



COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

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Nurse-Led Intervention Helps Patients with Parkinson’s Disease

Covers all areas affecting patients’ health

A care management intervention that focuses on coordinating care for people with Parkinson’s disease helped patients self-manage medication, follow up with specialists, and identify problems and topics important to patients.

The program included nurse care managers and self-care tools. It started with a task force of nurses, physicians, educators, and members of the Parkinson’s disease community, says **Karen Connor**, RN, PhD, MBA, health services researcher at the UCLA department of neurology.

The goal was to present stakeholders’ perceptions and study what affects patients. “They came to a consensus on 38 quality goals to reach,” Connor says.

The program included nurse care managers who attended orientation on the Care Coordination for Health Promotion and Activities in Parkinson’s Disease (CHAPS) intervention. Some care managers had experience caring for patients with Parkinson’s disease, and others had extensive care management experience.¹

“Some nurses were brand new to these sites and ideas, and took more time to feel confident,” Connor notes.

CHAPS started with an organizing framework for topics to be addressed and managed, says **Hilary Siebens**, MD,

principal with Siebens Patient Care Communication in Seal Beach, CA.

“There were gaps in communication and gaps in whole patient care,” Siebens

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explains. “This contributed to the fragmentation of care and care not being focused on the real issues that the patient and care partners were facing.”

Different Perspectives

CHAPS helps clinicians and care managers look at patients from different perspectives, making it more likely they will see the whole picture. “It covers all the areas that might be affecting the patient’s health,” Siebens says.

CHAPS drew its organizing framework from the Siebens Domain Management Model. Siebens developed it after years of working in internal medicine with a focus on geriatrics.

This model uses a framework of four domains in improving patient care:

- Medical/surgical issues;
- Mental status/emotions/coping;
- Physical function;
- Living environment.

“We looked at all the different problems, through these domains, that can occur with people with Parkinson’s disease,” Connor says.

Patient problems were divided into the four categories to simplify tasks for nurse care managers.

“Nurses are overwhelmed with doing so many things, so if you have buckets to concentrate on, it helps,” she explains.

For example, if care managers learn a patient struggles to buy enough food or pay the electric bill, these issues would be put into the living environment bucket. Fall risk is placed in the physical function bucket, and difficulty with swallowing or gastrointestinal issues would be in the medical/surgical domain. Patients with depressive symptoms and challenges in coping with their disease symptoms would fall into the mental status bucket.

Notebooks Engage Patients

Patients keep a notebook about their needs. Nurse care managers place information sheets in the notebooks and review these with patients. The notebooks build the patients’ confidence in their self-care, and patients feel more engaged. The notebooks are an effective communication tool that patients also can share with other providers.

“One patient said, ‘I had to go to the ED, and in my notebook, there was a medications and assessment summary,’” Connor says. “The nurse

EXECUTIVE SUMMARY

The Care Coordination for Health Promotion and Activities in Parkinson’s Disease (CHAPS) intervention provides patients with self-care tools and care coordination from nurse care managers.

- The program’s management model uses the four domains of medical, mental, physical function, and living environment.
- Results of a randomized clinical trial showed better adherence to many indicators of care management.
- CHAPS creates consistency in assessments and provides an individualized approach to patient care.

in the ED said, ‘Oh my gosh, I’m so glad you have this.’”

The notebook helps patients adhere to goals and improve secondary outcomes. Some patients will decline it, but care managers can ask caregivers or family members would like it. “You never want to toss anything out the window,” Connor says. “Maybe their daughter or son might be interested in using it.”

Notebooks are a simple, concrete way to give patients some confidence in their self-care. They also give healthcare providers a quick look at priority health issues. (*See story on the notebook self-care tool in this issue.*)

“In our randomized clinical trial of the nurse-led intervention, we had better adherence to many of the 18 indicators that had to do with care management,” Connor says. “There was no increase in depressive symptoms in the intervention group, but there was an increase in depressive symptoms in the usual care group.”

Nurse care managers receive support through regular meeting with a Parkinson’s disease specialist. They also maintain evidence-based and empirical protocols for each of the patient’s problems identified in the assessment.

The assessment contains algorithms and a tracking tool. “Nurses found the CHAPS assessment was helpful,” Connor says. “They put in the patient’s answers and get a list of problems, activated by these algorithms.”

It creates consistency in assessments and provides an individualized approach to patient care. “Nurses say to patients, ‘Because of the way you answered these questions, here are the problems that came up, so let’s talk about them,’” Connor explains. “They ask, ‘Which one is more important to you? Is there one that’s

important to you that’s not on that list?’”

Care managers and patients decide which issues to work on first. “Their function is getting worse, so let’s work on that problem,” Connor says. “We decide what to work on, and that individualizes the care.”

The goal is to develop a holistic picture of the patient and deliver care suggested by that picture. “It’s not prescriptive,” she says. “When you do care management, you’re not telling the person what to do.”

Care managers keep in mind the patient is in control. Their role is to engage patients in designing their own care, guided by the nurse’s expertise. The care managers follow the physician’s treatment plan.

Huddles Are Crucial

“One more component of CHAPS, which is critical, is the routine clinical huddles at least monthly between the nurse care managers and the neurologist or Parkinson’s specialist,” Siebens says. “Problem-solving between them can occur on specific issues that arise.” Therefore, care managers might want to bring this project to the attention of Parkinson’s disease specialists/ neurologists with whom they work.

This care management approach has worked for other populations, such as people with dementia, but it is particularly useful in managing people with neurological degenerative disease like Parkinson’s disease, Connor notes. For example, CHAPS includes a problem/topic intervention protocol that lists the nurse care manager’s steps in one column, and examples of questions and actions in another column.²

Here are sample items under mediations:

- **Assess further:**

- What is your routine for taking medications?

- How do you remember to take your medications? (alarm, watch, clock)

- NOTE: Compare to electronic medical record.

- **Provide information:**

- Teach the importance of a medication routine (e.g., put dose next to toothbrush). “Same time every time.”

- Recommend taking medications when “on.”

- Use notebook to provide information.

For a clinical trial, there has to be an endpoint to the intervention, but in the real world, the care management may continue indefinitely.

Follow-up is important in the beginning of the intervention, Connor says. After meeting with patients, giving them a notebook, and showing them how to use it, the care manager and patients can decide together when they would next meet. Follow-ups could be set at six months, with a reassessment performed annually. The reassessment is an abbreviated version of the initial assessment.

“You don’t have to ask every single thing,” Connor says. “You summarize and go over it, looking at the person holistically.”

Care managers expect it might take several phone calls to reach patients for a follow-up. The calls should be kept as brief as the patient needs.

“Let patients work with you to decide how this works best,” she says. “Some people may need two or three phone calls for 15 minutes every week or month. Some people will have a good understanding of their disease.”

With long-term degenerative diseases, the patient's medical condition does not change rapidly. This is why a holistic approach is helpful.

"Care management is proactive, long-term, and it has the self-management tool, so it could be you're only contacting the person once

or twice a year," Connor adds. ■

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Self-Care Notebook for Patients Improves Care Navigation

Tool helps patients inform providers

A care management program gives patients a notebook with simple sections and easily accessible information about the patient's health. It is an efficient way to help patients improve their care management.

The Care Coordination for Health Promotion and Activities in Parkinson's Disease (CHAPS) intervention uses the Siebens Domain Management Model's four domains for improving patient care, including medical/surgical issues, mental status/emotions/coping, physical function, and living environment.

The notebook incorporates those domains and framework, but it uses

simple language — not technical language, says **Hilary Siebens**, MD, principal with Siebens Patient Care Communication in Seal Beach, CA.

Health literacy experts helped craft the notebook's language. It is a three-ring binder in which patients and healthcare professionals can insert and remove information.

"The notebook has been researched in other projects, including for women with breast cancer, and this is the first project for which it is issued in Parkinson's disease," Siebens says. "The notebook has the same four buckets in plain English with a simple organizing structure. The feedback we got from nurses was this framework was user-friendly, patient-

centered, and organized. That's what care managers need."

For example, the notebook's sections include:

- **Section 1 (The Body):** Health issues;
- **Section 2 (The Mind):** Taking care of your mind and feelings;
- **Section 3 (Activities):** What you do;
- **Section 4 (Surroundings):** Where you live and work.¹

Each section is divided into subcategories within that domain. For example, these are the subcategories under Surroundings:

- Home;
- Family and friends;
- Caregivers;
- Money concerns;
- Community resources.¹

Additional sections in the notebook are for important information, including phone numbers, business cards, lists of visits, and a section for the doctor.

Researchers studying CHAPS found participants said the notebook was helpful, informative, and useful as a tool for organizing information. They also reported liking the education sheets, medication list,

EXECUTIVE SUMMARY

A care coordination notebook provides a useful tool for patients, their caregivers, and providers.

- Care coordinators and providers place information in the notebooks about how patients can improve self-care and learn more about the disease and symptoms.
- The notebook uses the Siebens Domain Management Model's four domains for improving patient care.
- The notebook is presented in plain language, with a simple organizing structure.

section organization, and the doctor visit sheet the most. Of the one out of five participants who deferred review of the notebook, their primary reason was they did not have time for it.¹

The notebook includes a plastic business card holder for patients to collect the cards they receive from their healthcare providers. “It’s so helpful,” Siebens says. “I used the notebook when I took care of my mother, who had dementia. It was valuable to me to have all the essential information in one place.”

Care managers can help patients personalize the notebook by including educational sheets based on what the patient wants to address. The program

created educational sheets for each of 31 potential problems that are common to people with Parkinson’s disease.

The CHAPS program, with the notebook tool, provides a standardized approach to patient care. It could be applicable to patients with different diseases and conditions. “Self-care tools like the notebook really help care managers educate and help patients and their families,” Siebens says.

The notebook of the patient’s medical and other issues also is helpful to healthcare providers, especially in the emergency department (ED).

“A lot of people are using electronic systems, having health information on their phone and portals to electronic health records, which is all great,” Siebens says. “Some people like having a notebook to grab off the shelf and to take with them, quickly, to the ED.” ■

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A Care Path Program Helps with COVID-19 Case Management

A coordinated care approach to treating patients with COVID-19, including workers’ compensation cases, can provide patient-centric healthcare that is efficient and effective.

“Our care path program provides either a patient-centric model or an event-based model that helps bring in a care coordination aspect, following a diagnosis or tied to an event,” says **Linda Colsen**, vice president of customer service with One Call in Jacksonville, FL. One Call provides

workers’ compensation services. “Our primary focus is in post-discharge recovery. It’s focused on coordinated care after their discharge.”

For example, a person might undergo surgery related to an injury. After surgery, the person may need durable medical equipment, home healthcare, physical therapy, and — if the person speaks a language other than English — language services.

“Coordination has to take place in a finite period,” Colsen says. “People need a lot of products and services.

The goal is to bring them together in a coordinated approach.”

The care path model includes pullout pathways, such as the respiratory pathway. This originated with coal miners and people who experienced silica illnesses and deaths, she says.

“Because COVID started out as primarily a respiratory illness, we looked at the care path to see what we could do to help people recover faster and return to health,” Colsen explains. “There was so much we didn’t know about COVID. There were not specific procedures and care plans.”

The public holds some misconceptions about COVID-19 because of the invisibility of patients’ long-term debilities from the disease.

“One piece that has fed into a lot of misperceptions is what you see on the news of a person in the hospital and in the ICU and on the ventilator for six weeks, and now they’re getting

EXECUTIVE SUMMARY

A patient-centric care coordination model is needed to help patients with COVID-19 after they are discharged from the hospital.

- The program brings durable medical equipment, case management, and services to patients with symptoms that continue after discharge.
- Many people become long-haulers after contracting COVID-19.
- Many COVID-19 patients with long-term health issues were not hospitalized and experienced only mild to moderate illness.

discharged,” Colsen says. “There are two lines of hospital workers cheering as the person is wheeled out of the door.”

But the COVID-19 story does not stop there. “If you’re in the hospital for weeks and weeks, you have issues with your strength, the diet restrictions are different, and you need a lot of things,” Colsen explains. “People are not wheeled out of the hospital today and then back to life tomorrow.”

Instead, many people became long-haulers, people who continued to suffer physical and psychological problems for weeks or months after they were discharged.

“We believe it is important to treat the whole person so they can get back to work,” Colsen says. “There are long-haulers, and medical professionals need to know why they are still having issues with brain fog and why they can’t go back to being their fully functioning selves.”

Many people who suffered from COVID-19 had done nothing more dangerous than go to work each day and, suddenly, they lose four weeks or more of their lives in the hospital. “As we learn more about the virus and subsequent complications, things are going to change,” Colsen adds. “We’ll be able to adapt to those changes and recognize that the person is trying to get better and needs assistance.”

They devised a model that would help people recover and also provide savings to payers. “The model was based on COVID cases,” Colsen says. “But if we take the COVID diagnosis out of the picture, I believe the patient-centric care coordination approach is better for families because people get the help they need.”

This approach provides case management help in an efficient and

evidence-based way. “We partnered with [a company] that does outcomes research, and they looked at Medicare data because it’s widely available for those patients with a COVID diagnosis,” Colsen says. “They started looking at their complications and other symptoms.”

For example, blood clots are a common complication for people with COVID-19. “It could be a blood clot in the lungs, or it could cause stroke,” she says. “All sorts of bad stuff could happen.”

“THERE ARE LONG-HAULERS, AND MEDICAL PROFESSIONALS NEED TO KNOW WHY THEY CAN’T GO BACK TO BEING THEIR FULLY FUNCTIONING SELVES.”

The idea was to look at the various COVID-19 complications, collect data, and determine the frequency and duration of each. They also studied how long it took for patients to recover, and made comparisons of the care path vs. general care among a Medicare population. The research revealed a coordinated care approach could save \$6 million among 1,000 patients. This was based on illness severity reporting by the Centers for Disease Control and Prevention (CDC), which showed unmanaged costs as potentially \$21 million. This is based on unpublished data Colsen shared with *Case Management Advisor*.

“Using CDC-published severity

percentages, 81% had mild to moderate illness, and 14% were severely ill and were admitted to the hospital. Five percent were in the ICU with multisystem organ failure,” Colsen says. “They had cardiac, vascular, gastrointestinal, neurological, organ, respiratory, musculoskeletal, and other complications.”

The study also showed coordinated care shortens the length of skilled nursing facility stays by an average of 9.5 days, with an additional cost savings of about \$10,000 per patient. The One Call data conclude payers and employers could save between 31% and 53% when applying a coordinated approach to care with network pricing.

“We looked at illness severity among people in the ICU after severe events or being critically ill,” Colsen says. “We looked at what they needed and for how long.”

There is a larger population of COVID-19 patients who are not hospitalized, but have mild to moderate illness. “We looked at what products and services they needed, and compared how the model looked in terms of utilization,” she explains. “The coordinated clinical management approach drives clinical savings.”

One of the coordinated care techniques that helped drive significant clinical savings was monitoring patients. Physical therapy is one example.

“When patients receive physical therapy, we actively monitor their utilization and recovery plan,” she says. “Once they reach their rehabilitation goals, they don’t continue with physical therapy.”

Also, if patients are not progressing, there are triggers in the system to bring about a peer review and discussion with the physical therapist. ■

Teletriage Applications Help EDs Improve Efficiency, Respond to COVID-19 Pandemic

A virtual intake process has helped many providers handle the multiple priorities involved with caring for a surging number of patients with a highly infectious disease while keeping staff and other patients safe.

As the demand for virtual care has accelerated, teletriage has melded well with other telemedicine innovations that may permanently change many of the ways in which emergency care is delivered. Some early adopters explain what pushed them out of the gate early, how teletriage has helped them manage the challenges posed by COVID-19, and how they see the approach evolving.

Eliminate Downtime

Milwaukee-based Aurora Health Care turned to teletriage in 2016 when leaders there realized it could provide a big boost to efficiency in the way the health system leveraged the provider-in-triage (PIT) model in its multiple EDs.

Under the PIT approach, an advanced practice clinician (APC) is stationed at triage with a nurse. They start ordering labs and imaging for patients while those patients are

waiting to see an emergency provider overseeing care. However, placing one APC at every site was not that efficient, according to **Paul Coogan**, MD, president of emergency services at Aurora.

By implementing teletriage, health leaders theorized one provider operating from a remote location could perform the PIT function for multiple EDs, thereby eliminating the need for onsite APCs and all the downtime. Although teletriage can be implemented in several ways, Aurora elected to work with the virtual platform developed by Brookfield, WI-based EmOpti.

After a patient checks in to the ED, he or she will be downloaded automatically into the teletriage system, explains **Christopher Ellingsen**, PA-C, the lead APC for Aurora's teletriage team.

"When it is their turn to be triaged, they will come into a triage booth, the nurse will do their vitals and get their story, and the nurse will then enter that information into the electronic medical record [EMR] chart," he says. "Then, the nurse will request a consult with [the teletriage provider] through the EmOpti software." (*For more information on*

the teletriage program, visit: <http://bit.ly/2K9PIDU>.)

Typically, the encounter with the teletriage provider will last for about 90 seconds. If any tests are ordered, those can start while the patient waits for the emergency provider. When the process works well, many tests are completed before the emergency provider arrives, according to Ellingsen.

Coogan notes the time-to-discharge for patients is 20% to 25% shorter when they have undergone a teletriage consult. "That only makes sense because half of their labs are done by the time the physician or APC in the ED sees the patient," he offers.

Teletriage also is associated with a significant improvement in door-to-doc times. For instance, in the ED at Aurora Sinai Medical Center in Milwaukee, that time averaged an hour or longer before teletriage implementation. Now, that time is closer to 10 minutes because the patient encounters the remote teletriage provider on the front end of the ED visit.

Patients suffering from stroke, heart attack, or other conditions requiring immediate attention will



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bypass teletriage and go to the ED for immediate care. However, there are some low-acuity circumstances in which patients can be managed and discharged based solely on the encounter with the teletriage clinician. This is a scenario that has proven particularly useful in the context of the COVID-19 pandemic.

Generally, the tactic is used only for a few patients per day, but it does deliver benefits in terms of patient and clinician safety. “It decreases the amount of PPE that we need to use ... and it also decompresses the waiting room, allowing us to see the patients that need us most in the ED, those who are most acutely ill,” Ellingsen says.

Patients directly discharged from triage following their encounters with a remote clinician might be younger individuals with no comorbidities and stable vital signs. This group might include patients who have been exposed to someone with COVID-19 and need to be tested. “They are not hypoxic, they do not have tachycardia, and they are not febrile,” Ellingsen notes. “Certainly, they are not our elderly patients, patients who require oxygen, or those with significant medical histories.”

Identify Champions

Remote teletriage providers tend not to write anything in the EMR other than orders because that hampers efficiency. “The patients understand their interaction with [the remote provider] is just a quick screening exam, and that they will eventually be seen by one of our onsite providers,” Coogan explains. “The physician assistant or nurse practitioner who is working ...

can do 15 to 20 consults an hour, frequently covering five [ED] sites.”

For the most part, patients have been receptive to teletriage, and providers immediately saw value in the approach. “There is a lot of wasted time in medicine and in the ED,” Coogan notes. “Any time you can get things going on patients while they are waiting for their ultimate destination helps to improve the workflow.”

There were some initial concerns from nurses that teletriage might slow the process. Coogan explains that while nurses may spend an extra 60 to 90 seconds in triage, there are 20 to 30 extra minutes saved in overall LOS downstream.

“It can be perceived initially as a challenge to nurse autonomy, but once they see the process going, nurses have realized that it is actually championing their autonomy,” Ellingsen says. “Our nursing staff ... are really in control of this process, and I think they are the most important players.”

Aurora uses teletriage at five EDs between 10 a.m. and 8 p.m., the busiest period. In addition, the system uses the platform with the 15% to 20% of patients who arrive by ambulance. Each ED uses “free-roaming ED,” or “Fred,” which is essentially the teletriage platform in portable form. This tool can be transported easily, allowing patients to interact with a remote provider even while they are traveling from an ambulance gurney to a regular bed.

Aurora leaders are thinking about how they can leverage teletriage in even more ways. One idea is to use it for discharging patients at short-staffed sites. For example, there may be only one physician physically present — and he or she is busy sewing a complex laceration on one patient while many others are

waiting for final instructions before going home. Coogan suggests these waiting patients could interact with a remote clinician through a mobile teletriage tool, receive their needed information, and leave without waiting so long.

Coogan says EDs struggling with boarding, patient flow, long waits, or patient satisfaction might want to consider teletriage. The platform could work well for sites thinking about adding staff but are unsure if there is enough volume to pay for extra personnel.

“It is not a cure-all for all of your problems, but it is a way to address the front end of the process of patient arrival and getting things started,” he says.

Philadelphia-based Jefferson Health’s journey toward teletriage began as part of an effort to reduce the leave-without-being-seen (LWBS) rate in one of its EDs. First, the health system implemented the PIT model, which made a sizable difference. The LWBS rate declined from about 5% to less than 1%. Door-to-provider times shortened from an hour or more to between nine and 14 minutes, explains **Judd Hollander**, MD, senior vice president for healthcare delivery innovation and the vice chair for finance and healthcare enterprises in the department of emergency medicine at Thomas Jefferson University.

Then, in a different ED, Jefferson started experimenting with teletriage between 11 a.m. and 6 p.m. “We picked those seven hours for practical reasons because we had a provider who could double-dip, doing two duties at the same time,” Hollander explains. The approach proved successful, reducing the LWBS rate from about 3% to 1% in that ED.

At this point, it occurred to Jefferson leaders that one remote

clinician could be handling the PIT role for the EDs at both hospitals: Thomas Jefferson University Hospital and Methodist Hospital. Administrators expanded teletriage hours to cover most of the day. The approach has delivered significant dividends in terms of efficiency.

“We see as many as 235 people through a single provider during the 16 to 18 hours we are covering [with teletriage], depending on the day of the week,” Hollander reports. Overall, teletriage kept the LWBS rate in the 1% or less range at both EDs.

Clarify the Role

Be clear about what the role of the remote teletriage provider is. “I don’t need to know what is wrong with the patient in teletriage. It may be pneumonia, bronchitis, or asthma. Once I decide the patient needs an X-ray, I am done,” Hollander says. “The patient can then go to X-ray or I can give him a nebulizer, but I don’t need to do a complete history and a complete exam.”

Hollander adds teletriage providers do not really need any high-tech instruments to fulfill their

role. In fact, when teletriage was implemented, he notes there was a remote stethoscope available to the remote clinicians, but providers barely touched it. “We used it eight times in the first 10,000 patients,” Hollander says.

In the few cases for which more information might be helpful to the remote clinician, the in-person nurse or the tech who is with the patient during the teletriage encounter is on hand to listen to the lungs or perform any other assessments.

The teletriage process has helped frontline providers manage the demands of the COVID-19 pandemic, but they did make some adjustments. “We were able to take the teleintake process and put it out in front of the ED,” Hollander explains. That helps minimize in-person contact for both screening and testing while also preserving PPE supplies.

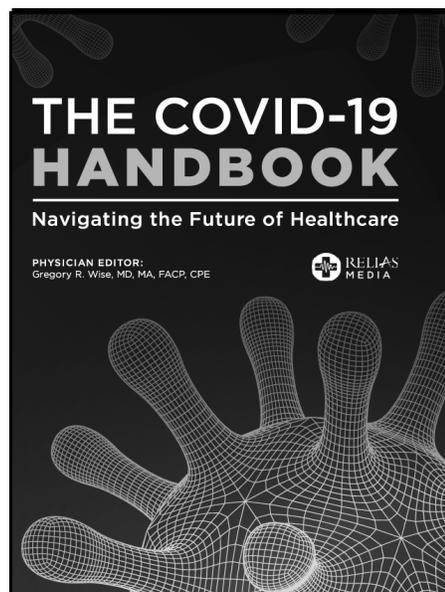
The teletriage function also has fit in well with some other telemedicine initiatives Jefferson has deployed. For instance, ED staff have placed tablets in patient rooms to facilitate communications while minimizing clinician exposure. “We have decreased the amount of in-room visits

to our COVID-19-positive patients and our patients under investigation. We have [also] leveraged those tablets to do face-to-face consults with other services as well,” Hollander says. “We have a very low infection rate [among staff], and I think part of that is related to these [techniques].”

Another innovation is “Just Connect,” an on-demand app that enables anyone in the Jefferson region to visit with an emergency provider at any time of the day or night. Hollander notes the health system has leveraged clinicians who are quarantining but are well enough to take calls through this service.

To launch an effective teletriage process, EDs need a secure platform, reasonably clear video, software that can queue patients, and an ability to integrate the process into the EMR. Hollander acknowledges these features can be costly.

“I think [you need] to figure out what the institution’s needs are, and balance them with the fact that healthcare is having a lot of financial issues right now,” he says. “The trick is going to be [determining] how we can provide better virtual technology in a way that is money-saving for everybody.” ■



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Hospital Cuts COPD Readmission Rates with Bundle Checklist

The development of a bundle checklist for patients with chronic obstructive pulmonary disease (COPD) has helped a Maryland hospital sharply reduce its readmission rates for these patients. Overall care quality improved for these patients while admitted.

The effort was spurred by a hospitalwide effort to improve processes and identify gaps in care, says **Vanessa Piñeiro**, BA, RRT-NPS, RRT-ACCS, manager of respiratory care services, PFT Lab & EEG at Adventist HealthCare Shady Grove Medical Center in Rockville, MD.

“Our chronic obstructive pulmonary disease patients were readmitted at a very high rate, sometimes as high as 30%. Of course, the hospital is not reimbursed if you are readmitted for something that was not adequately treated during admission, so that had a big impact on the hospital overall,” Piñeiro reports. “We respiratory therapists looked at that and thought there must be ways we can improve those rates.”

Task Force Studies Processes

At that time, the hospital’s COPD readmission average rate was 16.09%, an all-time high for the facility. Reimbursement for hospitals in Maryland was determined in part by the state’s Health Services Cost Review Commission. COPD readmission rates higher than 10.8% resulted in a penalty.

The penalty, in addition to the other negative effects of readmission,

inspired the hospital to set a target goal of 10.7%, and a stretch goal of 10.2%, Piñeiro explains. The hospital would surpass both goals within a year.

The hospital established a task force that met monthly to study processes, people, and how the hospital’s electronic medical record (EMR) affected readmissions or could be used to reduce them. In addition, respiratory care specialists studied the patient education process at discharge to look for possible improvements.

Others contributing to the project were the medical director of pulmonary services, case management professionals, discharge nurses, hospitalists, and home health nurses. The informatics department assisted with data collection and analysis. “One of the first things we did was to flag the patients who were diagnosed with COPD and who were readmitted. We looked at each case, tried to peel the onion and see why these patients were readmitted to the hospital,” Piñeiro says. “We actually did a small case study of about 28 patients and monitored them for readmissions for about three or four months. We ... [tried] to identify gaps in care and potential reasons for readmission.”

In some cases, the task force found the patients were readmitted for a comorbidity. Many COPD patients experience comorbidities such as diabetes, high blood pressure, and uncontrolled infections.

“Once we identified why these patients were coming back to the hospital, we tried to identify what we as respiratory therapists can control. We don’t treat them for

diabetes, but from a respiratory viewpoint we wanted to identify all the points of care that might be improved,” Piñeiro says. “There were multiple factors related to the readmissions, but we wanted to see what we could influence as respiratory therapists.”

Piñeiro and task force members from several departments used the Lean Six Sigma approach to tackle the problem, including the DMAIC methodology, which stands for Define (the problem), Measure (the gaps in the problem), Analyze (the problem), Improve (the problem), and Control (how do we maintain the process).

That prompted a wider investigation into how the hospital could address issues such as comorbidities and noncompliance with COPD patients.

For example, some COPD patients continued to smoke. Other patients would feel worse after they returned home, in part because they did not comply with instructions for medication and monitoring. This could lead to a trip to the emergency department.

“From the time they came in the door, we had to educate them on the things that would make their treatment successful and avoid coming back,” Piñeiro says. “That meant educating them on their medications, whether they knew what the medications were for and how to use them. A lot of these patients knew what COPD was, but never really understood the medications and why their conditions had to be carefully monitored, even after they went home.”

The task force created a COPD bundle, addressing issues such as the signs and symptoms of infection, education, inhaler management, and smoking cessation. A new patient education plan was integrated into the EMR. “It was a huge undertaking to revise the education process, and that took about six months,” Piñero says. “But immediately after we implemented that education, we saw a dramatic drop in readmissions.”

Many Touchpoints for Patients

A significant revelation for the task force was understanding how many touchpoints were involved with a COPD patient. A single patient might be treated by a physician for diabetes, an infection specialist, a respiratory therapist, and others.

“None of us were really collaborating. We all worked in our own little silos,” Piñero says. “The patient heard different things from different providers, and that left the patient overwhelmed and a little lost.”

To help clinicians implement the COPD bundle, the task force created a “swim lane” process map that shows the various roles involved with the bundle so each clinician could clearly see what he or she was responsible for completing with the patient.

The Shady Grove facility also collaborated with an Adventist team that was working systemwide to improve aftercare for COPD patients at home, helping ensure the education provided to COPD patients in the hospital was consistent with and reinforced by the education provided at home.

Sharp Reduction in Readmissions

After the plan was implemented, the COPD readmission rate decreased from an average rate of 16.09% in 2017 to an average rate of 14.62% in early 2018. By June 2018, the rate was down to 9.54%, surpassing the hospital’s stretch goal.

Those results have been sustained since then, and the COPD task force still meets monthly. New staff are onboarded to the bundle, and Shady Grove is working with other Adventist hospitals interested in adopting the same approach.

“We’ve been under 10% for two and half years. We have never gone back up to 30%,” Piñero says. “The task force and all the others involved in the care of these patients feel like we’ve made a real difference for them. When a patient does come back now, we are very interested in looking back at their experience and trying to see if there was a gap in care that could have prevented that readmission.”

Piñero says she and her fellow task force members did not realize the enormity of the problem until they were deep into the analysis of COPD readmissions.

“That’s when we realized we needed collaborations with the nurses, discharge nurses, home

health, so many people,” she says. “If you think you can do this by yourself and you don’t need anybody, you’re very mistaken. When you’re implementing an idea, it’s very important that you have all the stakeholders at the table to share their input. You have to consider how all of these different people affect the patient’s experience before you try to implement change.”

She recalls one example involving patient education about COPD. The task force originally developed a three-page patient education document, but then others pointed out that patients are unlikely to read such lengthy material. It was revised to a one-page document that included the most important information.

“You have to be willing to ask for help and be vulnerable, to say you’re trying to do something but it’s not working out,” Piñero says. “As respiratory therapists, we can focus so much on our part of the patient care that we don’t realize there are others we can reach out to who have the same goal of improving the quality of care. It takes a village.” ■

SOURCE

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CE QUESTIONS

- 1. Two domains of the CHAPS model for care coordination are:**
 - a. social determinants of health and medical.
 - b. education and oral healthcare.
 - c. mental status and physical function.
 - d. living environment and social support network.
- 2. The goal of the CHAPS program is:**
 - a. to prescribe a specific course of medical actions based on the patient's diagnosis.
 - b. to develop a holistic picture of the patient and then deliver care suggested by that picture.
 - c. to train the patient's family to manage medication and medical issues.
 - d. to set up a schedule of home visits by nurses and care aides.
- 3. In the care coordination notebook for patients, which is one of the subcategories in the surroundings section?**
 - a. Athletic activities
 - b. Family pets
 - c. Emotional health
 - d. Money concerns
- 4. A coordinated care approach to treating patients with COVID-19 follows a patient-centric healthcare model that focuses on post-discharge recovery for patients with a variety of symptoms, including:**
 - a. insulin resistance.
 - b. epilepsy.
 - c. heavy bruising.
 - d. brain fog/neurological issues.

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.