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INSIDE

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Asthma Case Management Program Helps Improve Children's Health

Program produced results and won award

The Changing High-risk Asthma in Memphis through Partnership (CHAMP) asthma program worked so well during its three-year Medicaid Innovations grant pilot period that Tennessee payers and providers collaborated to continue its work after the grant money ended in 2015.

The purpose of the innovation grant project, which was launched by the Centers for Medicare & Medicaid Services (CMS), was to address a problem in the health system's area, says **Susan Steppe**, LAPSW, director of CHAMP and 38109 Population Health at Le Bonheur Children's Hospital in Memphis, TN.

"The main focus for us is children with high-risk asthma," Steppe says. "It's the most prominent chronic disease of childhood for most cities across the country."

> "THE MAIN FOCUS FOR US IS CHILDREN WITH HIGH-RISK ASTHMA. IT'S THE MOST PROMINENT CHRONIC DISEASE OF CHILDHOOD FOR MOST CITIES ACROSS THE COUNTRY."

Data from 586 CHAMP patients, who were enrolled for 12 months beginning in July 2016, showed the following positive outcomes:

- ED visits were reduced by 60%;
- inpatient admissions/observations reduced by 71%;
- urgent care visits cut by 56%;
- 53% decrease in total asthma exacerbations;

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• 52% reduction in asthma-related ambulance calls.

A recent independent evaluation of CHAMP and other pediatric asthma programs nationwide found that Le Bonheur's relationship with TennCare in targeting high-risk asthma patients was a success. The program reduced ED visits and all-cause asthma hospitalizations, and helped produce a savings of more than $2,000 per year per child, Steppe says.

CHAMP also won the 2015 National Environmental Leader Award in Asthma Management from the U.S. Environmental Protection Agency.

In Shelby County, where Memphis is located, there are tens of thousands of children on TennCare, Tennessee's Medicaid program, and many of them have asthma. Statewide, an estimated 12% of children have the chronic illness.

Asthma is a big focus for BlueCare of Chattanooga. A managed care company, BlueCare has a contract with TennCare to handle Tennessee's Medicaid population.

"We have 600,000 members and multiple contracts with the state," says **Frances Martini**, BSN, MBA, vice president of population health at BlueCare.

Steppe and Martini met at a 2014 CMS panel on asthma in Atlanta, and that meeting sparked collaboration.

"Once I saw what an impact Le Bonheur's asthma program had on our population, Susan and I became connected at the hip to see what we could do to impact this population together," Martini says. "We realized the program was so successful with asthma that the outcomes were positively impacting the state, numbers, and the quality numbers were better than any other program in Tennessee."

Le Bonheur's CMS innovation grant expired on June 30, 2015, so Martini worked with Steppe to design a similar asthma program that could help the Memphis area and serve as a model for the entire state. *(See story on how CHAMP works, page 63.)*

CHAMP focuses on clinical aspects, social determinants of health, and the administrative aspect to case management.

"We saw the outstanding results, but knew it was important to remember the administrative opportunities for similar provider-payer partnerships across Tennessee," Martini says.

BlueCare partners with primary care provider groups that have strong asthma knowledge and an ability to coordinate, she says.

One aspect of the asthma

EXECUTIVE SUMMARY

A Memphis-based pediatric asthma program quickly produced positive results for patients and Tennessee's Medicaid program due to its community, healthcare provider, and payer collaboration.

- The program cut ED visits by 60%.
- An independent evaluation showed that the program saved more than $2,000 per enrolled child.
- The program addresses social determinants of health, including housing and legal issues that patients' families face.

program that might be challenging to replicate in some areas of the state, such as more rural regions, is its focus on ending barriers caused by social determinants of health.

In the Memphis area, there are several community agencies and resources that case managers can use when trying to find solutions for patients' nonmedical problems, such as housing insecurity and transportation.

"Memphis and Shelby County are rich with interested community agencies and resources," Martini says. "Not being originally from the South, I am so impressed as to how robust community commitments are helping their populations become healthy and how strong the faith-based community is."

Shelby County community programs include early childhood intervention, nurse-family partnerships, legal aid, and programs that deal with the link between childhood traumatic events and health, Steppe says.

"The program is dealing with patients' housing issues, and we are trying to expand the housing portion of what we do," she says. "Sometimes people need help with landlords."

Le Bonheur Children's Hospital has a medical-legal partnership with the University of Memphis Law School and Memphis Area Legal Services. Together, the organizations help patients deal with housing problems and other legal issues, Steppe says.

It helps if case managers can use a multipronged approach to tackle patients' barriers.

"What we find as case managers is it's a case manager's dream to find community agencies to help," Martini says. "These agencies are needed when you work with a population where there are challenges, and families are often more concerned about how they can eat and pay rent and pay utilities and get to school."

Community support is key to having case managers address patients' social determinants of health, she adds.

"You identify a family that has a child with asthma, and the home might have carpet with dust mites, so the first step is to get the home healthy," Martini says. "These solutions are not usually covered by insurance companies, but if you have community resources to tap into for the benefit of the child, that's what Susan's team offers."

A Medicaid-funded program trying to model CHAMP would be challenged to succeed as well as CHAMP has without access to community resources, she notes.

"You have to work within the Medicaid benefit and there are exclusions of services not permitted by the contract, so that's why case management is so important," Martini says. "The idea of case management is not to find out what the member needs and pay for it — the idea is to look between that gap and see where there is support available within the community."

In addition to their work in Memphis, BlueCare's case managers regularly work with partners to ensure members receive services to close the gap between the benefit and the member's need, such as nebulizers in one school district. ■

Here's How CHAMP Helps High-risk Asthma Patients

Start by identifying early

Le Bonheur Children's Hospital in Memphis, TN, offers a pediatric asthma case management program that improves the health and outcomes of area children who have asthma and are on TennCare, the state's Medicaid program.

Called Changing High-risk Asthma in Memphis through Partnership, or CHAMP, the program incorporates various best practices, including early identification of children who could most benefit from the case management intervention, says **Susan Steppe**, LAPSW, director of CHAMP and 38109 Population Health at Le Bonheur Children's Hospital.

"The program promotes a strong asthma action plan for the child and works with schools and day cares to make sure asthma triggers are addressed," says **Frances Martini**, BSN, MBA, vice president of population health at BlueCare of Chattanooga, TN. BlueCare is a partner in the program.

Martini and Steppe describe how the program works:

• **Early identification.** There were several options in identifying which children to target for the asthma case management program. With

an estimated 12,000 children with asthma in the Memphis area, the program had to identify those who were most in need of an intervention.

"We have a high poverty population in Memphis," Steppe says. "A lot of poor children frequently visit the hospital."

The goal was to provide high-risk asthma patients with a multidisciplinary management approach. This reduces their hospital and ED visits, improves health, and saves Medicaid funding.

"High-risk asthma" as defined by the CHAMP program includes children who meet any one of the following criteria:

- three or more ED or urgent care visits for an asthma-related event within one year;
- two or more hospital admissions for asthma in the past year;
- one or more ICU admission within the past two years;
- a physician refers a child who is on the cusp of these guidelines or who has special circumstances.

Also, all of the children needed to be on Medicaid and live in Shelby County.

CHAMP receives a daily report that lists all asthma patients admitted or seen within the previous 24 hours for an asthma-related condition at a Methodist Le Bonheur hospital or facility.

The criteria recognize that these children are at the most risk of long-term health problems.

"The frequency and severity of those asthma exacerbations for a very young person can have the capacity to impact the growth of lungs," Steppe explains. "Getting help for this population was something our physicians really wanted to do."

• **Ongoing screening.** "Every day, we get a report from a hospital record system that tells the names of any child who came to the hospital with a diagnosis of asthma, and then we screen to see if the child meets criteria," Steppe says.

The program measures a number of data points for the pediatric asthma population, Martini says. These include ED visits; inpatient use; prescriptions; medication management; and prescription rate refill.

> "OF THE PEOPLE WHO CALL THE CALL LINE, 70% HAVE BEEN ABLE TO MANAGE THE EXACERBATION WITH HELP BY PHONE, AND THEY HAVEN'T HAD TO GO TO THE ER."

"We look at the percentage of kids using rescue inhalers," Martini adds. "What we found was a 20% improvement in quality scores for children in the asthma program over children who were not, and we want to improve quality for all children."

The higher the percentage of asthma patients using their inhalers, the better they are managing their medication and asthma, she says.

Thanks to the program, the Shelby County medication adherence rates were so high that their outcomes positively affected the state's overall adherence rate for BlueCare, Martini says.

• **Community health educators.** The CHAMP community team reaches out to patients to see if their families agree to enrollment in the program. Three community health educators (CHEs), who are peer educators without a medical degree, work with the enrolled families and patients.

"The community health educators have experience in doing home visits and connecting with people," Steppe says. "They're also on the community team, which includes a medical director and nurse practitioner."

CHEs work with them in their homes, and they educate families in ways they understand.

"Educators speak the language of asthma, talking a lot about asthma and adherence," Steppe says. "It amazes me how many times we have to remind people which medicine to take. We even put red stickers on their albuterol, and they still take the wrong medicine each day."

CHEs continually reinforce the right way to take medications and prevent asthma attacks.

• **Clinic visit**. The high-risk asthma patients visit an allergy health clinic for their initial case management. The initial clinic visit goals include developing an asthma action plan and giving patients access to a 24/7 call line, Steppe says.

"At that clinic visit, we give the patient a loading dose of prednisone," she says.

Patients also are told to use the call line whenever there's a medical emergency or breathing problem.

"Of the people who call the call line, 70% have been able to manage the exacerbation with help by phone, and they haven't had to go to the ER," Steppe says.

• **Other community team members.** Other team members include an RN and a respiratory therapist who work with families in both health clinics and community settings.

The nurse handles sick call triage, helping the families deal with their

child's asthma flare-up at home unless an ED visit is necessary. Respiratory therapists help the children handle issues that might arise while they're at school. This could include meeting with school nurses or other staff and educating them about asthma emergencies.

• **Asthma and schools.** Since Shelby County schools only have a nurse one day a week, the respiratory therapist also meets with school secretaries and anyone else who might be called upon to help with a child's asthma attack.

"We also want schools to know that they have high-risk patients in their schools, and if one of their students comes to the ER, we tell them about it," Steppe explains.

Also, respiratory therapists give families a school packet with medication and information.

"Then I follow up with the school and try to make a personalized visit for each patient with the school," she says.

Occasionally, one of the team members will visit a school to help with a child's asthma attack, she adds.

"If you don't have a nurse in every school, every day, it's a great challenge for us," Steppe says. "In our area, asthma is the No. 1 health-related reason why children miss school, and it has a domino effect of children missing school and parents not working that day."

• **Home visits.** After the first clinic visit, CHEs visit the patient's home and perform an environmental assessment, looking for common allergens as defined by the Environmental Protection Agency.

CHEs also identify patients' social determinants of health and make referrals to help them with issues related to housing, utilities, transportation, and so forth.

Health educators also reinforce what patients heard in the clinic about their illness. "Hearing it once in a busy clinic is never enough," Steppe explains. "They explain what asthma is, how it's a constriction, swelling, and mucous, and that's why people need a daily medication."

They'll educate the children, if they're old enough to understand. They'll also reinforce the need for families to visit with a primary care physician for annual check-ups and vaccines.

• **Primary care provider visits.** In CHAMP's pilot program, the only negative outcome was that enrolled families visited their primary care providers less frequently than families not in the program, Martini notes.

"We found that when people had a strong positive relationship with the allergy clinic, the parents thought of the clinic physicians as their doctor," Martini explains. "We'd call and say, 'We need you to have your doctor's visit,' and they'd say they just went to the doctor, but it wasn't the family doctor."

This was an area the program needed to strengthen, Steppe says.

The solution was to have CHEs ask families if they've made an appointment with their family doctor and to follow up to see that the appointment was kept.

"Professionals working with families might actually go with them to the family doctor appointment and share the patient's asthma action plan with the primary care physician," Martini says.

• **Asthma registry.** "We developed this program with an asthma registry, a data system where we record everything we do," Steppe says. "All of our children are Medicaid patients, so every month the Tennessee Medicaid Administration downloads all medical information from all patients into our registry."

CHEs use the data to see which patients have not filled their prescriptions on time. Then they'll call the family and ask if they need someone to pick up the medication.

"The ability to look at that data and have access to it makes the difference for any asthma program," Steppe says. "We've crafted the data and made it usable." ■

Mobile Integrated Health Helps With Patients' Transitioning Gap

Healthcare providers continually seek new strategies to improve patient transitions. One Portland, OR, health system started a pilot program using mobile integrated health. The program involved a partnership between the health system and community paramedics, resulting in a drop in readmission rates from 6.75% to 5% within its first year.

"We started the pilot program to prevent readmissions for patients with chronic obstructive pulmonary disease [COPD] and heart failure," says **Tracy Neidetcher**, MBA, MSN, NE-BC, manager of utilization management at Legacy Health System in Portland.

The program's initial results were positive, so the hospital approved funding to continue the program.

"We noticed the patients we were referring to the program were not being admitted to the hospital," Neidetcher says. "I shared data with our administrator, and we got the approval to go ahead and continue the pilot."

The health system also opened the program to anyone who needed the service. Case managers could decide which patients would benefit.

"The nice thing about mobile health is you can serve a lot of homeless and underserved people," she notes. "With mobile health, you can see patients who don't even have a home."

For instance, the program's paramedics sometimes visit patients in their cars or at a tent city — even under a bridge.

The seven-day readmission rate dropped from 40 patients readmitting to the hospital to 15 patients, Neidetcher says.

The program is community-based and involves staff training. "We educated care managers, who are talking about the program and explaining it well to patients," she says.

The pilot project's own results showed what a big difference education made. After a great start, the program's staff changed and the readmission rate bounced back to its baseline level because case managers were not enrolling people as aggressively as before.

"The numbers dropped, and people were not committing to the program," Neidetcher says. "When paramedics reached out to them, they'd decline the service, so people weren't doing as good a job of educating patients about it."

After putting more effort into education, the outcomes again improved.

"It's so critical to do a good job of educating staff. It takes time and does not happen overnight," Neidetcher says.

Here's how the mobile integrated health program works:

• **Train staff.** "The key is it takes time to get nurses to understand the program and buy into the program, to understand its value and how it takes extra time to see patients," Neidetcher says.

Nurses need buy-in for the program, and their enthusiasm can help foster patient buy-in.

• **Select patients.** Legacy Health System uses a complexity score that is assigned to patients, and each patient has a readmission score.

Case managers review the complexity scores, readmission rates, risk scores, comorbidities, and support system to decide which patients would benefit most from the program.

"Maybe a patient is homeless and can't receive home healthcare," Neidetcher says. "The patient still needs support to go into their home, check on their medications, and follow up on their care."

With a passion to help patients, case managers can succeed in helping even the most challenging cases.

"We have had patients who were readmitted 13 times, and we finally get them into mobile health, and now they don't come back to the hospital," Neidetcher says. "Those are the stories we need to tell case managers about."

• **Provide case management support.** The case management workload was reduced to nearly half as many patients as previously.

"We've hired more people and moved some FTEs [full-time equivalents] in the system around," she says. "Case management ratios were unruly, and we had to fix that to get staffing under control."

The case managers meet with patients on inpatient floors. They talk with patients about the program, sharing information written at a fourth-grade reading level. Case managers also help facilitate transitions to paramedics in the program.

Once the patient enrolls in the program and leaves the hospital, paramedics take over.

• **Paramedic follow-up.** "Paramedics watch for the patient to be discharged, and then they commit to us they'll make first contact within 24 to 48 hours," Neidetcher says.

Usually, the paramedic's first step is to call or text the patients. Often they have phones, but some can only receive text messages. Paramedics visit patients, using their regular vehicles instead of ambulances. Their work is separate from their emergency duties.

"If a patient is homeless, we'll try to find out where they live," she adds.

EXECUTIVE SUMMARY

A health system uses mobile integrated health to improve outcomes and reduce readmission rates among patients with chronic conditions, such as heart failure and chronic obstructive pulmonary disease.

- The program involves sending a paramedic to where people, including homeless patients, live.
- The community-based program uses case managers.
- Among the positive outcomes was a seven-day readmission rate reduction from 40 people readmitting to 15 patients readmitting.

"Paramedics know where the tent cities and the little cities under the bridge are. They're very familiar with the homeless population."

Paramedics even know various daytime habits of their homeless patients: "If they know a patient stands on this island to ask for money, they'll drive past that island to see if they can find this person," Neidetcher says.

• **Making first visit.** For patients with homes, the first visit might last two hours or longer. It includes an assessment of the patient's activities of daily living, a physical assessment, and a full environmental survey.

They check all medications in the house to make sure patients are taking the right prescriptions and know how to take the medicine correctly. They check to see if shower bars are in place and if the toilet seat is raised and accessible. They pull up rugs that might be a hazard to patients. They check patients' medical equipment and show patients how to handle and clean the machines, Neidetcher says.

The in-person visits typically are once a week. After the first visit, each visit might last 45 minutes to an hour. "They do vitals and use a health assessment checklist," she says.

• **Communicate with physicians.** Paramedics will reach out to primary care physicians, as needed. This might happen to get a medication adjusted or to notify the doctor that the patient never picked up the new prescription because of a transportation problem.

"Paramedics will pick up their medication and bring it back to them," Neidetcher says. "The important thing is to manage the patient's health at home."

• **Concluding cases.** "The program is for only 30 days. It's to prevent the 30-day readmission," she says. "Once we hit the 30-day post-discharge, the patient graduates from the program."

The health system tracks the graduation rate and readmission rate, but does not continue to connect with the patient, she adds. ■

Avoiding Costs, Risks Through Reduced Hospitalization Among Older Adults

There are many reasons for emergency clinicians to avoid hospitalizing patients when appropriate alternatives are available. Expenses can be reduced drastically, but so can the incidence of hospital-associated risks like central line-associated bloodstream infections (CLABSI) and methicillin-resistant *Staphylococcus aureus* (MRSA) infections. Furthermore, research shows older adults face even greater risks when they are hospitalized, including a heightened potential for falls, ulcers, adverse drug reactions, and functional as well as cognitive declines.

Consequently, while hospitalization is required in many cases involving older adults who present to the ED with acute care needs, interventions that can help facilitate the discharge of appropriate patients to the home setting may offer considerable value in both clinical and financial terms. In fact, new research involving three medical centers suggests that older patients seen by transitional care nurses with geriatric training are less likely to be admitted than similar patients who do not receive these specialized evaluations.[1] Investigators studied the care of more than 57,000 patients over the age of 65 years who presented to EDs at the participating sites between 2013 and 2015. Roughly 10% of these patients were seen by transitional care nurses, and these patients were, on average, 10% less likely to be admitted when compared with similar patients who were not evaluated by a transitional care nurse.

In other findings, researchers reported that at two of the three participating sites, inpatient admission rates remained lower during the 30 days following the ED visit for the patients who were seen by transitional care nurses in the ED and discharged to the home setting compared to similar patients who were not seen by transitional care nurses.

Consider Potential for Discharge

While further investigation is warranted to assess ED revisit rates among the patients seen by transitional care nurses, investigators noted that the study offers evidence that there is value in providing ED-based, geriatrics-focused care to older patients deemed at risk by clinicians. Further, the approach used by the participating medical centers in this study offers a roadmap for other EDs that consistently see a significant number of older adults.

Because of demographic changes in recent years, EDs are seeing a growing number of patients older than 65 years of age. The Emergency Care Research Institute notes that this population now accounts for 25% of all ED visits. In response to this trend, many hospitals have developed ED-based geriatrics initiatives or changes.

For instance, the three participating centers in this study (Mount Sinai Health System in New York, St. Joseph's Regional Medical Center in Paterson, NJ, and Northwestern Memorial Hospital in Chicago) follow the Geriatric Emergency Department Innovations in Care through Workforce, Informatics, and Structural Enhancements (GEDI WISE) model, an approach developed to address the unique healthcare challenges of this growing population of older adults.

A key part of the GEDI WISE model is the transitional care nurse, explains **Ula Hwang**, MD, MPH, the lead author of the study and an associate professor of emergency medicine, geriatrics, and palliative care at the Icahn School of Medicine at Mount Sinai.

"This is a nurse who is based in the ED and is focused on facilitating assessments and identifying patients who can benefit from care coordination that will [ease] their transition of care out of the ED, primarily with the goal of having them discharged ... hopefully back to home," she explains.

Transitional care nurses don't necessarily evaluate all older patients who present to the ED. Rather, these nurses focus on patients who potentially can be discharged, Hwang notes.

For instance, a patient who arrives at the ED in cardiac arrest and is intubated is going to be admitted, so a transitional care nurse will not see this patient. However, a patient who has been discharged from the hospital recently and has some ongoing chronic health concerns may benefit from seeing the transitional care nurse to determine what added steps or interventions can help this patient avoid a readmission. Hwang says that a typical case might involve a patient who presents to the ED complaining of dizziness.

"We know in the background that this patient recently had his diuretic medication changed, and perhaps the dosing is too high," she says. "The patient is in the ED with a nonspecific complaint of dizziness, he is not acutely ill, and he is not someone who needs to be resuscitated."

The transitional care nurse likely will assess the patient's functional status and cognitive function, and then ask about the patient's medications, Hwang observes.

"The nurse will then have a geriatric pharmacist review the patient's medications," she says. The pharmacist will identify that the patient's diuretic was hiked recently, and adjust the dosage.

"The transitional care nurse might now be able to reach out to the primary care provider [PCP] and explain that the patient is in the ED for dizziness and that [the pharmacist] is going to modify the patient's dosage so that his blood pressure does not drop dramatically, causing the dizziness," Hwang explains.

The nurse can arrange a follow-up appointment for the patient with his or her PCP so that there is a clear handoff and the patient's blood pressure and symptoms of dizziness are monitored appropriately.

"The nurse can also make sure that the medication is filled with the appropriate dosing before the patient is discharged," Hwang says.

The nurse will make a follow-up phone call to the patient later to make sure he or she is feeling better and answer any questions the patient may ask, Hwang adds. "Knowing how to facilitate all of this is an example of what a transitional care nurse could do," she says. "Maybe it is going to take a little bit longer in the ED because you are going to make all these calls to the [PCP] and coordinate the medication management, but you have also just saved the hospital money because you have avoided a hospital admission."

While the goal is to avoid an unnecessary hospital admission, the transitional care nurse also focuses on taking a more holistic view of the patient. "It's looking at their function [in terms of their ability to walk], their psychosocial elements, and what is going on with their social supports at home," Hwang says. "Understanding the bigger picture is what makes the geriatric transitional care nurse different from someone who might be looking at the transitions of care for someone with sickle cell anemia or younger patients who are homeless and have other types of social support needs that are very different from the older population."

Typically, a transitional care nurse will assess patients for cognitive function, delirium, agitation, functional status, fall risk, and any signs of caregiver strain. The results of these evaluations will guide what care coordination or support services may be needed so that the patient can be discharged safely. However, Hwang notes the three centers involved in the study have developed their own approaches for identifying

patients who require a transitional care nurse and for implementing the overall GEDI WISE model.

For instance, Mount Sinai and St. Joseph's have created distinct geriatric EDs, and Northwestern Memorial Hospital has elected to offer the GEDI WISE program components as part of the main ED.

"We don't have a specific space that is dedicated only to older adults, although we do have some rooms that are designed with older adults in mind," explains **Scott Dresden**, MD, MD, MS, FACEP, a co-author of the study and director of geriatric emergency department innovations in the department of emergency medicine at Northwestern Memorial.

Dresden notes the senior-friendly rooms feature doors instead of drapes, nonskid floors, and (generally) windows. "We try to get our older patients placed in those rooms as much as possible, but we use them for other patients as well, especially cancer patients," he says.

However, aside from this handful of rooms, the ED at Northwestern Memorial has focused primarily on providing senior-focused care through the transitional care nurses (referred to as GEDI nurses here) and a team consisting of an ED-based pharmacist, physical therapist, and social worker who are on hand to work with the GEDI nurses. "The GEDI nurses will go to the patients wherever they happen to be in the ED," Dresden notes. "They don't have to be in a designated space."

Establish a Baseline

What triggers the involvement of a GEDI nurse in a patient's care at Northwestern Memorial? Generally, an emergency physician or nurse will request a GEDI nurse when they raise concerns about an older patient and think that added evaluation would be helpful in optimizing the patient's care and eventual disposition. Dresden notes that a typical example might involve a patient who has multiple medical problems, takes several medications, and appears confused.

"The GEDI nurse will do a thorough evaluation, looking for delirium, dementia, fall risk, polypharmacy, and those sorts of things," he says. "They will do an overall, comprehensive evaluation and then work on trying to do the care coordination for whatever the patient needs, whether that involves the pharmacist in the ED, the physical therapist, or our social worker in coordination with primary care." In the early days of the GEDI WISE program, the ED used an instrument called the Identification of Seniors at Risk (ISAR) score to assess all older patients at triage to determine whether evaluation by a GEDI WISE nurse was warranted.

"That is still the recommendation of the Geriatric ED Guidelines that were published and endorsed by ACEP [American College of Emergency Physicians], ENA [Emergency Nurses Association], and the American Geriatrics Society, but we found that this screening was not very specific," Dresden says. "We had a lot of patients who would screen positive, but the nurses kept saying that [the screening] wasn't all that helpful."

Ultimately, what worked better was when a nurse or physician would call the GEDI nurse, specify the concern, and request an evaluation, Dresden notes.

"Those were the consults that helped the most, so after the funding we received through [a Medicare Health Care Innovation Award] ... ended, we modified the program very slightly, and removed the ISAR [screening] at triage," he says.

However, Dresden stresses that using the ISAR for a period helped establish a baseline for the types of patients who might benefit from further evaluation by a GEDI nurse.

"As we learned what [the GEDI WISE approach] can do and who it can help, it helped to change the culture in the ED," he says. "But after our nurses and physicians became more aware of the types of things that can put older patients at risk, we found that the screen itself wasn't all that helpful."

Northwestern Memorial has developed its own training program for GEDI nurses. Typically, these nurses spend time in a skilled nursing facility, assisted living environment, and a geriatric clinic; they also conduct rounds with a palliative care team, Dresden says.

"[Additionally], we have geriatricians, pharmacists, and social workers who give didactic sessions in a classroom setting, so there is a wide mix of classroom and experiential learning," he says. Dresden adds that one or two GEDI nurses are available in the ED at Northwestern Memorial between 8 a.m. and 10 p.m., Monday through Friday.

Training for transitional care nurses is delivered in a similar fashion at Mount Sinai, Hwang says.

"They have an orientation with regards to protocols and they have education modules [that focus on] communicating and working with older adults," she says. "At some of our other sites, there is a two- to three-week curriculum where [the nurses] rotate through outpatient geriatric clinical services just to see what it is like to work in an outpatient geriatric clinic, palliative care clinic, and, more specifically, to

get training on the assessments that are done."

Consult Guidelines

Dresden's advice to other EDs interested in improving care for older adults is to start by focusing on the Geriatric ED Guidelines. "It is a good list of how to improve care," he says. "The main thing is identifying patients who are at risk and identifying ways to [address] those risks."

This can occur in various ways, but it will require resources. "We found that emergency physicians and emergency nurses are overloaded with many tasks," Dresden advises. "I think if we had just said, 'Here are all these protocols that we are going to put in place for our bedside nurses and our emergency physicians,' I don't know that it would have been as successful as [our program] is, so having a separate team that comes along and works alongside [the physicians and nurses] really helps."

Another step that can be helpful is to work with colleagues who are exploring similar innovations. For instance, Dresden notes that Northwestern Memorial is part of the Geriatric Emergency Department Collaborative, a group that was established by the Hartford Foundation and West Health. "We are working with that group on disseminating models like this throughout the country," he adds.

Dresden explains that focusing on the care team rather than creating a designated space for the care of older adults may make implementing improvements in this area somewhat easier for many EDs. "It makes [the model] a lot more flexible," he says.

Hwang agrees that the focus should be on the care that is delivered, rather than the space. In fact, she notes that while Mount Sinai Hospital contains a designated 14- to 20-bed unit that is equipped with senior-friendly features, the geriatrics care team often sees patients in the main ED when the space is full. Also, there are times when the unit must be flexed into use for younger patients, too, which has been the case this winter.

"Especially with the flu, there has been a lot of crowding and boarding of patients in the ED, so the space has now been overrun by boarding patients," she says. Hwang reiterates that the designated space is not what makes the geriatric ED, but rather the assessments and care that address the needs of older adults — aspects that are evident throughout the main ED, too. "That is what really makes a geriatrics ED," she adds.

Repurpose Existing Resources

When taking this approach, hospitals should assess what resources they already have in place, Hwang advises. Some staff may be able to be repurposed to provide geriatrics care in a way that is effective and efficient.

"If your ED does not already have a social worker or access to transitional care services, maybe those services already exist in your hospital," she says. "[Look at how] the ED can bridge with those services and how the ED might leverage technicians."

Hwang notes that some Veterans Administration hospitals are using technicians to fulfill some of the assessments that transitional care nurses typically perform. For example, technicians might conduct a fall risk assessment in consultation with the emergency physician.

"It is taking into account that bigger picture of what is going to happen to the patient, whether they will be admitted or discharged," she says. "And that additional information about fall risk or their medications or their functional status can help facilitate transitions of care." Avoiding hospitalization is not just a money-saving exercise, Hwang stresses.

"People sometimes think if they are hospitalized it will be better for them, but it is actually not — especially in the case of older adults," she says, noting that older adults often become more frail following an inpatient discharge. "If a patient doesn't need to be hospitalized, then we should try to avoid it."

Now that it has been shown that transitional care nurses with geriatric training can reduce hospitalization among older adults who present to the ED, innovators are looking for additional ways to improve care to this patient population. For instance, at Northwestern Memorial, Dresden just implemented a universal screening program for delirium for all patients 65 years of age and older, and he is looking into developing a protocolized screening approach for elder abuse.

"These are major problems in EDs throughout the country — delirium and elder abuse," he says. "They are hard to find, so those are new areas we are looking to explore ... so that those patients aren't slipping through the cracks." ■

REFERENCE

1. Hwang U, Dresden SM, Rosenberg MS, et al. Geriatric emergency department innovations: Transitional care nurses and hospital use. *J Am Geriatr Soc* 2018 Jan 10. doi: 10.1111/jgs.15235. [Epub ahead of print].

Study: Diagnostic Accuracy Still Largest Claims Risk

Diagnosis-related events are the single largest root cause of medical professional liability claims, according to a recent analysis from Coverys, a medical malpractice insurer based in Boston. They account for 33% of medical professional liability claims and 47% of indemnity payments, the report says.

Coverys analyzed more than 10,500 closed medical liability claims from 2013 to 2017 to determine the root causes of diagnosis-related allegations. The analysis determined that testing is involved in more than half of all diagnosis-related malpractice claims. Testing issues, including failures in ordering, performing, receiving/transmitting, and interpreting test results, account for more than 50% of diagnosis-related claims.

Adverse events involving cancer were most prevalent, followed by infection, cardiac/vascular conditions, fracture/dislocation, and myocardial infarction.

Most diagnostic errors occur in outpatient settings, according to the report, with 24% of diagnosis-related claims taking place in the ED and urgent care facilities, but 35% of diagnostic errors occur in non-ED outpatient settings, such as physicians' offices or clinics. *(The full report is available online at: https://bit.ly/2qlmVtz.)*

The missed or delayed cancer diagnoses are largely acts of omission, which makes the claim particularly difficult to defend, notes **Robert Hanscom**, JD, vice president of business analytics with Coverys.

"They didn't make the diagnoses, so they don't even know anything is wrong until weeks or months later when they are served with a lawsuit. By then they don't remember the case well, if at all, and they don't know what the circumstances were or why they may not have made that diagnosis at that point," Hanscom says. "Despite all the systems we put in place for monitoring care and documenting what happens with a patient, there is a dearth of information about these missed or delayed cancer diagnoses."

The claims analysis shows the risk of physicians yielding to the pressure of a heavy workload by rushing the decision-making process, Hanscom says. Physicians must take the time to consider all the possibilities.

"We want providers to not get caught in traps where they shortcut the diagnostic process from the cognitive side. We know that time is very limited and everything is frenzied for the physicians, but they still need to be getting differential diagnoses," Hanscom says. "Even if they're pretty sure of a diagnosis, they need to always be asking what else could this be. In many of these cases, we see a narrow diagnostic focus in which they home in on what they think this is, and that becomes fact."

Even the best physicians can be derailed by poor processes, Hanscom says, such as an electronic medical record not showing the patient's entire history. Failure to follow up on test results also can result in inaccurate diagnoses, and patient referrals to other specialists may get lost in the system, he says.

Diagnosis errors are cropping up more in outpatient settings partly because more care is being provided on an outpatient basis, but Hanscom says there is more going on than simply a proportional increase in claims. Outpatient settings tend to have fewer risk management resources available, and that results in more claims, he says.

Radiology poses a challenge because there can be variability in how they read tests, Hanscom says. Providers should take steps to reduce that variability as much as possible, he says.

"Radiologists tend to write lengthy reports that are sometimes not clear. They may say there is something that looks kind of suspicious and should be followed up, but it's buried in there at paragraph four of page two," he says. "For the primary care physician to find that and figure out he should do something, that can be a real challenge. Radiology has put it in the report so they think they're covered, but if the physician doesn't recognize that something should be done, they both get named in the lawsuit. The plaintiff's attorney doesn't make a distinction over who is more responsible for the communication failure." ■

COMING IN FUTURE MONTHS

- A quick way to reduce ED visits
- With the ACA in flux, where does case management stand?
- Workers' comp continues to grapple with opioid epidemic
- Case management program reduces overall costs

CASE MANAGEMENT ADVISOR™

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CE QUESTIONS

1. **CHAMP, a Memphis, TN, pediatric asthma case management program, reduced inpatient admissions or observations by what percentage?**

   a. 24%
   b. 47%
   c. 71%
   d. 88%

2. **To be enrolled in CHAMP, children with asthma must meet certain criteria. Which of the following is one of the program's enrollment criteria?**

   a. Three or more ED or urgent care visits for an asthma-related event, within one year
   b. Two or more hospital admissions for asthma in the past year
   c. One or more ICU admissions within the past two years
   d. All of the above

3. **In the Memphis area, what is the No. 1 health-related reason why children miss school?**

   a. Influenza
   b. Asthma
   c. Measles
   d. Mononucleosis

4. **A case management program that uses mobile resources relies on paramedics to follow up with discharged patients who suffer chronic illnesses. How might paramedics assist with the program?**

   a. Paramedics check on these patients during lull periods of their daily ambulance runs.
   b. Paramedics handle 24/7 phone call lines for case managers during off hours.
   c. Paramedics contact patients within 24 to 48 hours of discharge, meeting them at their homes.
   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.