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INSIDE

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New Year Starts with Challenges of COVID-19 Vaccine Rollout

Case managers will need early access

By Melinda Young

Case management directors found themselves facing many questions and fewer answers as the new year ushered in a continuation of surges in the COVID-19 crisis. The good news was the early rollout of a possible solution: COVID-19 vaccines.

"There is some hope, and that hope is yet to be defined," says **Sandra Lowery**, RN-BC, CCM, president at CCMI Associates in Humboldt, AZ. CCMI Associates provides case management, consulting, and education services.

"It's going to be a bumpy road ahead, but hopefully, the vaccines will be effective," Lowery adds. "We see this glimmer of hope now, and that's the good news."

Healthcare sites, insurance companies, and other case management employees face various logistical and cultural obstacles to vaccinating their staff.

> "IT'S GOING TO BE A BUMPY ROAD AHEAD, BUT HOPEFULLY THE VACCINES WILL BE EFFECTIVE."

Below are some challenges case management leaders will need to address:

- **Access:** The first challenge will be to determine who will be included in the first phases of vaccination, which are expected to be in limited supply.

"Who is going to meet the criteria, and which healthcare workers are considered frontline workers?" Lowery asks. "Every state will have its own policies. As they get various amounts of vaccine given to them,

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they will have different policies, but everyone will have frontline workers at the top of the list."

Case managers who work in nursing homes, physician offices, and other ambulatory clinic settings might be considered frontline workers and receive vaccine access in the first or second phase. Case managers who work telephonically in other settings likely will not receive priority access, Lowery says.

Vaccine access also might depend on what case managers' employers decide to do about administering the vaccine. For instance, not all healthcare employers will want to mandate the vaccine for all staff.

"I think the organizations are going to require vaccination for those who have face-to-face contact with their patients," Lowery says.

For example, in workers' compensation, if case managers work directly with injured employees, their employers could require them to be vaccinated, she adds.

Many organizations already require an annual flu vaccine. Mandating a COVID-19 vaccine also may become a priority, Lowery says.

In some areas, there may be less supply than demand for the initial vaccine rollout. This could be true especially in rural areas because the first phases of the rollout will focus on centralized vaccination in more highly populated settings, says **Tinglong Dai**, PhD, associate professor of operations management and business analytics at Johns Hopkins University Carey Business School in Baltimore. Dai also is core faculty at Hopkins Business of Health Initiative.

"That's a wise use of resources," Dai says. "For small clinics, it will be very challenging for them to get vaccination."

Temperature and timing constraints may create opportunities for mistakes in handling the vaccine. This means case management departments might have to send their staff to a central location — possibly out of town and miles away — to be vaccinated.

"It would make sense for clinics to have a vaccine day," Dai notes.

• **Logistics:** State health departments and hospital systems are among the first sites that will receive the vaccine and staff available to administer the shots. But some pharmacies, ambulatory clinics and offices, and other locations might receive the vaccine.

Employers will need to determine where staff can be vaccinated and the process for getting on the

EXECUTIVE SUMMARY

As the COVID-19 vaccines are rolled out to U.S. healthcare organizations, there will be challenges in access, logistics, and maintaining infection prevention practices.

- The first step is determining which employees are eligible for the first phase of the vaccine rollout.
- Leaders will need to identify where staff can be vaccinated and which vaccine they will receive.
- Case management directors should emphasize the importance of continuing to follow COVID-19 prevention actions, including wearing masks, maintaining strict hand hygiene, and keeping away from group settings, until the pandemic ends.

appointment priority list. They also will need to know which vaccine will be available and whether the vaccine can be delivered to their facilities.

If a primary care clinic or long-term care facility receives the vaccine, staff will need to know how to store it. The Pfizer vaccine, which was the first to receive an emergency use authorization from the Food and Drug Administration, needs to be kept at ultra-cold temperatures (-70 C) requiring special freezers. However, Pfizer has built thermal containers that can be stored in a freezer or at room temperature to keep the vaccine cold for more than a week.[1]

Other logistical considerations include maintaining records of who has received the first dose of the vaccine and when the second dose of the same vaccine is due.

Accredited organizations need to refer to existing standards for the treatment of expired medications and vaccines, says **Frank Chapman**, MBA, chair of the standards development committee at the Accreditation Association for Ambulatory Health Care (AAAHC). Chapman is the director of strategic development and the former chief operating officer of Ohio Gastroenterology Group in Columbus.

For guidance on storage and handling of COVID-19 vaccines, organizations will need to refer to the Centers for Disease Control and Prevention, Chapman says.

• **Infection prevention:** "All safety protocols will need to remain in place for quite some time — even for staff members who have been prioritized for receiving vaccine," says **Eli Rosenberg**, PhD, associate professor in the department of epidemiology and biostatistics at the University at Albany School of Public Health, SUNY – The State University of New York in Rensselaer.

"You can imagine a staff member who has been vaccinated might feel more complacent and think, 'I can't transmit the virus.' We want to urge them to not have that complacency," Rosenberg says.

Healthcare professionals should not lower their guard because early data from the Pfizer vaccine do not show that it prevents asymptomatic transmission of the virus. Study results show people who are vaccinated have a 95% chance of not developing COVID-19 illness. But it doesn't provide evidence that the vaccine stops people from developing the virus at even a minor level that could be contagious to others.

Case managers should set an example for their patients: "If you're letting up in any protocols, unvaccinated patients will take that message and that example of their healthcare providers not taking COVID-19 seriously," Rosenberg says. "If we're letting up now on precautions, these can have untoward effects."

The vaccine rollout will take time, so staff should continue to follow infection prevention measures, Dai says.

"We're not on an island, so unless we're talking about the United States as a whole getting vaccinated, I don't think we should stop practicing social distancing, masking, hand hygiene, and all of those important practices," Dai says. "We have experts talking about how people should still wear masks and maintain some social distancing since we're not sure how effective the vaccines are to prevent infection."

One of the most difficult things leaders will need to do is to convince staff to maintain prevention vigilance, Lowery says.

After people become vaccinated, there will be a tendency to think they do not need to wear their mask at all times, she notes.

It will be difficult to maintain compliance with COVID-19 prevention activities. Leaders will need to provide staff with as much information as they can, and explain how the early vaccines have not proven they will stop asymptomatic transmission of the virus, Lowery explains.

"Case managers care about their patients, so you can make the point that they don't want to feel like they've harmed anyone in trying to help them," she adds.

"Then, it will be part of a major educational challenge to get everyone on board," Lowery continues. "It may come down to the employer's policy and someone saying, 'This is our policy, based on science, and here is the information we have about what we need to do to protect you and those you serve.'"

• **Options:** It might not be possible to vaccine the entire staff for several months because the expected first doses of the Pfizer and Moderna vaccines will cover less than half of the American populace.[2]

Case managers who work telephonically might have to wait until the vaccine is rolled out to the general public before they can receive it.

If case managers met with some patients in person before the pandemic, their organizations could lobby local public health officials to prioritize these staff for vaccination.

"If case managers are going to work face-to-face — in hospital, clinic, and home health settings — then they should be considered [for priority vaccination]," Lowery adds.

But if case managers plan to continue to work through televisits

until the pandemic ends, they might not be able to move up on the priority list, she says.

"Some government health departments don't know what case managers do," Lowery says. "They think of nurses, nurses' aides, physicians, and maybe lab techs, but do they think of case managers? It's kind of a newer thing, so case management leaders might need to advocate for their staff, plead the case." ■

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Help Case Managers Overcome Vaccine Hesitancy

Distrust can be nuanced, personal

By Melinda Young

Many Americans and healthcare workers have doubts and skepticism about the first vaccines for COVID-19, despite the need for a rapid end to the pandemic surge that began to overflow hospitals before the December holidays.

"The truth is that healthcare workers are not immune from vaccine hesitancy," says **Tinglong Dai**, PhD, associate professor of operations management and business analytics at Johns Hopkins University Carey Business School in Baltimore. "It's a phenomenon with real public health impacts."

In hospitals that have mandated a COVID-19 vaccine for all staff, it is a good idea to communicate to employees why they should be vaccinated, says **Amelia Burke-Garcia**, PhD, MA, program area director of digital strategy and outreach, public health, NORC at the University of Chicago.

"If you are forcing someone because of their job or role to get a vaccine, and you do not explain why this is important and why everyone in the same position has to be vaccinated, then there's a risk people will feel they are being pushed between their livelihoods and [concerns]," Burke-Garcia explains.

This approach is unfair and does not recognize the fear, grief, and loss employees have experienced, she adds.

Approaching a mandated vaccination program from a buy-in perspective can empower employees and reduce the risk of people taking a hard line against vaccination and leaving their position over it.

Dai and other healthcare professionals and vaccine researchers offer these suggestions for how leaders can help their staff become receptive to the vaccine:

• **Case management administrators can lead the way.** "Leaders need to set examples," Dai says. Vaccinating department or peer leaders in front of staff or showing photos of their vaccination on social media can inspire people: "That's brilliant messaging," Dai says. "We're all social animals, and we learn a lot of things by observing what other people do."

• **Understand vaccine hesitancy nuances.** "Vaccine hesitancy is nuanced and has a lot of different roots," says **Kate Strully**, PhD, MA, associate professor of sociology at the University at Albany, State University of New York. "It is context-specific. Interventions that are found to be the most effective tend to be multilevel and community-engaged."

This means the healthcare department takes a distribution plan and comes up with culturally appropriate information and outreach to staff, she says.

"You are understanding people's concerns and trying to come up with interventions that address those specific concerns," Strully says.

For instance, some staff may be concerned about new vaccines, especially those that are distributed through an emergency use authorization. They might have heard about historical medical abuses that disproportionately affected Black Americans or other groups, she explains.

Administrators can acknowledge and address these concerns by pointing out these COVID-19 vaccines were given to thousands of volunteers from all age, racial, and cultural backgrounds.

"Generally, there's a need for plain and transparent information about where things have been sped up [in research] and where they have gone according to normal procedures," Strully says. "Giving people information allows them to feel informed about the process that

has led to the current vaccine, as well as previous vaccines."

• Know and respect influencers. Researchers found that online influencers can affect people's attitudes toward vaccines. The study revealed that influential mothers with motherhood blogs can spread antivaccine messages on social media.[1]

"While some of the influencers felt resistant to outwardly talk about vaccines on their platform, they'd highlight these technologies [used by anti-vax groups]," says **Amy E. Leader**, DrPH, MPH, associate professor of population science and medical oncology, and associate professor of community integration at Sidney Kimmel Cancer Center, Thomas Jefferson University in Philadelphia. Leader is the first author of the vaccine hesitancy study.

"Anecdotal stories were very powerful," Leader says. "We noticed that sometimes they would tell a story about vaccination and call it their data."

If an influencer knew someone who experienced a negative physical reaction to a vaccine, that was enough to turn them against vaccination.

Among the 15 online influencer mothers who participated in the study, not one had a personal, proven, negative experience with vaccines, says Burke-Garcia. "Most heard stories from others, and that was compelling enough to them," she adds.

The influencers also used the Centers for Disease Control and Prevention database on vaccine injuries to back up their belief of vaccine injury. Those incidences were powerful to them, Leader says.

Case management leaders who understand how influencers come to their beliefs and how influencers can sway others in their beliefs can take actions that ensure staff compliance with vaccination policies, but also obtain their buy-in.

"There are multiple channels from a behavioral change communication perspective," Burke-Garcia says. "Clearly, there is an enforcement angle you can take with mandates and asking staff to show proof they had their COVID-19 vaccine."

However, another approach is for leaders to ask influencers and thought leaders among staff to become vaccinated and share the positive aspects of their experience with other employees, she adds.

"I don't think we can rely on just the effectiveness data around vaccines to compel people to get vaccinated," Burke-Garcia says. "It's going to take a number of actors at a number of levels to let people know it's safe and effective and also good for their community."

It will involve peer-to-peer work, especially when there are employees who express distrust or vaccine hesitancy, she adds.

• Address fears. "It comes down to crafting key messages," Burke-Garcia notes.

"I would take a health communication science approach to it, understanding what people's fears are and crafting messages to address those fears," she explains. "From a workplace safety perspective, help people understand why certain policies are being implemented."

Have conversations about their fears. Leaders need to be armed with messaging on why the vaccine is important. They should provide staff with information on efficacy and scientific safety data, but don't stop there, she adds.

"There is a lot of evidence that just providing data is not enough," Burke-Garcia says. "Allow people to be heard and give them space to express their emotions and their fears."

Then, leaders should respond with empathy and explain why the mandate is crucial, based on the population employees work with, she adds. ■

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Family Spirit Nurture Intervention Study Shows Benefits for the Little Ones

Coaches help problem-solve

By Melinda Young

In an obesity prevention program targeted to Native American mothers and infants, participants reduced consumption of sugar-sweetened beverages and improved responsive feeding habits, both of which can contribute to healthier infant weights.[1]

The authors of the Family Spirit Nurture program compared mothers who received a home-based, six-lesson curriculum targeting infant feeding practices with a control group of mothers who received an injury prevention education program. All participants were part of the Navajo community.[1]

Family Spirit Nurture is a home visiting intervention aimed at reducing early childhood obesity in Native American children. It is based on the Family Spirit program, which sought to improve the mental and physical well-being of mothers and young children, says **Summer Rosenstock**, PhD, assistant scientist at the Center for American Indian Health at Johns Hopkins Bloomberg School of Public Health in Baltimore.

The early intervention was distributed to 130 communities across 21 states, Rosenstock adds.

"The original Family Spirit intervention had been rigorously tested through randomized clinical trials and had been widely disseminated," she says.

Native American children record some of the highest obesity rates in the United States. Research suggests this problem can begin before birth, especially if the mother is obese or gains too much weight in pregnancy, she adds.

"We started to think about intergenerational cycle of obesity and where it was the right place to intervene," Rosenstock says. "Then, a lot of literature came out about the first 1,000 days and how this was an important point for intervention."

Early intervention is very important, especially for infants born to mothers who are obese or who have gestational diabetes. The interventions included educational sessions presented by family health coaches.

The clinical trial was developed based on these ideas, as well as the priorities of the Navajo community.

"The key to the study's success is this is an issue we identified as a priority by the community, and everything is developed in partnership with the community," Rosenstock says. "One example is that the family coaches incorporate cultural practices into the lessons."

Every part of the educational sessions was developed in partnership with the community, she adds.

"Given the evidence that was already there for a Family Spirit intervention and how well it was received, this seemed like a platform for an intervention," Rosenstock says. "Evidence is that pregnancy through the first 24 months of life is a critical time for an intervention to put children on a healthier growth trajectory to prevent obesity."

The Family Spirit Nurture intervention starts when the infant is 3 months of age and continues through the first six months of the baby's life. The researchers follow up with families through the first year.

"It's a relatively short intervention for that critical time," Rosenstock says. "The reason that time is so critical is because babies are changing really rapidly and growing rapidly."

The 45-minute educational sessions appeared to significantly affect sugar-sweetened beverage consumption, the mother's response to feeding, and the infant's growth trajectory.

EXECUTIVE SUMMARY

Researchers studying the Family Spirit Nurture intervention found that having family health coaches educate new mothers on healthy infant feeding practices led to positive results for the first year of the infants' lives.

- Each new mother received six-week educational curriculum about infant feeding practices.
- Early intervention is very important to prevent obesity in children.
- The clinical trial was based on the ideas and priorities of the Navajo community, which participated in the study.

The intervention group reported the infants consumed an average of 0.56 cups of sugar-sweetened beverages each week, compared to an average of 1.78 cups per week in the control group.

"The educational topics included the importance of healthy eating for the whole family and the parents' roles in feeding in early infancy," Rosenstock says. "The lessons also featured infancy personality traits related to responsive feeding, avoiding sugary drinks, and eating healthy foods."

For example, the lessons defined sugary drinks and helped mothers visualize the amount of sugar in the drinks they might give their babies.

"Drinks like juice or Gatorade that might be perceived to be good for hydration also fall into that the category of sugary beverages," Rosenstock says. "The recommendation is to just give water and milk to infants, and mostly it's just milk until they're a bit older. That's what we promote through Family Spirit Nurture and programs."

Family health coaches helped the mothers problem-solve barriers to success and build on their personal strengths. "I believe the family health coaches were the secret sauce to this intervention's success," Rosenstock says.

For example, some families lived in areas where it can be difficult to access a grocery store that sells fresh fruits and vegetables. Safe water also could be challenging for some families. As a result, following the healthy advice of the educational sessions could be challenging for some mothers.

When family coaches identified a problem, such as food insecurity, they would connect the mother to community resources, including transportation, she adds.

"About 35% of the mothers enrolled in this study reported they were water-insecure when they enrolled," Rosenstock says. "This is definitely an issue they are dealing with, and one of the things you worry about when water is not available is whether you substitute something for water."

Problems arise when parents substitute sugary drinks for water.

When the babies were between ages 6 and 9 months, all families in the intervention and control groups received water through the program, Rosenstock says.

"We did not analyze the data yet; it's the next piece we'll look at," she explains. "The idea was to try to see how much of an impact water insecurity has on sugary beverage consumption and infant growth."

Responsive feeding information was a big part of the educational piece of the intervention.

"It's the practice of responding to the baby's cues for hunger, but you don't use food to soothe the baby," Rosenstock says.

Family health coaches taught mothers how to find out whether the infant was fussing for a non-hunger reason, such as needing a diaper change.

"We found the intervention group had better responsive feeding practices through 9 months of age," Rosenstock says.

The infants in the intervention group recorded lower rates of standardized body mass index (zBMI) scores than infants in the control group, starting at six months postpartum.

"By 12 months of age, the infant zBMI score for the intervention was at the 73rd percentile," Rosenstock adds. "For the control group, the average was a zBMI score in the 86th percentile, which is above the 85th percentile — the threshold for categorizing children as overweight."

Ideally, researchers would follow up on the infants to see if there is a long-term effect of this intervention on obesity.

"We're hoping to submit for traditional funding to do that, and we're dependent on getting funding," Rosenstock says. "We're hoping to continue the research." ■

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Acute, Hospital-Level Care in the Home: A Glimpse of the Future

By Dorothy Brooks

The Mayo Clinic has unveiled an ambitious new model designed to deliver hospital-level acute care to patients whom program administrators determine can be cared for in their homes safely.

Called Advanced Care at Home (ACH), the model seems ideally timed to respond to the COVID-19 pandemic-related demand for more virtual care options. However, plans for the approach were set in motion in 2019, well before COVID-19 was identified, explains **Margaret Paulson**, DO, chief clinical officer for ACH in the Mayo Clinic's Northwest Wisconsin region.

"Dr. [Gianrico] Farrugia, MD, the president and chief executive officer of Mayo Clinic, and his team were planning out the 2030 vision of how they were going to care for our patients in the future, and this idea really rose to the top," she says. "In other systems, [hospital-at-home models] have been shown to improve outcomes and decrease costs, all while delivering high patient satisfaction. Certainly, at a time when patients are demanding more choices in their healthcare, there were a lot of great reasons why our executive leadership wanted to roll out the project."

Two Mayo Clinic sites were selected for the initial implementation of ACH: the health system's Jacksonville, FL, medical campus, which is a destination medical center, and Mayo Clinic's community specialty system in Northwest Wisconsin, which includes four critical access hospitals and a hub hospital in Eau Claire, WI.

Paulson notes the model went live in Jacksonville in July, and it began serving patients in Wisconsin in August. This gave emergency providers in both regions a fresh option to consider for some patients who meet the criteria for inpatient hospitalization.

Leverage Technology

A signature feature of the new model is that care for patients at both sites is driven out of a command center located on the Jacksonville campus. "This is a little bit of a nod back to the way that the Mayo brothers practiced 150 years ago where they would do house calls, going to [the homes of] their patients who were sick," Paulson says. "We can do that now pretty instantaneously with the power of technology."

To deliver this type of care, Mayo Clinic has partnered with Medically Home, a Boston-based technology company that specializes in innovations designed to help medical providers deliver advanced care in the home. This includes an integrated technology platform as well as a network of in-home services directed by Mayo Clinic providers.

The ACH program is focused on two patient groups, including what program administrators refer to as the "reduced length-of-stay" group and the "acute substitution" group. "Reduced LOS is basically where we identify patients who are already hospitalized and would be appropriate to continue their acute hospitalization in their homes," Paulson shares. "They no longer need any invasive procedures or testing. They are safe to go home, continue their acute hospitalization in the home, and then transition to a restorative phase."

Patients identified for acute substitution have been identified in the ED as requiring inpatient hospitalization. However, they are safe to receive their acute hospitalization level of care in their homes through the ACH model. "These patients end up in the ED, and then they go straight to their home for home hospitalization in that acute phase. Then, they transition to the restorative phase," Paulson explains. "It's nice for the patients because they never need to be hospitalized in a brick-and-mortar hospital."

Establish Criteria

Working a new option into the workflow and processes of the ED can be challenging. To head off any potential problems, the ED was involved early on in the planning for the ACH model. **Susan Cullinan**, MD, an emergency physician at the Mayo Clinic in Eau Claire, took a leading role in making sure the ACH option would be set up for success in the emergency environment.

"Early on, [Paulson] got my concerns and was willing to work with us," Cullinan notes. "She included me in the [planning] meetings, and I think that was very helpful so I could give feedback to our ED team as this was coming out and moving ahead. I would talk

about it at our monthly ED meetings so that people were aware."

One big issue involves determining which patients who present to the ED are good candidates for the ACH approach. Cullinan explains potential candidates include patients with a range of diagnoses, such as COPD, bronchitis, heart failure, deep vein thrombosis, pancreatitis, and pneumonia. In general, the program is designed for "sick but stable" patients. However, these need to be patients who meet the criteria for hospital admission. "There are two models in how we get these patients [in the ED]; a push and a pull is how we look at it," Cullinan says.

For example, under the pull model, the ACH medical team is monitoring all patients in the ED constantly to determine if any meet the criteria. When a potential candidate is identified from the ED tracking board, the ACH team will contact the emergency provider.

Conversely, under the push model, the emergency provider may identify a potential candidate. If so, the provider will initiate discussions with the ACH medical team. "The criteria can be met from their staff looking at our patients or our staff," Cullinan notes.

Identifying potential candidates for the program mostly is the responsibility of the ACH medical team. This likely will be the case until emergency physicians are more accustomed to the program. In fact, for now, an ACH representative is on site in the ED, and takes the lead on introducing the program to potential candidates.

The emergency provider will see the patient and explain that he or she needs to be admitted. The provider also will explain to the patient that someone from the ACH program is going to be speaking with them. Furthermore, the ACH program is presented as optional, which allows the patient to choose the program or pick a traditional inpatient admission.

Remove Barriers

While emergency providers always are consulted about potential ACH admissions, it is critical they are not asked to wade through any new processes or steps if a patient elects to receive their hospital-level care at home. "There is a discussion [between the ACH representative and the emergency provider], but I can tell you from the emergency provider standpoint it isn't any more work to go this route. It is actually probably less," Cullinan says. "It is as easy a practice as it is to admit a patient to the hospital, and I think that is the key thing. If you make the process more difficult, it is not going to happen."

When patients identified for ACH agree to this option, they are discharged from the ED, ending their workup in that setting. At this point, an ACH team takes over the patient's care. This team will arrange for an ambulance ride home and subsequent care. Paulson describes the patients admitted thus far to the ACH program from either the inpatient setting or the ED as requiring inpatient hospitalization, but not needing ICU-level care or advanced-level diagnostics or procedures. For instance, a patient with heart failure may need continued IV diuretics, or a patient may need IV antibiotics for their pneumonia or cellulitis. "Those are patients who can be safely cared for in the home," Paulson says.

Each ACH patient is equipped with a home kit that includes a blood pressure cuff, scale, and pulse oximetry monitor. "All of those things are Bluetooth-enabled ... so that we can get those vital signs pretty instantaneously," Paulson says.

However, Paulson stresses the program also relies heavily on providers going into the home, such as nurses, community paramedics, and advanced practice providers. "We can use the technology, but we also have people at the bedside if needed to help facilitate some of those very delicate times when we need a hands-on approach," she says.

EXECUTIVE SUMMARY

Emergency providers can provide hospital-level acute care to patients at home under Advanced Care at Home, a new program from the Mayo Clinic that leverages technology and in-person services. The approach has been introduced in Jacksonville, FL, and Eau Claire, WI.

- A signature feature is that care for patients at both the Wisconsin and Florida sites is driven out of a command center located on the Jacksonville campus.
- The program is focused on two groups: inpatients who can be discharged earlier, thereby reducing their length of stay, and patients who present to the ED and meet inpatient criteria, but can be safely cared for in their homes.
- Patients admitted to the program do not need ICU-level care or advanced-level diagnostics or procedures.
- Patient stays in the program tend to be prolonged, but providers aim to conserve resources by preventing the need for admission to a skilled nursing facility or a repeat hospital admission.

During the acute phase of a patient's admission to ACH, a nurse practitioner or physician assistant will visit the home on days one and three, although additional visits can be arranged as needed. "The nurses round virtually just as they would in the hospital, but they do that through the technology," Paulson explains. "If our patients are requiring IV medications, then our command center will help to determine whether they require a nurse for that, or perhaps a community paramedic."

Make Use of Extra Time

One particularly innovative aspect of the ACH model is each episode of care is prolonged. "We have the luxury of time. Our length of stay tends to be on the 30-day average rather than the four or five days a patient would typically spend in the hospital," Paulson says.

This period includes both a patient's acute phase and what Paulson refers to as the restorative phase. "This ... gives us time to help with strengthening, patient education, and with ensuring that the patient has become completely independent in their care, or as independent as they can be," she says.

Throughout an ACH episode a patient's primary care provider (PCP) is encouraged to be involved. Toward the end of the episode, ACH care managers will set up an appointment with the PCP before discharge.

"That gives the PCP a warm handoff so that [he or she] understands what has happened during the stay," Paulson says. "If the PCP feels comfortable, then we arrange for discharge [from ACH]. If there are things that still need to be worked on, then we can hold on to the patient a little longer."

With such long episodes of care in the ACH program, how does the program conserve resources?

"The patients who benefit most from this model are patients who are older, they are deconditioned, and they would ordinarily end up in a skilled nursing facility following their acute inpatient hospitalization," Paulson explains. "That is where we can save money, if we can prevent a skilled nursing facility admission or if we can prevent a readmission."

Paulson reiterates that patients in the ACH program have more time to recover while they are monitored closely for their care needs. "A lot of patients need that time," she says.

For example, Paulson notes that discharge from an inpatient hospitalization typically is a rushed time. Even though providers try to make sure patients receive all the education and follow-up appointments they need, many just feel overwhelmed.

"With this program, instead of giving patients a handout on what reducing their salt intake looks like, we can work with them," Paulson notes. "They invite us into their home, sometimes through video and sometimes in person, but we can work with them." During in-person visits, a clinician might inspect a patient's refrigerator or pantry to make sure someone with heart failure understands which foods he or she should avoid. "Through that educational period, we hope that readmissions to the hospital can be avoided," Paulson says.

Paulson acknowledges admission to the ACH program is limited to patients with certain types of insurance. "We are working with individual payers to try to create bundled agreements," she says.

While not all payers are on board with this approach yet, ACH is available to a large population of patients within an accountable care organization in the region. The health system is continually working to add additional payers to the mix so that more patients can access it.

Take It Slow

In the first three months of the ACH implementation in Wisconsin, roughly 18 patients were enrolled. "We have been intentionally slow because we learn a lot with every admission," Paulson observes. "There are a lot of things we can work on to make things better for the next patient."

While there are not enough data to report on outcomes or financial returns, the program has made some progress. "Patients have been overwhelmingly supportive of the model. They are really happy that they are not in the hospital and that they are not in a nursing home," Paulson shares. "Our first three patients cried because they were so happy they didn't have to be in the hospital and were able to go home."

ACH's first patient was a man who had been hospitalized 10 times in the previous 12 months for exacerbations of heart failure and COPD.

"When he got home and I was on a video visit with him, his two dogs, Skittles and Roosevelt, were by his side. He had a big smile on his face. He was just so happy to be in his home environment, able to sleep in his own bed, and have his family visit," Paulson reports.

The second patient enrolled had undergone spine surgery and needed a prolonged period of IV antibiotics.

"He was a gentleman who had been in the hospital a few times before and had become delirious. This hospitalization was no exception," Paulson notes. "He had his surgery,

did really well with that, but became delirious."

The patient's medical team looked at all the angles and found no other source of the delirium.

"This was someone who we identified could be safely cared for in the home. We talked with his surgeon as well as his family, and they were very excited about him going home."

Otherwise, the patient probably would have spent a few more days in the hospital before transferring to a facility 40 miles away. The family did not want to go through that. "When the patient got home, within a few hours his delirium resolved. It was just stunning," Paulson recalls. "He and his wife were over the moon about the program."

In the early days of the ACH program, the focus was on identifying hospitalized patients who could return home early, thereby shortening their LOS. Now, there is a growing focus on the acute substitution group — patients who are identified in the ED as meeting criteria for an inpatient admission, but can be safely cared for at home.

"We have had two patients so far from the ED that have been admitted [to the ACH program] with COPD, both of them in their 70s," Cullinan says. Further, she notes both patients and emergency providers seem comfortable with the option.

In fact, no patient has declined the option thus far. The emergency providers' program acceptance can be attributed in part to multiple simulation sessions. This helped staff understand how patients would be identified and admitted to the ACH program.

"The multiple sessions helped with different providers," Cullinan says. "We talked about it, too, with those providers who weren't actually available at the time [of these sessions]. But even if they weren't part of a simulation session, this is very easy ... because there are not a lot of extra things to do."

Including the ED in the early planning sessions and asking ACH administrators to strongly advocate for the program have been significant keys to the smooth implementation of this option in the emergency setting. In addition, Cullinan sees opportunities to further strengthen the program once the surge in COVID-19 patients eases.

"We have case managers in the ED who were pulled at one point to do more work in the hospital," she says. "But I think once we can get them back in the ED, they will be advocates, and they can help us look for [potential] ACH patients." ■

Telemental Health Survey: Increased Risk of Fraud

By Greg Freeman

The expansion of telehealth services brings more risk of fraud and a greater need for internal compliance programs, according to the 2020 Telemental Health Laws survey from Epstein Becker Green in Washington, DC.

In its fifth year examining state telemental health laws, regulations, and policies, the firm found the COVID-19 pandemic has put pressure on lawmakers to increase access to telemental health services, while also finding greater potential for fraud. *(The full report is available online at: https://bit.ly/32ijff5.)*

State laws are changing rapidly regarding the use of telehealth services, says **Amy Lerman**, JD, an attorney with Epstein Becker Green and the main author of the report. That increases the risk of noncompliance as organizations work with providers across state lines.

"Within many of the states, for instance, there are evolving approaches to remote subscribing. Tracking issues like that can be challenging to keep track of what your licensed professionals can do in that area," she says "We don't see as often that states remove these laws, with it being more common to provide positive guidance. But there are nuances, especially with mental health services. A mental health provider may need to follow more requirements and have more obligations than other providers."

Fraud is another concern as the use of telemental health services increase, Lerman says.

"The enforcement bodies are watching, so it more important now than ever to make sure you are doing everything in the right way. You need to know if you can do in Texas what you are doing in Pennsylvania," she says. ■

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CE QUESTIONS

1. **Why is it important for case management leaders to ask staff to maintain strict COVID-19 infection prevention practices, including wearing masks?**

   a. Only one out of 10 Americans will receive the vaccine before June 2021.
   b. The first vaccines to receive FDA approval were only 60% efficacious.
   c. Early data from the Pfizer vaccine trials showed that it largely prevents illness from COVID-19, but does not necessarily prevent asymptomatic transmission of the virus.
   d. Even if people are vaccinated against COVID-19, they could still be infected with influenza and other viruses, so stricter prevention measures are necessary.

2. **A study about online influencers and their views on vaccination showed the mothers participating in the study relied less on scientific vaccine data and more on what information to form their opinions on vaccines?**

   a. Technological information
   b. Personal experiences
   c. Peer information
   d. Anecdotal stories

3. **What was the key to success for a Family Spirit intervention that directed family health coaches to educate new parents about healthy feeding of infants?**

   a. Researchers carefully selected highly motivated families for the intervention.
   b. The study's success was due to researchers working closely with the targeted community and basing the intervention on the community's priorities.
   c. Researchers provided a $100 financial incentive to families that participated in the study.
   d. Family health coaches became personal friends with the families they worked with, even adopted as siblings in some cases.

4. **The Mayo Clinic's Advanced Care at Home program is focused on two groups of patients, including what program administrators refer to as the "reduced length-of-stay" group and the:**

   a. "reduced hospital visits" group.
   b. "mental health support" group.
   c. "rehabilitation services" group.
   d. "acute substitution" group.