HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Your New Best Friend May Be a Community Health Worker

Peers gain patients' trust and help them navigate the system

New reimbursement models and increased financial risk for hospitals make it imperative for case managers to work even harder to ensure that patients have what they need to be safe and follow their treatment plan after discharge.

Making follow-up calls, setting up primary care appointments, and scheduling home health visits all help, but they are short-lived. Some patients have needs that go beyond a telephone call or a few visits from a home health nurse.

Hospital stays are episodic and about 10% of patients who return to the community cannot manage independently, says **Toni Cesta,** RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts. Home care is one solution, but the visits don't last forever, and the at-risk patients will need continued support after home care ends, she adds.

> HOME CARE IS ONE SOLUTION, BUT THE VISITS DON'T LAST FOREVER, AND THE AT-RISK PATIENTS WILL STILL NEED SUPPORT AFTER HOME CARE ENDS.

Navigating the healthcare system is challenging for everyone, but it's particularly difficult to understand for patients who are uninsured, undocumented, living in poverty, and/or have limited proficiency in English, says **Patricia Peretz**, MPH, lead for the Center for Community Health Navigation at New York-Presbyterian Hospital.

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That's where community health workers can be helpful, she says.

Community health workers (CHWs) live in the communities in which they work and understand the culture, language, and the challenges of the people they support, says **Jill Feldstein**, MPA, chief operating officer for the Penn Center for Community Health Workers at the University of Pennsylvania Health System.

"Hospitals and other clinical providers are now being held responsible for the health outcomes of their patients, but the social determinants of health have a tremendous direct impact on these health outcomes," says **April Hicks**, MSW, chief operating officer of the Community Health Worker Network of NYC. "Clinicians are not trained or equipped to address these barriers, but community health workers are. That is precisely where they live and work. They help address the root causes that are creating barriers to improving health outcomes."

Community health workers share life experiences with the patients they assist, which allows them to form relationships more quickly and easily, Feldstein says. "Because of the shared life experiences, patients are more likely to tell them what is going on in their lives," she adds.

Community health workers are uniquely positioned to build trusting partnerships, Peretz says. "They can be the voice of the community in clinical settings and bridge gaps in care," she adds. *(For details on New York-Presbyterian's two community health worker models, see related articles on pgs. 129 and 131.)*

When case managers make follow-up telephone calls to patients, they receive a limited amount of information and never know if they are getting the whole story, says **Donna Zazworsky**, RN, MS, CCM, FAAN, principal of Zazworsky Consulting in Tucson, AZ.

"Telephone calls rarely uncover all the issues a patient is facing — they aren't addressed and the patient's condition worsens. Someone who visits patients in the home gets a much better picture of the patients' condition and the obstacles the patients face," Zazworsky says.

Home health nurses may be in the home for 30 minutes at a time for a few weeks. Physicians typically spend as little as 10 minutes with patients,

EXECUTIVE SUMMARY

Community health workers, lay people who live in the community they serve and understand the challenges of the people who live there, can teach at-risk patients how to navigate the healthcare system, help them obtain community services, and support them in overcoming obstacles to care.

- The concept of community health workers is gaining ground as healthcare payers move toward basing reimbursement on quality and hospitals assume risk for patient outcomes after discharge.
- Case managers should familiarize themselves with community organizations that offer care coordination and partner with them to ensure that at-risk patients avoid unnecessary hospitalization and ED visits.
- For a community health worker program to be successful, providers must plan the process carefully, clearly delineate the roles and responsibilities, and hire people with good communication skills and who relate well to others.

Hicks points out. "That's not enough time to build the trust needed to help some at-risk patients overcome the obstacles to receiving care," she says.

Patients see community health workers in the grocery store, in the park, in church, or other places in the community, Hicks points out. "They know them and trust them. They let them into their homes and tell them things they would never tell a provider in an office," she adds.

Many hospitals have a transitional case manager who touches base with patients by telephone, Cesta points out. This works with lower-risk patients, but high-risk patients may need more support. Community health workers are part of the neighborhood and spend time with patients in their home, which makes a big difference, she adds.

"There is a difference between making a referral and ensuring that the connection actually happens. The community health workers make sure appointments are scheduled, go to them with patients, answer questions, and make sure the visit goes well and the patient understands everything," Feldstein says.

The community health worker model lends itself to healthcare reform and innovations in how care is provided, Hicks says.

"Community health workers are the wave of the future. People are recognizing their value in helping at-risk people stay healthy in the community. The hope is that as we continue to think differently about how to care for people, healthcare providers will be able to appropriately and effectively integrate community health workers into the continuum of care," she adds.

"Community health workers are someone that patients are familiar with, whom they trust, and who they are likely to listen to. They go into the home and can see the conditions in which the patient lives and get a firsthand impression of the family dynamics and the patient's support," she says.

Hicks recounts reports from CHWs who worked in a program designed to teach parents how to care for their children's teeth. But, the CHWs reported that they seldom were able to immediately address oral health because the parents had so many pressing issues.

> "SOMEONE WHO VISITS PATIENTS IN THE HOME GETS A MUCH BETTER PICTURE OF THE PATIENTS' CONDITION AND THE OBSTACLES THE PATIENTS FACE."

"Oral health wasn't relevant or a priority when they are concerned with feeding their family or having a job. This is the difference between program goals and individual goals. CHWs help bridge the gap in these goal differences and help systems better engage and support client needs," Hicks says.

The parents asked for help finding a job, getting their utilities reconnected, or finding a food pantry so they could feed their families, Hicks says. "They were burdened with so many other complexities and realities that they couldn't work on oral health. These are the social determinants of health. CHWs are not clinical and while they may be working in programs addressing chronic illness and clinical issues, they are addressing root causes. CHWs learn firsthand about what these people are facing in a way that other providers cannot," she says.

People want other people to like them and think highly of them, so they aren't likely to discuss their status or living situation with authority figures like physicians or case managers, Hicks says. "Community health workers are in the community and in people's homes and they see the issues that need to be addressed," she says.

The concept of community-based care coordination is not new, but the idea is beginning to gain traction as reimbursement shifts to value-based payment, Cesta says.

"The healthcare industry is starting to realize that we have to address costly at-risk patient populations. If we don't stay on top of them and support them in the community, they are likely to be problematic and detrimental to the hospitals' bottom lines," Cesta adds.

At-risk patients may be people with chronic conditions who aren't managing themselves well, people who have behavioral health issues, and many who also have a clinical condition, elderly patients who need help with activities of daily living, or other patients who just can't manage without assistance, Cesta says.

Hospitals need to hand off their at-risk patients to someone in the community who can help them overcome the obstacles to care, Cesta says.

Studies in the 1990s pointed out the advantages of having case management in the community to help patients avoid readmissions or ED visits after discharge, Cesta adds.

"But without financial incentives, providers were not interested in reducing readmissions. We've been waiting for reimbursement to catch up with the idea. Now with bundled payments, the Centers for Medicare & Medicaid Services' readmission reduction program, and accountable care organizations, we're almost there," she says. ■

Who Are Community Health Workers?

If your hospital doesn't have its own community-based workers to support at-risk patients, you should research the providers in the community and what services they can offer, advises **Donna Zazworsky**, RN, MS, CCM, FAAN, principal of Zazworsky Consulting in Tucson, AZ.

"When they work with patients who are at risk for readmissions or additional healthcare costs, case managers should get their high-risk patients into a system where there are trained people who can work with them and follow them until they can manage on their own," Zazworsky says.

This may be a large medical group, a community clinic, or a community service organization, Zazworsky says. "But many times, case managers on the unit don't know that care coordination services in the community exist," she adds.

"A lot of times, when case managers arrange follow-up appointments with primary care providers or specialists, they consider only locations where they can get the patients in quickly," Zazworsky continues. "If their office doesn't have the ability to support at-risk patients in the community, the patients are likely to bounce back to the hospital."

Zazworsky recommends that case management directors set up meetings with the community organizations that can provide assistance to their patients after discharge.

"Identify key point persons and the referral process. Most importantly, ensure that the hospital will get feedback to show that the baton was successfully handed off," she adds.

Where does one find someone in the community to manage discharged patients?

Community-based case managers are most often found in patient-centered medical homes or health homes, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

Accountable care organizations hire them to coordinate care across the continuum, she adds.

"I see more and more primary care providers taking on the community outreach role," Zazworsky says. "Physician practices operate on small margins, but if they can meet the criteria, they can be reimbursed by using the chronic care management and transitions in care codes," Zazworsky says.

In addition, some commercial health plans are offering grants to providers to set up a care management program.

Federally qualified health centers and other community health centers often have eligibility workers, chosen for their communication skills and trained to determine if patients are eligible for Medicaid, help them enroll, and assist in accessing other community services, she adds. "The patients may be handed off to a person with a higher level of training if they need help over the long term," she says.

The type of programs available are very population-driven, Zazworsky points out.

For instance, organizations that work with the homeless are likely to have a community outreach worker, probably a lay person, who connects the homeless with supported housing and other community resources, she says. In the Tucson area, recovery coaches within behavioral health agencies work with Medicaid beneficiaries to help them work on recovery and to access other community resources, Zazworsky adds.

Cesta advises case managers to work with their hospital's information technology staff to automate the process of risk stratifying patients. Each hospital should determine its own parameters, she advises.

Include a patient registry that flags patients when they miss an appointment or a test, or when they have an abnormal lab result, she suggests. With high-risk patients, take a proactive approach and give them the support they need to follow their treatment plan, she says.

A hospital's readmission prevention program and/or transition program should encompass the entire continuum and link the hospital team to the transition care coordinator, home health services, post-acute providers, and the community at large, Cesta says.

As providers move toward population-based care, hospitals have an opportunity to partner with community-based organizations to coordinate care for the patients they serve, Zazworsky says.

Hospital EDs are one area where community outreach workers can be effective, she adds. "That's where the homeless, the uninsured, and patients without a primary care provider come for treatment. There is a lot of value in having someone who can connect these patients to a primary care provider and help them sign up for disability insurance, Medicaid, or other funding and support resources," she says. ■

Successful CHW Programs Are Complex and Require Meticulous Planning

Successful community health worker programs don't just happen by magic: Providers have to plan the initiative carefully and be clear about the roles and responsibilities, says **April Hicks**, MSW, chief operating officer of the Community Health Worker Network of NYC.

"Providers often don't recognize all of the complexities of a community health worker program. They hear other providers' success stories and think they can bring CHWs into their facility and magic will happen. It won't," Hicks says.

There's no one-size-fits-all model for a community health worker program, Hicks says.

She advises organizations to take their time when planning a program. Determine the patient population you want to reach, research how other programs work, and design a program tailored to the unique needs of your community, she adds.

"There is often confusion about the role of community health workers. The entire treatment team should have a clear understanding of what community health workers are and their role in the organization," Hicks says.

The Community Health Worker Network of NYC began in 2001 as a way to support community health workers and give them an opportunity to learn from each other, Hicks says.

"We want to raise the profile of community health workers and ensure that they are integrated into the continuum, but make sure that they aren't turned into something they are not," she says. *(For information about the organization and community health workers, visit www.chwnetwork.org.)*

For instance, some providers are trying to use community health workers as mini medical professionals or extenders for licensed staff, but that's not within their scope of practice, Hicks says. "If they are asked to perform duties similar to those of licensed staff, such as coordinating care in the community, it can lead to a turf war," she says.

"Instead of feeling threatened, the interdisciplinary team should understand that that community health workers focus on the social determinants of health," Hicks adds. "They are not clinical. They add value to the team, allowing others to work at the top of their license by taking on tasks that don't require a licensed clinician. Their scope of practice is complementary to the work of the rest of the team."

Before starting the community health worker program, researchers at the University of Pennsylvania Health System conducted extensive research to find out what other organizations were doing and what patients needed.

The community health worker program was a vision of **Shreya Kangovi**, MD, MS, a pediatrician and assistant professor of medicine at Perelman School of Medicine at the University of Pennsylvania, who wanted to reach beyond the hospital and clinic walls to help patients, says **Jill Feldstein**, MPA, chief operations officer for the Penn Center for Community Health Workers at the Philadelphia-based health system.

Kangovi and her team talked to hundreds of patients to get an understanding of what patients thought was getting in the way of their health.

"They described a sense of disconnect from providers. They felt that their physicians were good at describing their illness and medication regime, but they had no idea of what was happening in the patient's world in the community," Feldstein says.

The research uncovered three areas where patients thought a community health worker could benefit them: help in navigating the healthcare system; connections to resources in the community, such as food banks, housing assistance, transportation, and childcare; and emotional and instrumental support — someone to accompany patients to physician visits, help them fill out forms, or go with them to exercise programs.

"Community health worker programs have been around for a long time with mixed success. We determined what the major pitfalls were and designed our program to avoid them," Feldstein says.

Since many programs they reviewed reported high turnover, Kangovi's team explored better ways to recruit and hire the right people. They developed standardized work practices and created very clear responsibilities for the role and the focus of the CHWs, including a goal of providing holistic patient care.

The result was the Individualized Management for Patient-Centered Targets (IMPaCT) program that is currently used at the University of Pennsylvania Health system and outlines how hospitals can create an effective and standardized program. *(For more details on IMPaCT, visit: http://chw.upenn.edu.)* ■

No Degree? No Problem: CHWs Need the Ability to Connect With People

Sharing life experiences with patients is important

When it comes to being a successful community health worker, academic background takes a backseat to life experiences and characteristics like compassion, reliability, and the ability to connect with people, experts say.

"To be effective, community health workers should be compassionate, resourceful, and most importantly, be a member of the community they serve and/or have a shared life experience. Some community health workers have a high school diploma or even a general educational development [GED] diploma, but they also have a wealth of experience that makes them invaluable to the people they are serving," says **April Hicks**, MSW, chief operating officer of the Community Health Worker Network of NYC.

Community health workers should share a life experience, language, culture, or disease with their clients and be a trusted member of the community they serve, Hicks adds. "Their life experiences and familiarity with the community is critical to their success and fills a need in the continuum of care," Hicks says.

New York-Presbyterian Hospital doesn't require its community health workers to have a specific degree or level of training. Instead, the health system chooses candidates that have community-based experience working in local organizations, says **Patricia Peretz**, MPH, lead for the Center for Community Health Navigation at New York-Presbyterian.

"We look for natural connectors who speak the language of the community and have a good understanding of the community and know how to navigate the local resources. We want people with shared life experiences that make them able to support and empathize with the patients," she says.

Candidates for the Individualized Management for Patient-Centered Targets (IMPaCT) community health worker program at the University of Pennsylvania Health System must have a high school diploma or GED, be familiar with the neighborhood they will serve, and have some experience with the healthcare system, which could be as a patient or a caregiver, says **Jill Feldstein**, MPA, chief operating officer for the Penn Center for Community Health Workers at the University of Pennsylvania Health System. "We have a thorough hiring process that uses a mix of tools in the selection process, and as a result we have almost no turnover," Feldstein says.

> "WE WANT PEOPLE WITH SHARED LIFE EXPERIENCES THAT MAKE THEM ABLE TO SUPPORT AND EMPATHIZE WITH THE PATIENTS."

One step in the hiring process is a "meet and greet" for applicants and staff members. The center staff invites about 15 applicants at a time to a "meet and greet" where they talk informally. Interviews also incorporate activities that include role playing and patient case scenarios.

"We are looking for people who are good listeners, are able to think on their feet, who can stand up for people, and help them move through a complicated healthcare system," she says.

Many of the community health workers in the Penn Center for Community Health Workers program have a lot of experience helping people in their community, Feldstein says.

"They say they've been doing the same thing all of their lives and they are excited to be doing it as a career," she says.

A robust training curriculum is critical to the success of a community health worker program, Hicks says. "Community health workers don't necessarily have an academic background, but it is important for them to receive training so they can do their job effectively," she says.

The CHW Network of NYC's training teaches the participants how to think critically and how to relate to the people they work with, Hicks says.

"Our training was developed in direct response to the state needs of both CHWs and their employers. They are evidence-based and supported by original research we conducted in partnership with Columbia University's Mailman School of Public Health. This training provides CHWs with the

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Admission and Discharge Timeouts in Case Management Practice

By Toni Cesta, PhD, RN, FAAN

Introduction

The term "transitions in care" has become an important talking point for value-based purchasing, the Affordable Care Act, accountable care organizations, and bundled payments. The concept of transitioning patients also is critical to the field of case management and has been a process that we have owned for many decades. With the advent of the changes listed above, it has become clear that case management often is the driver of transitions in care. This month, we will discuss two important tools that case managers can use to improve their patients' transitions in care — the admission and discharge time-out processes. These processes can be hardwired and used to facilitate internal and external patient transitions and handoffs.

WITH THE ADVENT OF CHANGES TO HEALTHCARE, IT HAS BECOME CLEAR THAT CASE MANAGEMENT OFTEN IS THE DRIVER OF TRANSITIONS IN CARE.

Hospital Transitions: The Past

Prior to the changes listed above, the hospital transition process was fairly straightforward, with little deviation or variation. The patient was admitted to the hospital through the ED or via a planned admission or transfer. He or she spent a period of time in the acute care setting, including a period of extended stay in the ICU or a medical floor. The goal was for the patient to recover from illness or surgery prior to the discharge home. Home was the usual and customary discharge destination. On occasion, the discharge home might have included home care for a short period of time.

This simplistic example of how patients transitioned in the past illustrates the minimum number of handoffs required by case management staff during the acute care phase of illness. In those days, there were virtually no case managers in the ED, so there were no handoffs there. In addition, many departments were so grossly understaffed that handoffs were a luxury, only used for the most extreme cases where information-sharing was absolutely necessary.

Transitions Today

Today, case managers and social workers have many partners in the care transitions process, including post-acute care providers, physicians, patient-centered medical homes, home care case managers, and many others. We can no longer consider our work completed when the patient leaves the hospital. We must ensure that the arrangements we have made for the patient in the home are delivered timely and as planned. We must have an eye on the continuum of care and the availability of community-based resources from a much more global perspective then we did in the past. We must advocate for our patients and resolve gaps in the transition processes when necessary.

The American Case Management Association (ACMA) provides guidance in their standards of practice for transitional coordination of care. According to the guidance, transition management begins at the time of the case manager or social worker's initial patient encounter. It explains that the transition management plan must be re-evaluated and adjusted throughout the patient's stay. It recommends that electronic, telephone, or in-person contact be made with the patient within 72

hours of discharge from the hospital.

Today, our transition plans include more than just the discharge plan — they must also include the patient's risk for readmission in concert with their discharge needs, as these two elements of the plan should be carefully synchronized. When patients are determined to be at high risk for readmission, the case manager must apply post-acute interventions to proactively reduce the likelihood of that patient returning to the ED and/or the hospital.

Admission and Discharge Timeouts

Admission and discharge timeouts are an example of strategies for improving the effectiveness of your transitions. The admission timeout occurs once the patient has been transferred to the inpatient unit. The discharge timeout happens once the discharge plan is finalized, but before the patient leaves the hospital.

The Society for Hospital Medicine has called for what they call nonprocedural timeouts. Procedural timeouts are those that happen before a procedure or surgery. Nonprocedural timeouts are innovative communication tools that can potentially limit communication failures that might occur at critical transition points. *(For more information on nonprocedural timeouts, visit: http://bit.ly/2uPijM2.)* Let's review how each of our case management timeouts work.

Admission Timeout

The admission timeout is performed once the patient has made it to his or her inpatient or observation bed. It's a multidisciplinary process that can include the patient, family, and family caregivers. Many members of the care team are stakeholders in the admission timeout process. These include the physician, the case manager, the social worker if assigned to the case, the staff nurse, and clinical documentation improvement staff.

The goals of the admission timeout are to identify risk during the hospital stay and to prepare for discharge, and include the following risk assessments:

- readmission;
- quality metrics;
- financial metrics;
- care coordination;
- compliance;
- patient experience;
- clinical documentation metrics;
- potential transition gaps.

The admission timeout can be coordinated by various case managers, depending on where the patient is located. For example, the ED case manager can complete the readmission risk assessment and evaluate for any gaps in transition during the initial assessment process.

The perioperative case manager can perform the timeout prior to elective or emergent surgeries. The unit-based case manager can perform the timeout on both admissions and observation patients.

The admission timeout process is not a sit-down meeting — it is a process that can be completed by multiple team members.

Components of the Admission Timeout

The components of the admission timeout do not need to be completed in any particular order, but all must be addressed. Medication reconciliation is one that needs to be completed on admission, as this is as vital as the medication reconciliation performed at discharge. If the admission medication reconciliation is not done, there is an increased potential for errors to occur during the hospital stay. These errors will then translate to errors at the point of discharge.

The case manager's role is to identify any transition opportunities or concerns. These would include issues that might occur during the hospital stay or post-discharge. The case manager and social worker also should perform an admission risk for readmission assessment. Best practice would be to perform this assessment as part of the case management admission assessment and to embed the questions in the admission form. Once the readmission risk assessment is complete, the case manager and/or social worker should initiate a plan to address the cause or causes of the readmission. For patients presenting to the ED who will not be admitted but may have frequent visits or previous admissions, the ED case manager should complete a similar risk assessment and plan of correction. This may include a referral to home care or to a community-based case manager.

During the admission timeouts, other quality of care-related elements should be reviewed. These might include process of care measures, safety indicators, present on admission documentation, and medication reconciliation.

From a financial metric perspective, the following should be reviewed during the admission timeout process:

- Review medical necessity and Two-Midnight Rule documentation.
- Review plan of care to ensure that it is focused on the patient's reason for admission and refer to clinical documentation if necessary.

• Identify any specific contractual requirements for commercial payers, managed Medicare, or managed Medicaid.

• Identify any potential transition gaps, particularly in unfunded or underfunded patients.

• Determine if the patient is at high risk for a long length of stay and/or high cost during this hospitalization.

From a coordination of care perspective, the following should be reviewed:

• the plan for the day;

• the plan for the stay;

• case manager assessment for potential referral to social work and home care;

• the anticipated date of discharge — communicate this date to the patient and family and keep them involved in the discharge planning process to ensure that they are ready for discharge on the expected date;

• potential need for a case conference.

Finally, compliance measures should be reviewed. These include the following:

• appropriate admission order, including the level of care;

• medical necessity to ensure compliant billing and reduce the possibility of a denial;

• Two-Midnight Rule requirements;

• patient choice for home health or skilled nursing facility, if appropriate;

• anticipated discharge plan.

It is wise to consider implementing a process that includes the patient and/or family in the admission timeout process. During admission is an opportune time to see the patient's family. It is also a good time to determine if there are any family caregivers already involved in caring for the patient. The initial discharge plan can be shared with the patient and/or family at this point. It also is a good time to write the anticipated date of discharge on the whiteboard, if available.

Discharge Timeout

One of the major weaknesses of the discharge process is the relative lack of attention to detail from the patient's interdisciplinary care team at the time of discharge. While there is a great amount of attention to the patient at the time of admission, this amount of attention does not translate to the discharge process in the same way. Discharge timeouts are just as critical and answer the following questions:

• Has everything needed for discharge been performed correctly?

• Have all the patient's needs been addressed? (Including needs related to admission and other needs that can be addressed after discharge.)

• Has the patient's discharge plan been reviewed and all post-discharge needs addressed?

• Has the patient been educated on their medications?

• What was the patient taking on admission?

• What, if any, are the changes in medications for discharge?

• Have the patient and family agreed to the discharge plan and destination?

• Have they been educated to everything they need to know regarding care at home?

• Are all post-discharge arrangements in place?

• Have the medications been reconciled?

• Does the patient have a primary care provider?

• Does the patient have a follow-up appointment with his or her primary care and/or specialist within seven to 10 days after discharge?

• Does the patient have a written plan outlining the follow-up appointment?

• Does the patient have transportation to the appointment?

• Have you completed a discharge readmission risk assessment based on the admission readmission risk assessment and any additional changes that may be relevant?

Components of the Discharge Timeout

During the discharge timeout, you should review the admission metrics we discussed above. When giving final instructions, educate the patient on the factors that contribute to readmission risk and what he or she can do to reduce the likelihood of another unnecessary readmission.

From a quality of care perspective, the following should be reviewed. Each member of the interdisciplinary care team plays a specific role in addressing each of the following indicators:

• Medication reconciliation: 15-30% of patients will have a medication discrepancy during hospitalization. Patients with medication discrepancies are twice as likely to be readmitted. Age, high-risk medications, and polypharmacy issues should be reviewed as these also will contribute to an increased potential for readmission. This function typically is performed by a physician or midlevel practitioner.

• Final documentation of process of care measures and patient safety indicators.

• Make discharge summaries available to the primary care physician for the patient's follow-up visit.

• Primary care providers should be aware of any pending test results expected to arrive after the patient's discharge.

From a financial perspective, review the following:

• Be sure that all days have been authorized for commercial payers, including managed Medicare and managed Medicaid.

• Finalize documentation with the physician of record to ensure that medical necessity is reflected in the medical record.

From a coordination of care perspective, be sure that the following have been addressed:

• that a follow-up phone call is in place;

• that a follow-up appointment is in place within 7-10 days;

• community physician lead identified and in place;

• appropriate discharge plan has been activated.

Compliance requires that the following be checked and confirmed:

• delivery of the second Important Message from Medicare;

• an appropriate process was used, should the patient appeal the discharge;

• patient choice was documented in the medical record.

Time to Complete Admission and Discharge Timeout

Many interdisciplinary team members may have concerns about the time needed to conduct the timeouts and may feel that they simply can't fit them into their daily routines. In reality, these processes can be timesavers and assist in improving the efficiency of the discharge process by hardwiring and standardizing it. If a template is used, the timeout can be finished as the various actions are completed.

The following are some timeout communication strategies to improve efficiency:

• Include the patient and/or family in the process.

• Let the patient know you are specifically focusing on his or her admission and discharge during these timeouts.

• Each profession should discuss strategies after the admission timeout to coordinate, and not fragment, care planning.

• Plan with multidisciplinary team when admission and discharge timeouts will occur.

Before you implement a timeout process, create a development and implementation plan for each timeout. Follow the items as listed below to guide your plan of action.

• Determine which patients need discharge timeouts.

• Determine the role of each of the multidisciplinary team members.

• Develop a process to evaluate gaps in ability to implement admission and discharge timeouts.

• Audit effectiveness at least monthly.

• Share results of audits.

• Improve the processes, based on the audit results.

• Consider creating a multidisciplinary team to oversee the process.

• Plan for each process, including education and implementation.

• Evaluate the process as it rolls out.

• Audit the effectiveness of timeout processes.

• Determine which patients need admission and/or discharge timeout.

• Consider starting with pilot units or patient groups.

• Establish a plan for education that can be replicated.

• Emphasize focus of timeouts during annual National Time Out Day (June 8).

How to Audit Your Timeout Processes

As discussed above, audit a sample of patients each month. Track the number and percent of patients with documented admission and discharge timeouts. Do these percentages match the predetermined percentages? For example, do you expect that all patients have a documented timeout, or some subset of all patients?

Compare patients with documented admission and discharge timeouts with the number of days delayed. Hopefully, you will see this number go down over time. Do the same for readmitted patients.

If you have a readmissions dashboard, you might consider adding the following:

• percentage of patients readmitted with no admission timeout during previous admission;

• percentage of patients readmitted with no discharge timeout during previous admission;

• percentage of all-cause readmissions before and after timeouts implemented.

Summary

As case management becomes more and more complex, each department must develop the best, most effective strategies for staying ahead of the game. Admission and discharge timeouts are one example of a low-cost, successful intervention that can mean positive results for the case management department, the interdisciplinary care team, and the patients. ■

(continued from page 122)
care skills they need to conduct the tasks and fulfill the roles in the community health worker practice. It helps place their work within the context of client empowerment and individual/community development," she says.

"When the community health workers step into someone's home, they can't take a cookie-cutter approach; they have to work with every patient as an individual. They can't be judgmental and they can't just tell people what to do," she says.

Learning to communicate is one of the most important parts of training, Hicks says.

"Our training includes two full days just on communication. We teach them how to connect appropriately and to relate like a peer and not like someone on the top of the power structure," she says.

Community health workers at the University of Pennsylvania Health System go through a month-long 140-hour training program that qualifies for college credit. After the classroom portion of the program, they shadow a senior community health worker for up to a week. ■

CHWs Embedded in the Hospital and Clinic Support Patients in the Community

Patients who received interventions from a community health worker (CHW) experienced an increase in access to a primary care provider and a reduction in readmissions during a randomized trial conducted by researchers at Penn Medicine.

The two-week trial included 446 patients, half of whom received support from a community health worker and half who did not. The intervention group reported an increased level of patient engagement, and gave their providers higher scores on the Hospital Consumer Assessment of Healthcare Providers and Systems survey.

Based on the success of the trial, the health system invested in growing the program and now 30 community health workers are embedded on teams in the hospital setting and in the health system's primary care clinics, and work with 2,000 patients every year, reports **Jill Feldstein**, MPA, chief operating officer for the Penn Center for Community Health Workers, which is part of the Philadelphia-based health system.

The health system developed the Individualized Management for Patient-Centered Targets (IMPaCT) model based on input from hundreds of patients. Patients are identified for the program based on information in the medical record, by treatment team members who identify patients who need help with transitions, and by primary care physicians who refer patients who need assistance with managing one or more chronic conditions.

The community health workers work with patients for specific amounts of time, depending on the patients' conditions and needs.

The CHWs in the hospital program work with patients for two to four weeks, helping ensure a safe transition from hospital to home and reconnecting with a primary care provider. When hospitalized patients need more support, the CHW follows them for three months. Patients who need help changing their habits to improve chronic health conditions receive support for six months.

If patients are identified for

EXECUTIVE SUMMARY

After a randomized trial showed that patients receiving interventions from a community health worker had improved outcomes, Penn Medicine expanded the program and now 30 community health workers are embedded on teams in hospitals and primary care clinics.

- Health system researchers interviewed hundreds of patients about the roadblocks to receiving care and how community health workers could help, and developed the Individualized Management for Patient-Centered Targets (IMPaCT) model.
- Community health workers are referred by hospital staff or primary care providers and work with patients for specific lengths of time depending on the patient needs.
- They go into the community and meet with patients in their homes, often identifying nonmedical issues that need to be handled before patients can concentrate on their health.

the program while they are in the hospital, the CHW visits, explains the program, and enrolls the patients if they are interested.

When patients have chronic health conditions, a member of the IMPaCT team calls them before their clinic visits, describes the program, and arranges for a CHW to meet with patients at the clinic if they agree to participate.

"We inform the patients of the defined duration of the program at the time they enroll. It gives patients an incentive to work harder when they know how long they will have support from the community health worker, and it helps us manage the caseloads of the CHW," Feldstein says.

During their initial meeting at the hospital or the clinic, the community health workers spend time with patients, getting to know them and building rapport. They have a lengthy conversation that covers social issues as well as medical issues and helps the CHW identify the patients' support systems and barriers to taking care of their health.

"At the end of the interview, they walk out with a game plan based on each patient's individual needs and wishes," Feldstein says.

Each individual care plan centers around what the patient wants, Feldstein says. "The community health workers take time to get to know the patients and their goals, which increases buy-in. Sometimes, other people on the care team may tell the patient what they should do. This program turns that around and asks the patient what they want to focus on," she says.

Many times, the CHWs identify nonmedical issues that need to be addressed before the patients can concentrate on their health.

For instance, one woman in the program was in and out of the hospital with out-of-control blood sugar. The CHW determined that the patient was focused on the needs of her autistic child and wasn't taking care of herself.

The CHW visited the child's school and identified support services for autistic children. He set an alert on the patient's cellphone to reminder her to take her medication.

THE COMMUNITY HEALTH WORKERS OFTEN FOLLOW UP WITH PATIENTS BY PHONE, BUT A CORE PART OF THEIR JOB IS GOING INTO THE COMMUNITY AND ENGAGING WITH PATIENTS.

"The initial conversation revealed two problems that the CHW was able to solve by getting extra support for the child and setting up a simple alert," Feldstein says.

A patient referred to the CHW program by her primary care provider set a goal of losing weight, but during the conversation, she reported that one of the major stressors in her life was trying to find new housing so she could move out of her unsafe home.

When the CHW learned that the patient had been a basketball player in high school, he suggested they play weekly pickup games at a basketball court in her neighborhood. He brought along his laptop and cellphone and researched potential places to live, then helped the patient fill out housing applications after the game.

"The community health workers get things done in the moment to show people they are serious about helping them," Feldstein says.

The CHWs often follow up with patients by phone, but a core part of their job is going into the community and engaging with patients, she says. They have work space in the hospitals and the primary care clinics, but they spend most of their time in the community, at patients' homes, at the senior center, or wherever they need to go to support the patient.

"Community health workers go where they need to go and get done what needs to be done. Going into the home and meeting people where they are is an important part of the program," Feldstein says.

Caseloads for the community health workers range from 10 to 30 patients, depending on the patient needs and the setting. "In general, their caseloads are smaller than the licensed staff and they can devote more time to the patients' concerns," she says.

The program is designed so that the CHWs are part of the care team in both the hospital and the primary care setting. They communicate regularly with the nurses, physicians, case managers, and other clinicians.

In hospitals, CHWs participate in the care team activities in the best way for each team. They attend morning rounds or daily huddles with some teams, and with others communicate mostly through the medical record. In the clinics, CHWs may meet with the entire team on a regular basis, or have one-on-one meetings with the physicians to discuss individual patients. ■

Dual Approach Helps At-risk Patients Overcome Obstacles to Receiving Care

CHWs work with patients in the community and ED

To bridge the gap between at-risk patients and the providers treating them, New York-Presbyterian Hospital has developed two different models in which trained lay members of the community work with at-risk patients to help them navigate the healthcare system and manage their health.

Community health workers (CHWs) provide support to help patients in the community overcome any obstacles that interfere with receiving care or managing their conditions. They are employed by New York-Presbyterian's community partners and are co-supervised by community partners and health system personnel.

In the second model, CHWs, called patient navigators, are employed by the hospital to work with frequent ED visitors and patients without a primary care provider. *(For details on the patient navigator program, see related article on page 131.)*

"We see community health workers as being at the heart of healthcare. They speak the languages of the patient populations we serve, and understand the dynamics of the communities and the people who live there," says **Patricia Peretz**, MPH, lead for the Center for Community Health Navigation at New York-Presbyterian Hospital.

The program began in 2005 with a grant to provide community support for the parents of pediatric asthma patients and help them keep their children's disease under control. "It gave us the opportunity to work with local community-based organizations to develop a program design that encompasses the clinical aspects and social determinants of children with asthma," Peretz says.

The pilot program for asthma patients served an area where 43% of children live below the poverty line, Peretz says. The population of the community was 75% Latino, and 51% of residents were foreign-born. Most of the residents spoke Spanish in their homes.

ED visits and hospitalizations decreased by more than 65% among children whose parents completed the year-long program. Nearly 100% of parents who completed the program said they felt they could control their child's asthma.

The CHWs in the pilot program were bilingual and based in the community. They visited the patients in their homes and conducted an environmental assessment to identify any asthma triggers such as animal dander, house dust, or cigarette smoke, and worked with the families to eliminate the triggers.

CHWs also identified barriers to adherence to the child's treatment plan and provided peer support to parents who were trying to manage their children's asthma and cope with everyday stresses. They helped families sign up for assistance with housing and utilities, food, childcare, and other needs. They made sure the young patients were connected to a primary care provider, and reinforced the education family members received in the hospital and empowered them to understand asthma management.

They were part of the patients' primary care team and met with the providers regularly, collaborating on interventions to meet the patients' needs.

"The idea behind providing support in the community is that even the best-intentioned caregivers will have a difficult time managing their children's illnesses if they are

EXECUTIVE SUMMARY

New York-Presbyterian Hospital developed two models for community health workers (CHWs) who assist at-risk patients in the community and help frequent ED visitors connect with primary care.

- The program started with a pilot project to help the parents of pediatric asthma patients control the asthma. The project was so successful, the health system expanded the number of conditions and created partnerships with 14 community organizations.
- CHWs in the community program meet with patients and families, assess their social needs, help them set goals, and meet with the primary care team and attend rounds at the hospital when patients are hospitalized.
- CHWs called patient navigators cover five hospital EDs and help frequent utilizers connect with a primary care provider, set appointments, and follow up with patients until they go to an appointment.

about to be evicted or there's no food in the house," Peretz says.

The pilot project was so successful that the health system administration agreed to fund and expand the program.

"Our outcomes demonstrated that community health workers based in community organizations can help patients and caregivers overcome the obstacles to following their treatment plan and staying out of the emergency department and the hospital," says **Adriana Matiz**, MD, associate professor of pediatrics at Columbia University Medical Center and medical director for the Center for Community Health Navigation at New York-Presbyterian. "Using the data, we developed a business plan to continue funding the pediatric asthma project and to develop programs to support new populations."

The organization expanded the program to include adult-onset diabetes and multiple geographic areas, including primary care medical homes where the CHWs are part of the healthcare team. Currently, the health system partners with 14 community-based organizations across the city and has adapted the model to provide support for patients with HIV, behavioral health issues, and multiple chronic illnesses.

Patients are referred to the program by members of the hospital treatment team or primary care providers, Peretz says. Patients eligible for the program may have a specific condition, financial or other social needs, or they may be adults with multiple chronic illnesses who are at risk for readmission.

For instance, a case manager in the hospital might identify a patient who is at high risk for readmission, ask the physician for a referral, and bring in the community health worker to assist in discharge planning and follow the patient after discharge.

"In my practice, I may be treating a child with complex medical issues and barriers that impede the care. Then, I engage the community health worker who is on my team to meet with the family and help them overcome the barriers," Matiz adds.

Orders for a community health worker intervention go to the supervisory office where the case is assigned to the CHW, who then reviews information from the referring physician and uses it to plan the meeting and to support the patient in setting goals.

> "THE COMMUNITY HEALTH WORKERS SPEND A LOT OF TIME WITH THE FAMILY, GETTING TO KNOW THEM AND BUILDING TRUST AND IDENTIFYING ALL OF THEIR SOCIAL CHALLENGES."

"The order for a community health worker clearly describes what I want to focus on so the community health worker is informed about the patients' issues when they call to set up an appointment," Matiz says.

The initial meeting with the families may be in the home, a school, the community-based organization, or another location where the patients feel comfortable.

When they meet a family for the first time, the CHWs conduct a comprehensive interview that includes assessing social needs, self-management abilities, and other challenges. They work with the family to develop and meet goals that complement the medical team's goals. They help families navigate the healthcare system and access care in the appropriate setting. CHWs may accompany them to medical visits, and help them understand their medication regime and overcome barriers to care.

"The community health workers spend a lot of time with the family, getting to know them and building trust and identifying all of their social challenges. These may include housing needs, immigration issues, lack of food, or domestic violence. They find out what the family needs and connects them with resources," Peretz says.

The CHWs meet regularly with the multidisciplinary team in primary care practices and report on the patient and family, their living situation, and psychosocial needs. "It's an eye-opening experience for the medical team when the community health workers make their reports and we learn what is going on in the home," Matiz says.

While patients are in the hospital, the CHWs attend rounds, assist in providing culturally appropriate education, and collaborate with the care team on transition planning. When patients are readmitted, they help the case management team determine the nonmedical causes, such as financial problems or lack of transportation.

"We are developing true partnerships to provide better care for our patients. Our community health workers are based within community organizations, which helps them remain anchored in the community while they have a strong presence in the hospital and patient-centered medical homes," Peretz says. ■

Patient Navigators Help Patients Connect to Primary Care, Avoid ED Visits

Program reduced utilization by 50%

Frequent ED visitors decreased their visits by 50% at New York-Presbyterian health system hospitals after community health workers, called patient navigators, began connecting at-risk patients to primary care providers and educating them on how to seek treatment at an appropriate level of care.

The patient navigator program was launched in 2008 and focuses on patients who are not connected to a patient-centered medical home and/or have no funding for healthcare. In the first seven years of the program, 92% of the patients who did not have a primary care provider and who worked with a patient navigator had an appointment with a new provider after discharge, and 77% of patients attended their follow-up appointments.

The patient navigators are employed by the health system and located in the ED. They are bilingual, live in the communities they serve, and understand the cultural beliefs and practices of the population. Their shared life experiences with ED patients enables them to build trust and provide peer-level support, says **Patricia Peretz**, MPH, lead for the Center for Community Health Navigation at New York-Presbyterian Hospital.

The patient navigator program is in five different EDs, Peretz says. The largest hospital, New York-Presbyterian/Columbia University Medical Center, has patient navigators on site 24 hours a day, seven days a week. Patient navigators at smaller hospitals typically staff the ED from 7 a.m. to 11 p.m.

The ED medical record software includes built-in decision support to help the treatment team identify patients who could benefit from an intervention by a patient navigator. In addition, if the provider team determines that the patient needs to find a medical home or may need support with keeping their follow-up appointments, they can make referrals, says **Adriana Matiz**, MD, associate professor of pediatrics at Columbia University Medical Center and medical director for the Center for Community Health Navigation at New York-Presbyterian.

Patients eligible for the program are frequent ED users, are not established with a primary care provider, and/or have no funding source, Peretz says.

The patient navigators meet with the ED patients and link them to financial assistance programs and other community resources. They help patients identify a primary care provider in a convenient location, and schedule primary care and specialist appointments. They educate patients on why they shouldn't use the ED for primary care, and teach them how to navigate the healthcare system.

After the patients are discharged from the ED, the patient navigators follow up with them by phone and stay in touch until the patients schedule and attend a primary care appointment. They call the patients before their appointments to remind them to go, and call them after the appointments to make sure they went.

"In the past, emergency department staff would help a patient set up a follow-up appointment, but the relationship ended when the patient was discharged. The patient navigators in our program follow patients until they successfully make it to their appointments," Peretz says. ■

CE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

COMING IN FUTURE MONTHS

- Planning discharge of challenging patients
- Don't forget about managing your denials
- How social media is affecting healthcare ethics
- Managing the increasing senior population

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to AHCMedia.com, then select My Account to take a post-test.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE QUESTIONS

1. **According to Toni Cesta, RN, PhD, FAAN, what percentage of patients who return to the community cannot manage independently?**

   a. 25%
   b. 10%
   c. 15%
   d. 20%

2. **How long do community health workers at the University of Pennsylvania Health System work with patients who need assistance making a safe transition from hospital to home and reconnecting with a primary care provider?**

   a. Two to four weeks
   b. Three months
   c. Six months
   d. Up to a year

3. **What did patients tell researchers at the University of Pennsylvania Health System that a community health worker could do to benefit them?**

   a. Help them navigate the healthcare system
   b. Connect them to community resources
   c. Provide emotional and instrumental support
   d. All of the above

4. **New York-Presbyterian's patient navigators cover the emergency department 24-7 at all five hospitals in the program.**

   a. True
   b. False