for religious organizations and charities — whatever we can find," Wallace says. "We refer people to federally qualified healthcare clinics, where they can get psychiatric care, medication at a reduced rate, and medical follow-up."

• Hold weekly team consults. "We have a high-risk clinical team meeting weekly with administration and providers to review our caseload and discuss patient needs," Wallace says.

The team meetings cover readmissions, difficult dispositions, and throughput barriers. The goal is to come up with ideas of how to transition hospitalized patients without unnecessary delays.

"We try to make treatment decisions more rapidly," Hernandez says.

Each case has unique challenges. "Right now, we have one patient from a state mental health system," she says. "And we have another patient from a group home who is on a ventilator, has Parkinson's disease, and is unable to swallow and cannot go back to the group home."

The treatment plan will cover what are realistic transitions and expectations for each patient.

Each team member agrees: "We first meet the needs of the patient, and then, with the support of administration and the multidisciplinary team, we reduce length of stay and prevent readmissions," Hernandez says. ■

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Want a Case Management Revolution? Here's How It's Done

Hospice care leads the way

An Orlando, FL, hospice organization restructured care management to give patients and staff more meaningful and effective encounters. Called the seven-day case management revolution, their homegrown program gives case managers more time to get to know their patients.

The idea was initiated at a senior leadership meeting, says **Violet Argo**, RN, BSN, CHPN, executive director of Cornerstone Hospice and Palliative Care.

Hospice case managers are registered nurses who lead the care of patients in an interdisciplinary team that also includes a chaplain, home health worker, registered nurse, and physician.

Traditionally, hospice case managers worked eight-hour days, Monday through Friday. For evenings and weekends, there is an after-hours on-call service.

"Only 14% of the workforce work after hours," Argo says.

These evening and weekend shifts might include two shifts, such as a 4 p.m. to midnight and a midnight to 8 a.m. shift. "Some organizations will offer to pay nurses more to cover a 16-hour shift," she says.

The problem with the traditional workflow was that patients need a lot of help, and they might not feel comfortable with someone they will meet only if there's an emergency. There would be 60-70 calls and visits after hours and on weekends each month. Since making the change, the after-hours calls dropped to between 10 and 15 calls per month, Argo says.

Hospice leadership began to see this as a less efficient way to handle patient care during off hours.

"We started thinking about offering our patients longer hours, case management hours, rather than hours by nurses who really didn't know them," Argo says.

Shifts change Mondays through Thursdays from the original 8 a.m. to 4:30 p.m. to a shift that began at 8 a.m. and lasted until 6 p.m.

"Each patient has two case managers, one for Monday through Thursday, and one for Friday through Sunday," Argo says. "They're responsible for knowing everything about their patients, including which symptoms are controlled and when they can start new medication."

This change facilitates a continuum of care and improved quality of care, Argo says.

For example, if a patient needs an IV antibiotic started after hours, the weekend case manager can make that visit, she explains.

"Our census grew as a result of this model," Argo says. "Nursing homes and assisted living facilities love our model because they know their patients are being seen routinely over the weekend, and they know the case managers' names."

As a result, the hospice's quality care scores about whether someone would recommend the hospice to other people rose to above the national average, and the after-hours calls plummeted, she says.

"We're not getting the after-hours calls we did, and that means the two dedicated case managers are doing such a good job with patients that their need to call after hours is minimal," she says.

"At first, when we made the change there was hesitation and people thinking patients don't want to be seen on the weekend," Argo adds. "That concern was dispelled very quickly."

Patients quickly bonded with their weekend case managers, even calling and asking for them, she says.

For the best results, the program needed flawless communication between the weekday and weekend case managers, Argo says.

"We did not dictate how the hand-off should be done, letting the pairs make those decisions," she explains.

EXECUTIVE SUMMARY

Using a homegrown seven-day case management program, a Florida hospice gives case managers more time to work with patients, improving quality and efficiency of care.

- The program provides consistency by having two case managers work collaboratively to follow the patient seven days a week.
- After-hours calls declined significantly once the program was initiated.
- The hospice found that it was easy to find volunteers for the weekend shift because some case managers liked having weekdays free to attend advanced degree college programs or to spend time with their children.

"We are careful when we pair up people that we find people who will get along."

Any problems with workflow are quickly discovered.

"If you and I are partners and you're not doing what you should be doing, I will know and will not be happy," Argo says.

When problems occur, Argo expects the case manager pairs to speak with each other first.

"If that doesn't work, then go sit with the manager to figure out what the problem is," Argo says. "This change improved staff productivity and quality scores. We also noticed that our after-hours calls to the center dropped dramatically."

Case managers can handle communication in ways that work best for them. Some pairs choose to meet for breakfast on Friday mornings for a verbal report and handoff, Argo says.

"Breakfasts work for them," she adds. "I have pairs that communicate by phone, and others strictly do emails of all the things they've done for patients."

Although case managers often don't work on weekends, the hospice has not experienced difficulty finding volunteers for the weekend shift. "We had zero problems recruiting for those positions," Argo says.

"On our team, we have a few people who are working on their nurse practitioner degrees, and they're able to go to school during the week and then work on the weekend," Argo adds. "We also have mothers who want to be home with their children during the week, and one nurse just likes to work on the weekend."

The weekend shift is 36 hours and is paid the same as a 40-hour week, plus there is bonus pay. The model has worked so well that other hospices have expressed interest in learning more about how it works, Argo says.

"There was a hospice that came and spent two days with us and then implemented the model," she says. "A couple dozen hospices have asked about it." ■

JAHF Age-friendly Initiative Showing Results

Hospitals are reporting positive results from a program sponsored by The John A. Hartford Foundation (JAHF), a nonprofit, nonpartisan organization in New York City that works to improve conditions for the care of older adults in the healthcare system.

The Age-Friendly Health System initiative seeks to improve care transitions and the way episodes of care are addressed for an aging population, says JAHF President **Terry Fulmer**, PhD, RN, FAAN.

Five health systems providing care in 40 states have adopted the program, which focuses on four key elements that can be applied to any hospital or health system. JAHF calls them the four M's:

- what matters to the patient;
- medications;
- mobility;
- mentation, or mental activity. This includes confusion, delirium, and mood.

JAHF also urges an age-friendly healthcare system to employ leadership committed to addressing ageism, a geriatric care prototype specific to older adults, clinical staff who are specifically trained and expert in the care of older adults, care teams that are high-performing and can show measurable results for care of older adults, a systematic approach for coordinating care with organizations beyond their walls, and a strategy to identify, coordinate with, and support family caregivers.

The organization also should elicit patient goals and preferences so as to define a plan of concordant care, reduce polypharmacy, address common geriatric syndromes, manage pain and symptoms, and support the needs of family and caregivers.

The age-friendly initiative is an opportunity to explore population health and person-centric care models, says **Ann Hendrich**, PhD, RN, FAAN, senior vice president and chief quality/safety and nursing officer with Ascension Health in St. Louis. Ascension is adopting and testing many of the age-friendly prototype models not only in its population health management systems, but also on the acute care side, working directly with providers.

"In the area of pharmacy, there are a lot of medications that should be minimized or not used at all in the older adult. Often, they're unnecessary," Hendrich says. "We've worked with our pharmacists at a national health level to identify medications that can be minimized and avoided. We want to understand why the medication is needed before we provide it, especially if it might have an effect on mobility."

Ascension also is addressing ways to explore what is most important to older adults, including end-of-life care decisions.

"In our clinic and ambulatory

areas, our providers are changing the way they do assessments and taking histories, trying to understand what matters most to these patients. We are trying to have meaningful discussions about what they want and having that guide decisions in their care process," Hendrich says.

The four M's of the JAHF Age-Friendly Health System initiative provide a structure for any organization to address the concerns of older Americans, Hendrich says.

"Those four M's apply to any healthcare system regardless of size, and in the ambulatory system as well," Hendrich says. "Ascension has set a goal of reaching 20,000 adults this year with age-friendly care, and I think every system could set a goal like that to see how many older adults they reach."

The age-friendly initiative should fit into any integrated model of care, she says.

"Don't consider it an add-on. Look at it as an integral part of your healthcare system's efforts to improve quality of care," Hendrich says. "Once you get your providers involved, these changes are not hard to implement with small numbers and then you grow from there. The impact on older adults can be tremendous. Our challenge is to scale these programs up quickly."

There are existing geriatric models of care, but they reach only about 10% of the older adults who need that kind of care, says **Amy Berman**, RN, LHD, FAAN, senior program officer with JAHF.

"We brought together the people who developed these models and looked at 17 that had the greatest spread and the highest degree of evidence, asking these innovators to deconstruct their models to find the key elements. We found there were 90 key elements and a lot of overlap, with about 24 common themes," Berman says. "Then, we asked the people who developed this evidence, leaders from health systems, and older adults to pick the things that would have the greatest impact on cost and quality. We wanted to find the things that would be the most influential in helping this group of patients have a better life, and that became the four M's."

The four M's are implemented in various ways, including some small interventions. For instance, an older adult with cognitive impairment typically has a hospital length of stay 3.5 times longer than average, Berman notes. If that impairment is not recognized and addressed, nurses may take little notice of the fact that the patient did not eat a meal.

Under an age-friendly model, the clinician would be more attuned to that and perhaps suggest that family members stay with the patient during meal times, Berman says.

"One participating hospital is focusing on hydration. The typical bedside pitchers were not being used much, so they changed to the big cups with straws like people carry around in the park every day," Berman says. "They're finding that older adults are more comfortable with them and using them more, so hydration is improved. Something as simple as a cup and straw can have a huge impact because people who are dehydrated are at more risk of falls and delirium."

Mobility is another major concern. Clinicians can be so concerned about the risk of falls that they keep older patients immobile, which leads to an overall deterioration of health, Berman notes.

"Some facilities are implementing mobility programs that actively seek to keep older patients mobile and not let them decline to a state of immobility just because they are hospitalized," she says. "Some are making it a goal to improve the patient's mobility while an inpatient, even if that is unrelated to the primary reason for the hospitalization. This is a new way of looking at the care of older adults, but we're seeing organizations take these steps in the right direction." ■

ED-based Universal Screening Helps Identify Patients at Risk for Suicide

With the suicide rate on the rise over the past decade, suicide is now the 10th leading cause of death in the United States and very much on the radar of public health authorities. Further, while The Joint Commission (TJC) requires accredited hospitals to assess for suicide risk in patients with behavioral health issues, studies suggest that a relatively high number of patients seeking care for nonpsychiatric issues are at risk of suicide as well. Many of these patients present to EDs for care, creating the opportunity to intervene.

However, can a universal screening approach for suicide be implemented efficiently in a busy emergency setting

where taking care of acute problems is the primary focus? Parkland Hospital & Health System (PHHS) in Dallas has demonstrated that it can, and administrators there believe their approach, which also extends to the inpatient and outpatient settings, could be adapted for use in other hospital systems.

Think Creatively

The impetus for developing a universal screening program for suicide at PHHS stemmed from the clear clinical need for such an approach, explains **Kimberly Roaten**, PhD, CRC, the director of quality for safety, education, and implementation in the department of psychiatry at Parkland, and associate professor of psychiatry at the University of Texas Southwestern Medical Center. "We know from existing research that patients who die by suicide are much more likely to be seen by [primary care physicians] and emergency medicine providers in the months and years before they die, and that they are much less likely to be seen by psychiatrists and psychologists," she explains.

In addition, during a routine accreditation survey by TJC at Parkland in 2014, surveyors found that the hospital had neglected to conduct a suicide risk assessment for a medical inpatient who had a history of substance use. "Because he had that existing psychiatric condition, according to a national patient safety rule, he should have been assessed for suicide risk, and he was not," Roaten notes.

That incident, combined with the clinical need for screening, prompted administrators to think creatively about how they could both stop missing patients who were potentially at risk as well as pick up on occult suicide risk — cases in which patients only disclose suicidal thoughts or behaviors if they are specifically asked about them.

Guard Safety, Privacy

With more than 250,000 patient encounters per year, the ED at Parkland offers a rich opportunity for identifying suicide risk, but developing a way to implement a universal screen without adversely affecting patient flow or capacity took some time. Safety issues also were a big concern.

"We very intentionally decided to put the screening questions in the triage process in the ED for a couple of reasons. One, we didn't want patients in the waiting room in the ED with suicide risk that we didn't know about, so we wanted to ask them [these questions] as soon as possible, but we also wanted to pose these questions with a bit more privacy," Roaten explains. "So, as the nurse is taking vital signs and asking other basic questions, that is when these [suicide risk screening] questions are asked, and more specifically, they are asked in the context of other psychosocial screening questions, such as questions about alcohol use, drug use, and domestic violence."

Parkland uses the Columbia-Suicide Severity Rating Scale (C-SSRS), a validated six-item screen for patients 18 years of age and older. "Everybody gets question one and two, but if they respond 'yes' to question two, then they get questions three, four, five, and six. If they respond 'no' to question two, then we skip down to question six," Roaten notes. All the questions are prompted through the electronic medical record (EMR), and it takes about two minutes, on average, to conduct the screen.

Developing an approach for how to respond to the screening results required some additional work, Roaten says. "The piece that was missing when we first tried to start this program was a way to translate the standardized screening tool that already existed into the EMR in a meaningful way that was user-friendly for frontline staff," she explains. "So we created what we call the Parkland Algorithm for Suicide Screening. It is a weighting system for the screening items built into the EMR."

For example, when the ED nurse asks each screening question, which she reads verbatim from the computer screen, and then enters the responses of "yes" or "no," the EMR will prompt the nurse to take appropriate clinical actions, based on three distinct risk categories: no risk identified, moderate risk identified, and high risk identified. "The vast majority of our patients, about 96% in the ED, are completely negative. They say 'no' to all the screening items, and they fall into that no-risk category," Roaten observes. Most other patients fall into the moderate risk group, which is a very important group in terms of efficiency and resource allocation, she says.

"In the past, we were sort of throwing the whole ball of wax at everybody, and, frankly, not just for suicide risk, but anything psychiatric," Roaten observes. "We were putting everybody on one-to-one [monitoring] and taking away their belongings."

However, under Parkland's new protocol, patients categorized as moderate risk are evaluated by a social worker, connected to outpatient mental healthcare, and given printed mental health resources, including information about suicide warning signs and crisis hotlines.

Patients in the high-risk group include individuals who are reporting current suicidal ideation or a very recent suicide attempt such as within the past week. "These patients are put on one-to-one [monitoring], they have suicide precautions in place, and they are required to be evaluated by a behavioral health provider," Roaten explains. "This could be a social worker with suicide risk assessment competency, a psychologist, a psychiatrist, or a behavioral health nurse practitioner or physician assistant."

Patients at high risk also would receive the same connection to outpatient mental healthcare and the same printed list of mental healthcare resources as the moderate risk group. "They could, of course, also be hospitalized for their suicide risk, but most are not," Roaten notes.

In a study of the approach post-implementation, investigators found that 6.3% of patients presenting to the ED screened positive for suicide risk at either the moderate- or high-risk level.[1] Those findings have remained stable, with between 6% and 7% of all emergency patients consistently screening positive for suicide risk at either the moderate- or high-risk level, Roaten shares.

Notably, the universal screening program extends to Parkland's inpatient and outpatient care settings, too; however, the study data show that the odds of a positive suicide screen are higher in the emergency patient population. This finding could translate to many other EDs, but not necessarily all of them, Roaten advises. "In general, patients who show up in our Parkland ED have more psychosocial stressors that are associated with suicide risk factors than our patients who are traditionally seen in our primary care settings," she says.

For example, Roaten notes that a high number of emergency patients face financial and social stress. Many have limited social support, employment challenges, primary relationship issues, and psychiatric comorbidities. "There is just a higher concentration of people with these issues in the emergency setting than there is in other places, particularly at Parkland," she says.

Nurture Relationships

Although the universal screening program has been in place in the ED since 2015, administrators recall that in the early days of development, there were concerns about adding one more screening task to busy frontline providers. "The medical director of the ED at the time was concerned that it might slow them down," says **Celeste Johnson**, DNP, APRN, PMH, CNS, vice president of nursing for behavioral health at PHHS.

However, the data regarding the rising rate of suicides and the number of patients at risk who get missed when they visit healthcare providers proved convincing. "I think there was a basic belief that this was the right thing to do," Johnson notes. "We did not believe we would have a large percentage of patients that would be of high or moderate risk of suicide, but we felt like it was worth those two minutes to screen."

Johnson notes that Parkland is fortunate that it is a teaching facility and that it operates a psychiatric ED, but a key element to the screening program's success is targeting resources in the community for patients who screen positive for suicide risk. "There is not a wealth of care providers in the community for mental health; it is always a little bit tougher to get into," she says. "But we have really been fostering those relationships."

With funding for indigent care a continuing challenge, the psychiatric ED has experienced longer boarding times of late for patients in need of psychiatric beds, observes Johnson, but she notes that for most patients who require handoffs to outpatient mental health providers, the effort to nurture relationships with other agencies has helped tremendously.

Another key pillar of the screening program's implementation process was education for all staff about suicide risk and the program's components. "We created two separate education modules. One went to the people who would actually be administering the suicide screen — the nurses and nursing assistants — and the other module went to the physicians, house staff, and everybody else," Roaten explains. The people conducting the screening received basic education about suicide risk, including the statistics about the number of people at risk who are seen by primary care physicians or emergency providers vs. behavioral health specialists. Further, this group was required to view a 30-minute video provided by the group that created the screening tool instrument, and they received some scenario-based instruction, including tips on how to respond to patients in problematic circumstances, such as when patients refuse to answer screening questions or patients state that they don't want to see a behavioral health provider.

The second education module was much simpler, Roaten notes. "We did not require this group to view the video," she says. "Instead, it consisted of just the basic education about suicide risk, why we were screening for suicide risk, and basic information about how it would work in our EMR."

One early issue that emerged was a small subgroup of patients categorized

as high risk would want to leave the ED before they could be evaluated by a behavioral health provider. Some of these patients did not meet emergency detention criteria, so the ED could not hold them. To alleviate this problem, administrators finessed the workflow so that behavioral health staff could respond to these cases quicker.

"We prioritized those activations in our ED so that we are very aware when those patients are asking to leave and need to be seen as quickly as possible," Roaten explains. "We also have a very responsive police department that will help us convince these patients to stay, and we have provided additional education for the nursing staff about how they might talk to a patient about staying for the evaluation even when they don't want to."

Further, there is now a report released every morning that identifies any patient who was high risk, did not meet emergency detention criteria, and insisted on leaving the ED. "Then we follow up with those patients by phone, so our social workers will call them and try to do an assessment and make sure they have some kind of safety plan if that is needed," Johnson says. "The social worker will find out what the patient's follow-up plans are, and sometimes those patients are ready to come back and really do need to be seen."

There was some early hesitancy from the hospital social workers about getting involved in suicide screening. "They were fairly resistant to the idea of independently doing some of the suicide risk assessments. They were nervous about it," Roaten notes. "But once we talked about what their clinical training looked like, and what their true competencies were, we actually came to believe — and I think the social workers came to believe as well — that we were underutilizing their clinical skills."

The social workers are fully involved in the screening program at this point, and they have embraced their role. "Now that we have gotten past that initial anxiety, it is very much a part of their clinical practice, and something they seem to be very proud of," Roaten adds.

Hold Leaders Accountable

Now that there are ample data about the number of patients who screen positive for suicide risk and a formalized risk stratification process that dictates what the next steps are for these patients in terms of interventions, administrators hope to turn their attention to measuring results, a task that is not without complications.

"We are looking at a number of different types of outcomes. Obviously, one of the biggest limitations with suicide research data has been our limited ability to use suicide as a true outcome variable," Roaten explains. "It is a rare enough event that it is very hard to get the power you need statistically, but with a program this size we can do that."

Investigators hope to focus on what specific elements of the program lead to reductions in suicide — the screening itself or, perhaps, specific interventions.

"We are looking at suicide outcomes, but we are also looking at other things like return visits for suicide attempts or other types of self-inflicted violence," Roaten notes. "We are looking at ED recidivism and connection to appropriate outpatient mental healthcare, so we are definitely taking that next step and trying to look at this prospectively."

Roaten's advice to other hospitals that are thinking about traveling a similar road regarding suicide screening is to first thoroughly investigate what the existing behavioral health resources are, and how such resources might be leveraged into more active engagement with the hospital. "If you don't have a psychiatrist on site, is telehealth an option?" she asks.

The screening isn't the issue so much as putting the appropriate response mechanisms in place.

"If you approach an emergency medicine director with the idea of universal suicide screening with no idea of how to actually respond to patients, you are dead in the water," Roaten cautions.

Also, put specific people in charge of the program, and make them accessible and responsive to stakeholders, Roaten advises. She notes that this approach worked well at Parkland as she, Johnson, and another co-leader who primarily worked in IT were very invested in personalizing their roles in the suicide screening program.

"If the medical director of trauma services had a problem with the suicide screening or felt that something was not right with the workflow, I wanted him to call me directly to figure it out," she explains. "The three of us tried from the very beginning to take a lot of responsibility for this so that it wasn't one more thing that an emergency nurse or physician had to do without a reason and a face attached to it. We tried very hard to be consistent with that, and we continue to do that now." ■

REFERENCE

1. Roaten K, Johnson C, Genzel R, et al. Development and implementation of a universal suicide risk screening program in a safety-net hospital system. *Jt Comm J Qual Patient Saf* 2018;44:4-11.

CASE MANAGEMENT ADVISOR™

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CE QUESTIONS

1. **Thanks to a complex care management program, case managers were able to help a Hartford Hospital in Hartford, CT, save how many hospital days between 2016 and 2017?**

   a. 100
   b. 257
   c. 454
   d. 503

2. **Which of the following is a strategy Hartford Hospital's complex care team uses to improve quality of care and reduce readmissions, length of stay, and ED visits?**

   a. The team uses a risk stratification tool to triage patients.
   b. Address barriers to a successful transition.
   c. Reduce readmissions by using a root cause analysis to identify the underlying problems.
   d. All of the above

3. **Cornerstone Hospice and Palliative Care in Orlando, FL, employed a seven-day case management program that includes two case managers covering each day of the week, facilitating a continuum of care and improved care quality.**

   a. True
   b. False

4. **When a complex case management program has a patient who lacks entitlements and social supports, a health system might reduce the patient's extended length of stay by following which of the following strategies?**

   a. Rehabilitation while hospitalized or in rehab facility
   b. Extensive family or caregiver education
   c. Home health nursing care and in-home medical equipment
   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.