HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Tips for More Effective Pediatric Discharge Planning

Caring for hospitalized children involves a unique look at creating plans of care and keeping the family calm and informed, experts say.

A report from the American Academy of Pediatrics, titled "Physician's Role in Coordinating Care of Hospitalized Children," delves into ongoing challenges across the varied facilities in which children are hospitalized, principles to improve the coordination of care, and trends among expectations and practice.[1]

Whether it is a scheduled admission or an emergency, the hospitalization of a child is extremely stressful for the family. Deciding at admission which physician to designate as the final decision-maker can limit confusion and chaos, establish a clear care plan, and provide for a more seamless experience for the family.

DECIDING AT ADMISSION WHICH PHYSICIAN TO DESIGNATE AS THE FINAL DECISION-MAKER CAN LIMIT CONFUSION AND CHAOS.

In more and more cases, there is a hospitalist service, notes report author **Daniel Rauch**, MD, FAAP, SFHM, professor of pediatrics at Tufts University School of Medicine and chief of pediatric hospital medicine at The Floating Hospital for Children at Tufts Medical Center in Boston.

"With the hospitalist, they're the manager of the hospitalized patient and the subspecialist. Although they may have other people do consults, the hospitalist is the primary decision-maker," he says. "It's helpful for parents to know who is the one in charge. There's times that a patient may get a surgical consult and the surgical team says they're free to

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leave the hospital, but I may have to tell them the child is not leaving even though they don't need surgery."

The following are four specific ways nurse case managers can work with families during especially difficult hospitalizations:

• Watch for gaps among providers in unscheduled pediatric admissions.

Because the primary care physician may be unaware of the necessity for hospitalization, watch out for potential gaps in the patient's care. When something happens that shakes up the family, it is critical that the care plan involve the patient's primary care physician.

"The patient care comes first, but hopefully primary care physicians have been notified no matter when the child is admitted. It can be a struggle off hours, but from a patient's point of view, there's no difference between weekday and weekend," says Rauch.

The American Academy of Pediatrics (AAP) urges hospitals to have the following mechanisms in place:

- Confirm that the inpatient physician makes direct contact with the primary care physician as soon as possible after admission to establish the foundation for communication that will continue until the discharge process, as "direct communication with the referring physician and primary care physician should not be overlooked because this will help provide a context of the child's illness within the family, confirm current medication, and prevent unnecessary duplication of previous tests."[1]

- Check with the emergency department physician "about all evaluations that have already been performed and any pending tests and to understand the need for hospitalization," particularly because most unscheduled admissions are initiated in the ED.[1]

• Limit confusion for the family.

What happens when there is a disagreement among specialists? Should the family be involved in care meetings, or only when discussing treatment? Does the case manager attend these meetings and report back to the family?

Rauch says it is a fine line when including parents and patients in certain case discussions. That is where a nurse case manager can help to limit confusion for the family.

"It's always better for the family to see a unified front. Even if you think you're saying the same thing, slight nuances can create confusion for the family," he says. "The more that communication can be limited — so the family is getting the same message — the better that is for families."

"In difficult cases, case managers

EXECUTIVE SUMMARY

There are unique tasks involved with caring for hospitalized children. The following are strategies to limit confusion and chaos during this especially stressful time:

- establish a realistic care coordination plan;
- provide a more seamless discharge experience for the family;
- ensure that case managers work on the discharge process as soon as possible; that may include explaining to families that their children may not be "perfectly well" on discharge and suggesting services that exist outside of the hospital setting.

can be in one meeting with different specialists to hear their different points of view. Instead of telephone tag, or 'he said, she said,' they hear it directly. Then if the family has questions, the case managers can give direct quotes or go back for specific follow-up," he adds.

But in cases where there is a discrepancy in the management plan, the family may benefit from being there to hear the pros and cons. During an already chaotic time for the family, this meeting may limit confusion if they can hear everyone's opinions at the same time.

It also can be tough discussing things ahead of time with specialists, which often creates even more confusion for the family.

"I think a good amount of time it happens that you're there doing a consult and parents ask, 'What do you think?' and you may not have the whole story there, at least yet. So it's important to discuss with the rest of the team and share a collective plan first," he says.

• Start the discharge process early on.

It has been said before that discharge planning begins on admission, and that is especially important for the pediatric population. While discharge is the obvious goal of the medical team, it is critical for case managers to carefully explain discharge parameters to the family at the time of admission.

The American Academy of Pediatrics says that anticipating discharge needs at the time of admission helps to get services during the hospitalization or to arrange for appropriate outpatient follow-up, such as social work, occupational therapy, and physical therapy.

If a child is admitted for something like bronchiolitis/viral pneumonia, there are clear parameters for discharge, specifically stable respiratory status and adequate oral intake.

But in more medically complex cases — for example, if a child is admitted for abdominal pain — the care plan is trickier. In situations like that, it is difficult even getting to the discharge plan because of a drastic change in the direction of care; in this case, the child either goes to the operating room or is allowed to eat.

"I THINK A GOOD AMOUNT OF TIME IT HAPPENS THAT YOU'RE THERE DOING A CONSULT AND PARENTS ASK, 'WHAT DO YOU THINK?' AND YOU MAY NOT HAVE THE WHOLE STORY THERE, AT LEAST YET."

"Hopefully at the end of the admission note, and on every subsequent note, it's clear how the team is working toward the discharge goal," says Rauch. "There is a goal from admission that you follow. As much as I may explain that to parents, it's helpful having that repeated by other people."

One of the most importance facets of discharge planning is working with families to schedule follow-up appointments as early as possible.

"It's usually a fairly predictable course for children, and you know they're going to have to see their primary doctor. Don't wait until you're writing the discharge papers; instead, make that appointment immediately," he says.

"More and more studies have shown better results when families are discharged with an appointment in hand," he adds. "The challenge is usually not on the hospital end; it's making appointments after hours and weekends. If there's some way to anticipate those post-discharge services so you make the appointment before discharge, or have some really secure way to get back in touch with them and call, the child would be better off."

• Teach families about post-discharge realities.

It is important that case managers ensure that families really understand what is going on with their child. While the general standard is using AAP tip sheets and discharge instructions, families also may benefit from individualized discharge instructions. This may mean giving the families a list of websites for more information or links to relevant online videos.

But it often is more detailed than that. That's why it is important for case managers to start the process early on; doing so will help families understand that their child may not be "perfectly well" on discharge. Will their child be in pain? What do parents have to watch out for? What will that mean for the next day, or next week? What medications does the child need immediately? What options outside of the hospital setting exist for the families?

This education piece may also reduce 30-day readmissions, as direct, clear discharge instructions are proven measures for improved health outcomes.

For example, a study published in the *Journal of Child Health Care*[2] noted that families that go home ill-prepared experience high levels

of worry. The study noted that healthcare professionals should tailor postoperative recovery information, including assessment and management of pain, and that "information should be made available that describes the experience of other families who have undergone a similar surgery, and families should be made aware of what information they need and how to access it before and after discharge."

Indeed, Rauch points out that parents often are eager to get their child home, but that there are caveats.

"We have to observe how they are breathing and eating, for example, and they may not be able to return home and be immediately back to normal," he says.

Rauch recommends that case managers start working with parents immediately so they are prepared for post-discharge realities.

"If the case manager anticipates that the child will have ongoing needs, a parent may need to understand they'll have to take time off from work. Or if the child can't get up and down stairs in their home, how can the case managers support the family in finding an alternative place to stay for a few weeks?"

The sooner they know that, the better, he adds. ■

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Grant Funds ED Case Management for At-risk Population

$260,000 mental health grant connects ED patients with community resources

A new grant is helping to provide a path toward stability for patients with mental and behavioral health issues who come to the ED. Often, many of these patients do not need to be admitted for medical treatment at all, but without the right help could end up floundering once back on the streets. Funding from the $260,000 Mental Health Innovations grant from the Minnesota Department of Human Services is working to close that loop.

In many situations, this oft-neglected population walks out of the ED without adequate resources or a path toward stability, explains **Julie Wilson**, MHP, director of adult community support programs at the Human Development Center (HDC) in Duluth, MN.

"We see it all the time. This is just an effort to help. If we can help 25% of the people who go into the ED with mental health issues and connect them, that's just incredible. It's a benefit to the person and to the community," says Wilson.

Since its launch in July 2018, the HDC has responded to 25 "call outs," meaning a case manager is sent to the ED. Each situation is different — many patients are homeless or at risk for homelessness, while some experience drug/alcohol addiction — but most have not been connected to services or have not followed through with services.

The HDC case managers, who moved into their new office building less than a year ago, are within walking distance to the hospitals involved with the grant program.

"The case managers utilize space in the emergency department when they are called to the hospital. We do not have designated space at the hospitals, but they try to give us as much privacy as they have available that day," says Wilson.

As part of the process, HDC says it has a "memorandum of understanding" with each hospital. Part of that is HDC will not interfere with the hospital's processes. In other words, if a person presented to the hospital ED because he or she felt there was an emergency that should be addressed at the hospital, the patient needs to be examined first.

"We don't want the ED to not assess the person. It's their patient the minute they walk in," says Wilson. "Once that process is complete and determination has been made that the person will not be admitted, we get the call. We want them to get in the habit of calling us right away to say, 'There's someone who's agreed to talk to you, can you come over?' This frees the hospital personnel to work on other immediate issues."

Wilson says her team has ongoing communication with the ED case managers.

"Sometimes our calls come from the case managers and sometimes from other hospital ED personnel depending on which hospital and time of day," she says.

Wilson says her team from HDC has heard nothing but positive feedback since the program began. The HDC case managers hold monthly meetings with the lead hospital personnel for this grant (case manager, nurse supervisor, and clinical supervisor for the ED). At the meeting they discuss what is working and/or any barriers they are facing.

Accessing Community Services

Although hospital personnel often are aware of resources available to mental health patients, they may not understand the criteria to access those services.

"Everyone, and every program or service, has their own admission criteria, insurance criteria, and many other barriers to access that they just do not have the time to assess for each person. And it's about follow-through," says Wilson.

For example, take the case of a discharge order or recommendation for alcohol or drug treatment. For that to happen, the patient needs a Rule 25 chemical health assessment, apply for insurance, receive help finding a facility that will admit him or her, and then wait for a bed in that facility.

Even the HDC, which has been offering comprehensive behavioral healthcare services to the local population since 1938, acknowledges there are so many moving pieces to keep patients on track to get the right support. For instance, HDC performs targeted case management, which is a contracted service through the county and the state. In order to receive targeted case management, a patient must have a serious and persistent mental illness (SPMI), not just a serious mental illness (SMI).

"Unless you've worked in a community-based program for people with mental illness, such as HDC's Community Support Program, you can't possibly keep up or know everything that is out there and how to access. I believe the hospitals do a lot and they know a lot, but they are not out here working every step with the person to help them be successful," says Wilson.

"They just can't possibly do that. Otherwise, they would need to have their own Community Support Program, and there isn't enough money in these programs for the hospitals to consider that," she adds.

How EDCM Implementation Works

So how are the HDC case managers working to assist the ED personnel? The team, known as the EDCM, typically goes through this common process:

- patient presents to the ED with mental health and/or chemical health crisis/emergency;
- patient is medically examined and cleared, screened out for admission to inpatient hospital and/or mental health inpatient setting;
- ED contacts HDC on-call case manager;
- EDCM consults with ED staff regarding recommendations and proceeds to connect with the patient to develop a more detailed discharge plan (e.g., EDCM taking the person to a mental health crisis stabilization center).

The discharge plan and process with the patient include identification of immediate and longer-term needs. Core community support programs and other services are offered depending on the need. These may include:

- crisis stabilization center;
- peer support;
- outpatient therapy or counseling;
- addiction counseling and treatment;
- adult rehabilitative mental health services;
- case management;
- homeless services;
- benefits assistance;
- referrals to other services.

"This is about immediate follow-up, not setting up an appointment

EXECUTIVE SUMMARY

Funding from the Mental Health Innovations grant offered by the Minnesota Department of Human Services provides a full-time case manager weekdays and an on-call case manager until 11 p.m. weekdays and Saturdays.

- Case managers meet with patients in the hospital ED when an emergency physician determines that the patient will not be admitted.
- Case managers create a plan with the person to see what he or she is willing to do and also explain the criteria to access services and programs.
- If the patient already is working with another agency in town, the case managers work to reconnect them and schedule necessary follow-up care.

to see them next week. That doesn't work," says Wilson.

"They need immediate relief or help with 'fill in the blank' needs. And if we can help them immediately, they will likely trust us enough to seek help again or follow through with us on the discharge plan," she says.

The HDC process also includes:

- establishing rapport with the patient through an informal interview and encouraging engagement to facilitate alternatives and/or discharge;
- assisting with identifying resources for appropriate level of care based on supports, current functioning, abilities barriers, and identifying alternatives as opposed to remaining at the ED or being admitted to inpatient setting;
- communicating and coordinating with family, support, and other providers;
- creating a plan for follow-up and assisting with follow-up interventions, making referrals, and linking to resources;
- when appropriate, transporting to alternative setting — shelter, crisis stabilization, family, treatment, etc.;
- facilitating the transition to appropriate outpatient mental health services;
- continuing EDCM until connected to and receiving the services that they need, at which time the HDC can close the loop.

How many expensive, unnecessary admissions could be avoided with more programs similar to what this grant is offering? In December 2015, the Minnesota Hospital Association published a mental health services whitepaper that discussed "a comprehensive and robust statewide mental and behavioral health system that serves all residents of Minnesota with appropriate, high-quality, accessible care."[1]

The study sought options for mental health and behavioral patient care outside the hospital system. Among hospitals without inpatient psychiatric units, two participating hospitals had a total of 90 potentially avoidable days during the 45-day pilot. Of the behavioral health patients with potentially avoidable days, 83% of their stays were potentially avoidable, versus 17% that were unavoidable.

The hospitals noted the following reasons for potentially avoidable days:

- the need for an inpatient behavioral health bed accounted for nearly half of the potentially avoidable days;
- legal involvement accounted for about one-quarter of potentially avoidable days. In particular, criminal histories caused delays in placing patients in community-based settings;
- lack of access to community-based settings, though brief delays accounted for the rest.

Although it is only an 18-month grant, Wilson hopes this service, or some version of it, could be extended indefinitely.

"When people with mental health or chemical health issues reach the point of presenting to the ED, they need help now and not next week or next month when someone has time to follow up with them. If we can instill some hope at that time and physically show them that we can and will help them, we are then making a difference in their lives," says Wilson.

Although the hospitals offer support, there are other options available in terms of funding and walk-in help for these clients.

"What do they need to get into this or that place, for example? We also want the word to get out that we offer walk-in assistance for anyone entering our door. We're closing the loop so that they're not out there floundering, only to end up back in the emergency room," she adds. ■

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Stop on REDD: Researchers Study Discharge Data on High-risk Patients

Investigational tool tries to predict risk of readmission, ED visit, or death

What if there was a medical "crystal ball" that let hospitals glimpse three days into the future? Looking ahead would certainly allow physicians to improve their processes when treating the patient in the hospital setting. It also would give case managers a chance to improve their discharge processes overall.

It may not be magic, but researchers from Penn State and Geisinger Health System in Pennsylvania developed a model they say is ahead of its time because it does not focus solely on readmission risks. They named their model REDD: Readmission, Emergency Department, or Death.

To predict a patient's need for follow-up care, the researchers gathered two years of clinical, administrative, and socioeconomic data from the patient's previous hospitalizations.

During the six-month pilot, the team analyzed large amounts of these data to identify high-risk patients at the point of discharge, which may tell physicians which interventions may be able to limit adverse events.

"We knew we had a vast amount of data stored in our electronic health record. Geisinger and our department work diligently to discover insights in our data that can improve processes involved in patient care and ultimately improve patient outcomes and satisfaction," says **Eric Reich**, manager of healthcare re-engineering at Geisinger.

Geisinger also used the REDD model to allow for targeted intervention, better care, and reduced costs and to avoid CMS 30-day readmission penalties.

Interventions were varied, including scheduling return appointments with primary care providers, educating patients about their prescriptions, having the clinical pharmacist review the discharge medication list, filling the patients' prescriptions before discharge, and following up the next day with any patient discharged to a skilled nursing facility.

Reich says it made sense for his team to allocate resources for the research, design, development, deployment, and follow-up of a solution, leveraging patient data that could provide information on the risk of patient readmissions.

The results of the analysis showed that readmissions closer to discharge are more likely to be related to factors not identified at the time the patient is discharged, whereas readmissions after 30 days are environmental (e.g., poor shelter, no access to services, little social support, etc.).

"Scientific literature in the topic suggests that below 30 days, readmissions are usually due to hospital processes, while after this period, it is said readmissions are less correlated to the hospital care and more to other factors outside the hospital control," says Reich.

"This is the main reason why CMS decided to use 30 days as the timeframe to assess preventable hospital readmissions, and after measuring, penalize such hospitals with excessive preventable readmissions," he says.

If readmissions closer to discharge are related to factors that are not identified at the time the patient is discharged, how can that be fixed? That is not always an easy answer, as readmissions are heavily dependent on a series of patient, hospital, and socioeconomic factors.

"For instance, we know that extreme ages — either young or elderly — are associated with a higher risk of readmissions. Also, the readmission risk is heavily related to the main disease and their individual set of comorbidities," says Reich.

The timing of critical follow-up care also has been shown to influence readmissions. Patients who visit their doctor or receive a follow-up phone call from a nurse soon after discharge are less likely to be rehospitalized.

Indeed, a new study of about 11,000 heart failure patients in the Kaiser Permanente Northern California health system discharged over a 10-year period found that this critical timing of follow-up matters. The study authors pointed out that it should be done within seven days of hospital discharge to be effective at reducing readmissions within 30 days.

To solve the issue of excessive readmissions within our country, the Geisinger researchers propose the following strategies:

- further the understanding of individual factors that drive readmissions;
- communicate and translate this research into systems capable of assisting hospitals in deepening their knowledge about their patients in relation to these outcomes;
- develop a comprehensive approach to address all these factors to reduce readmissions.

The REDD model, as it was tested during the pilot study, was unable to give reliable estimates on the reduction in readmissions.

There are several barriers that may explain why they could not get concrete answers. Some of them are unique to the healthcare industry, while others are common across companies.

"From an empirical perspective, the risk score of readmissions informs the providers involved in the patient care about the risk for readmissions, and this team discusses options to reduce such risk with the tools they have at their disposal," he says.

In a perfect world, he says, the risk score would be embedded into the electronic health record and a patient would not be discharged until the care team assessed the condition and additional interventions were considered and/or completed.

"Then, we would be able to track discharged patients with additional interventions allocated to them," he says. "Finally, we would continuously monitor the performance of the model, update and refine it to ensure it reflected not only the most recent patient data trends, but also used the best algorithms available." ■

Offering Patients Hospital Care at Home

Model could deliver equal or superior outcomes at significantly lower costs

With hospitals and EDs overwhelmed with patients in many communities, there is growing interest in a concept that provides hospital-level care in the home for certain patients. Such candidates present to the ED and meet criteria for hospitalization with general medicine issues such as exacerbations of chronic conditions or infections.

Through this home care approach, advocates note that patients can avoid healthcare-associated infections and other adverse consequences that have been associated with inpatient care. Meanwhile, facilities can preserve hospital beds and other resources for patients who require intensive care or other services that must be delivered in the hospital. Further, when carried out on a large enough scale, advocates note that such an approach should be able to relieve ED boarding or crowding related to a lack of inpatient beds.

While the hospital-at-home concept comes with numerous challenges, particularly regarding reimbursement, several health systems are demonstrating that the approach can save significant dollars without jeopardizing care quality or safety. Studies show that along with equal or superior outcomes to similar hospitalized patients, such a model can deliver improved patient satisfaction. Now, some health systems with years of experience working with the concept are crafting new ways to leverage the approach.

Foster Collaboration

Emergency clinicians are an integral part of the home hospital program at Brigham and Women's Hospital in Boston, according to **David Levine**, MD, MA, an internist and clinical investigator who is leading the program. "This requires very close collaboration with emergency providers because they are the admitting team," he says.

Given that all appropriate patients are identified for the program in the ED, emergency staff played a significant role in development, particularly enrollment process designs, Levine observes. "We made sure we would be incredibly fast in approaching patients so that we wouldn't slow down [the ED] workflow and end up creating bottlenecks," he says. "We also then involved key ED stakeholders in the entire process so that there would be a feeling of collaboration the entire time."

The program, in effect for about two years, generally targets patients who otherwise would be hospitalized on a general medicine ward. "These are patients who require acute care, but they are not going to crash," Levine notes. "They are not going to need intensive care and end up in the ICU."

For instance, patients with pneumonia, heart failure, or complications related to chronic conditions such as diabetes or COPD might be good candidates for the home hospital program. "It's really the bread and butter of internal medicine," Levine adds.

Emergency providers triage and examine all patients as usual, Levine observes. First, a resident or physician assistant sees the patient. Then, an attending physician visits the patient. However, the case-finding process begins as soon as patients present to the ED. Nonclinical staff members who have been trained by the home hospital team rely on inclusion and exclusion criteria to identify which patients might be appropriate for the program.

Further, eligible patients must live within a specific geographic area surrounding Brigham and Women's main campus or Brigham and Women's Faulkner Hospital, a community facility in Boston that also is participating in the home care program, Levine says. Also, while there are no age requirements, the median age of patients in the program is around 82 years, Levine says.

"We are trying to take care of acutely hospitalized Americans," Levine says. "We have built a lot of important processes around older adults ... [however], we have 20-year-olds in our program sometimes."

With the list of potential candidates for the program, a member of the home hospital team will consult with ED team members to hear their opinions on which patients would be a good fit for the program.

"Sometimes, [the emergency clinicians] will call us [with a potential candidate for the program] because we have signs everywhere, including the conditions we treat," Levine notes. "However, we will often come to them, and our team will facilitate a conversation."

Following this discussion, both the ED team and the home hospital team will approach patients who both teams have mutually agreed are good candidates for the program. Team members will describe the program to patients and offer the home care option as an alternative to inpatient hospitalization. The option appeals to some patients more than others, some of whom may be hesitant or concerned about receiving acute care at home.

"It is an interesting struggle sometimes to get patients to enroll in the program," Levine acknowledges. "It really runs the gamut from patients who are cheering with joy after they learn of this opportunity to [patients from whom] we get very much the opposite response, who feel they never could go back home [in their condition]."

Patients who select the home hospital approach are returned to their residences via professional transport in a manner that is tailored to their needs, Levine explains. "Often, a team member will ride with [patients] or meet them at their home," he says. "The core of the team is a nurse and a physician who will see the patient. Then, we can ratchet up or down the needs of the team based on what the patient needs."

For instance, the team can bring in a social worker, physical therapist, occupational therapist, home health aide, or other assistant, as needed, during the acute episode, Levine notes. Everyone who goes home is monitored continuously through technology.

"We monitor heart rate, respiratory rate, and telemetry on patients," Levine says. "We have a set of machine algorithms that are monitoring the data, and when there is a problem in the data, it alarms ... whoever is on call in the home hospital team."

Further, the home hospital team can visit with patients via video. Patients are always free to communicate with providers via phone and text messaging. "We provide a tablet to patients and a platform for them to communicate with us while they are at home," Levine adds.

While the program generally serves only about four patients receiving acute care in the home at one time, results from the approach thus far show promise, Levine reports.

"In general, we have shown large reductions in the direct cost of care compared to a control group of patients who stayed in the hospital," he explains. "We have shown no appreciable differences in the quality of care or the safety of care between patients who go home in our program versus those who stay in the hospital. We have shown improvements in the patient experience [in the home hospital program]."

Levine adds that in one recent study, investigators found that patients in the home hospital program logged fewer readmissions at 30 days than similar patients who were cared for in the hospital.[1] However, it is still unclear how public and private payers will handle home hospital approaches, as the concept does not fit neatly into traditional payment models.

Currently, care provided through Brigham and Women's home hospital program is funded mostly through grants and support from the Partners HealthCare Center for Population Health, which is a group affiliated with Brigham Health. Some insurance reimbursement is available for physician house calls. Nonetheless, buoyed by performance outcomes, Levine notes that the program is in expansion mode. "We are adding lots of new diagnoses and some new technological capabilities," he says. "We are also working to increase the geography in which we operate."

While the home hospital program remains a research enterprise, it has evolved into a service line, Levine observes. "A lot of people think of research and operations as two completely separate entities. I would argue that is a very old-fashioned view," he offers. "I try to position our home hospital work in between both research and operations ... it is definitely both."

The Mount Sinai Health System in New York City started its own hospital-at-home program in 2014. Since then, the program's shape and focus have evolved significantly. For instance, the program initially was limited to patients with six conditions clinical leaders determined could be

managed safely in the home: community-acquired pneumonia, cellulitis, congestive heart failure, high and low blood sugars for diabetes, deep vein thrombosis, and COPD. However, those parameters have widened in recent years.

"We have definitely increased the number of medical diagnoses that we look for in our EDs," notes **Linda DeCherrie**, MD, clinical director of Mount Sinai's hospital-at-home program and a professor of geriatrics and palliative medicine. "Retrospectively, we have coded in over 59 different DRGs [diagnostic-related groups]. We really look at every patient who comes through our ED at this point in time who meets our insurance and geography criteria to see why they are being admitted and [whether] it is something we could take care of in the home."

For example, if someone requires care in the ICU or cardiac monitoring, that patient is ruled out from the hospital-at-home approach immediately, DeCherrie notes. "But if they are going to go to a general medicine floor, we are really looking at their case to see if it is something we could offer to them."

Another change from the early days: Patients referred to observation used to be prime candidates for hospital at home. "Observation is still a source, but I would say we try to go more upstream now and focus much more on our EDs," DeCherrie notes. "We used to wait to even review charts until after the ED physician had determined the patients required admission. We still absolutely need to make sure the patient meets criteria to be admitted. Now, we follow patients [electronically] from the moment they arrive in the ED."

Administrative assistants monitor the ED board continuously to see which patients meet insurance and geographic criteria. "Then, from that point, every potentially eligible patient is followed electronically by a clinical person," DeCherrie says. "One of our nurses, nurse practitioners, or physicians will follow them in the ED if there are reasons they seem appropriate for the program or definitely not appropriate."

Program developers have found that if one waits until after an emergency physician tells a patient he or she needs to be admitted, it is much harder for patients to conceptualize the idea of receiving care at home, DeCherrie explains. Patients already may have told family that they are going to be admitted and made arrangements for pets or other issues, she says.

Instead, what works better for the program is if the hospital-at-home concept is introduced to patients well before the emergency physician has made a decision on disposition. Typically, program staff will tell appropriate patients that if the emergency physician determines they require admission, they likely will meet the criteria for hospital at home. "Then, patients are generally more interested in doing the program," DeCherrie says.

DeCherrie adds that as soon as program administrators think a patient is appropriate for receiving acute care in the home, a hospital-at-home physician will visit the ED and talk with the emergency physician. "The emergency physicians are not the ones clinically deciding if someone might be appropriate, but they all have to know about the program," she says. "We are also making sure that primary care providers [PCPs] in our community know about us. People who are connected to PCPs are going to call [patients] from the ED to tell them they are being admitted [to hospital at home] and ask what they think about it."

However, training every single emergency physician who works at Mount Sinai's main campus hospital about the nuances of determining which patients are appropriate for hospital at home is practically impossible, DeCherrie notes. "We have a large group of faculty and a large group of residents," she says. "Plus, we have residents from multiple other services like medicine and psychiatry, and all sorts of services who all rotate through the ED."

At some smaller hospitals participating in the program, emergency physicians may play a role in identifying patients who are appropriate for the program. DeCherrie explains that because these providers are part of a much smaller faculty, training them about eligibility criteria and the other intricacies of the program is easier.

Note Benefits, Outcomes

Patients who are enrolled in hospital at home generally receive daily visits by a physician or nurse practitioner. If a patient needs IV medication management, a nurse might visit up to three times daily. "We do some visits via video in the home; that is a newer approach for us," DeCherrie reports. "We may do the middle-of-the-hospital-course visit as a televisit. A nurse will set it up in the home so the physician can [interact via] video with the patient."

At the program's busiest point, when it could receive Medicare fee-for-service patients as part of a Center for Medicare & Medicaid Innovation grant, the hospital-at-home program was admitting 10 to 12 patients every week. There could be as many as 30 patients involved in the program at one time. However, that grant ended in August 2017. Now, the

program works with just three payers: Healthfirst, EmblemHealth and Oxford-UnitedHealthcare.

The incentive for insurance participation? It could be that the approach has demonstrated consistently that it can deliver cost savings in the 19-38% range compared to similar patients who have been hospitalized. Further, one recent three-year study of the hospital-at-home model combined with a 30-day transitional care program demonstrated additional benefits. Those benefits included shorter lengths of stay, lower rates of hospital admissions, fewer follow-up ED visits, fewer transfers to skilled nursing facilities, and higher patient satisfaction scores.[2]

Monitor CMS Changes

Despite positive outcomes from the approach, numerous challenges to the hospital-at-home program remain. Certainly, coming up with a more consistent method of reimbursement is a big issue, although there has been some progress. DeCherrie notes that CMS has approved a proposal for a new payment model in which the government would provide 95% of the DRG to cover a 30-day episode of care, and shared savings based on quality metrics compared to similar hospitalized patients.

"It was approved for everyone in the country, not just for Mount Sinai," DeCherrie explains. "It was a pretty major thing."

However, with multiple leadership changes at the Department of Health and Human Services, implementation of the new payment approach has yet to occur, DeCherrie notes. "It was approved last September, and that is where it stands. No information has come to us since then," she laments. "We think it will be at least another year, if not longer."

In the meantime, for the insurers that have offered reimbursement for hospital-at-home programs, it has not been easy, DeCherrie notes. "[Insurers] have to fit a program that is providing inpatient care into outpatient rules and regulations," she says. "They have to process [reimbursements] through an ambulatory, outpatient methodology, which requires insurance companies to make ... infrastructure changes in order to process this."

Hospitals need to consider patient volume when thinking about starting their own hospital-at-home programs. Administrators have to justify the cost of employing a robust team providing 24-hour care in the home to acutely ill patients.

"Probably somewhere between 200 and 300 patients need to come through every year [to justify] appropriate minimal staffing," DeCherrie says.

To meet this requirement, Mount Sinai has expanded the reach of the hospital-at-home service line to maintain adequate staffing. For example, the program offers observation care in the home for patients who are only with the program for 24 hours. Also, Mount Sinai provides palliative care at home for patients who otherwise would be hospitalized in the facility's palliative care unit. In certain cases, Mount Sinai might even provide at-home services for patients who fear hospitals, even if clinicians believe those patients need to be in a medical facility.

"Also a very large, successful part of our program is something called subacute rehabilitation at home," DeCherrie says. "People don't want to go to a nursing home for three weeks [following an inpatient hospitalization]. We can provide six days a week of physical therapy, occupational therapy, nursing services, and oversight from a physician ... in their home."

It is a much higher level of service than a visiting nurse would be able to provide, DeCherrie observes.

"We have diversified our services as one way that we are able to have more robust staffing for our program."

Another barrier to consider with a hospital-at-home approach: the logistics of delivering the right supplies and equipment into the home at all hours. "Sometimes, I feel like we run a mini-Amazon here," DeCherrie quips.

Reducing ED crowding was a key goal of Mount Sinai's hospital-at-home approach. The idea might appeal to other large, academic medical centers that deal with volume-related congestion. However, the approach probably would not be a good fit for hospitals that rely heavily on inpatient admissions for revenue, DeCherrie says. She does note that if medical facilities use value-based contracts, then a hospital-at-home approach might be worth considering.

"One of the first things [interested hospitals] should do is talk to people who are already doing this, and get some help from the outset," Levine recommends. "Someone who has been doing this can help you figure it out." ■

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HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. **The American Academy of Pediatrics says that after an unplanned hospitalization, a hospital should have a mechanism in place for direct communication with the referring physician and primary care physician for all but which reason?**
   a. To provide context for the child's illness within the family
   b. To confirm current medication
   c. To prevent unnecessary duplication of previous tests
   d. To discuss availability of community resources

2. **Which was *not* one of the reasons cited by the Minnesota Hospital Association for potentially avoidable days in the hospital?**
   a. The need for an inpatient behavioral health bed
   b. Legal involvement due to prior criminal histories
   c. Lack of updated insurance documentation
   d. Lack of access to community-based settings

3. **Penn State researchers introduced a model called REDD (readmission, emergency department, or death) by using clinical, administrative, and socioeconomic data from patients to predict which patients will be at a high risk of adverse events after they are discharged. In a perfect world, the risk score would be embedded where before discharging the patient?**
   a. The electronic health record
   b. The care team's training manuals on interventions
   c. The Medicaid patient portal
   d. All of the above

4. **The home hospital program at Brigham and Women's Hospital in Boston generally targets patients who otherwise would:**
   a. be transferred to a skilled nursing facility.
   b. experience a lengthy stay in the ED.
   c. require a short stay in the ICU.
   d. be hospitalized on a general medicine ward but not require intensive care.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Case Management Leaders: Without You, We're Nothing, Part Two

By Toni Cesta, PhD, RN, FAAN

Introduction

In the last issue of *Case Management Insider,* we reviewed some of the leadership issues and challenges specific to the role of the leader of a case management department and discussed five traits of an effective leader. This month, we will conclude with the final five traits of effective leaders and examples of how they apply to case management.

Trait 6: Successful Conflict Resolution

One cornerstone of effective leadership is the ability to handle conflict. In case management, there is no shortage of conflicts that can arise. Conflicts can mean vulnerability or strength for a case management leader, depending on how they are handled. Conflicts can be turning points for issues that have been ignored. These areas of discord are a consistent element of case management and something one should expect to find on a regular basis.

As a leader of a case management department, you will encounter conflicts involving case management staff, physicians, payers, other departments, patients and families, post-acute providers, and even transportation companies. You likely will be asked to address these conflicts when your staff is unable to resolve them. As these events are unpredictable and unplanned, they may interrupt your day and require that you quickly get up to speed on the issue.

ONE CORNERSTONE OF EFFECTIVE LEADERSHIP IS THE ABILITY TO HANDLE CONFLICT. IN CASE MANAGEMENT, THERE IS NO SHORTAGE OF CONFLICTS THAT CAN ARISE.

In order to resolve these conflicts, you must be comfortable enough to jump feet-first into issues as they come up. Do not allow the conflict to become counterproductive — instead, use it as an opportunity for growth or improvement. As you solve the problem, include your staff in the resolution process so that they might be able to correct it themselves the next time something similar happens.

Conflicts also will arise between staff members. These conflicts can be equally challenging. My recommendation is to bring the two staff members together to work the issue out face to face. This will avoid a "he said, she said" situation. Once resolved, discuss takeaway lessons with the staff members so that in the future they can address such conflicts themselves.

As a case management leader, you will experience your own conflicts, usually between you and senior management staff, physician leaders, other department heads, and outside agencies and payers. Each conflict is your own learning opportunity, and compromise often is the best solution. Remember that each party in a conflict has his or her own point of view that may be as valid as yours. Listen to the other party and take his or her point of view into consideration. Validate it and be reasonable.

It will sometimes be true that you or your staff were incorrect; consider this before you dig your heels in. You will not win every conflict, nor should you expect to.

The key is to be prepared for conflict and to harness it to your advantage whenever possible.

Trait 7: Asking the Right Questions

Asking good questions is a leadership trait that often is overlooked. Many leaders do not know how to probe the thought processes of their direct reports, colleagues, or bosses — instead, they make assumptions about their actions when those actions are unclear. When those assumptions are wrong, dysfunctional patterns can be created. When someone finally helps by asking the right questions, a plan can be formulated and the problem resolved quickly, allowing the solution to move forward.

You may wonder why asking a question is important, or you may feel that asking questions demonstrates lack of knowledge or incompetence. In fact, asking the right questions can be an effective tool for improved communication, strategic planning, or conflict resolution. Conversely, do not ask questions just for the sake of it or to appear participatory in a meeting. Formulate your questions using some basic rules of thumb.

First, select your questions carefully and thoughtfully. A good question is one that unlocks a situation, or brings it forward for a bigger discussion. You can think of asking questions as a strategy to use when you want, or need, to get an issue out in the open without appearing too aggressive. Good questions can help the other party to look at the issue from a different point of view.

In more controlled situations, like a committee meeting, you may want to think of your questions in advance. Think of three great questions, jot them down, and interject them into the conversation when and if appropriate. By asking questions in this way, you can guide a discussion in a particular direction.

Use good questions as part of your leadership strategy. Ask questions about yourself, plans, projects, or initiatives you are working on, and ask questions about the organization.

When asking questions of yourself, consider how you might do things better or differently. When asking questions about projects or initiatives, try to pose them in a way that not only advances the work but also builds relationships and helps to get others involved and committed. Probing questions should be posed in the spirit of moving the project forward in a collegial way.

Finally, asking questions regarding the organization can help you to think of the organization as a whole and better ensure that you are in sync with the organization's strategic plans and goals. Think carefully about them in advance whenever possible. Bring them forward in meetings or with colleagues. Select questions that provoke thoughts or actions.

Trait 8: Making High-quality Decisions

Making decisions is one of the fundamental roles of any leader. While it is easy to make a decision, it is much harder to make a quality decision.

Start by reflecting on your decision-making process. Do you make quick and spontaneous decisions, or are you more deliberate? Do you seek guidance before making a decision, or do you usually fly by the seat of your pants?

The challenge for case management leaders is to make both quality and timely decisions. Sometimes the work of a case management department does not allow for a long period of deliberation, as many decisions are time-limited and need to be addressed right away. Conversely, others may allow you the time needed to work through your decision by gathering information that you need to support the decision.

Let us review a process that can help you to improve your decision-making skills. The first thing to do is to identify the decision you need to make as well as the objectives or outcomes you are trying to achieve. Whenever time allows, do your homework by gathering as many facts and as much information as you can to assess your options and choices.

Next, brainstorm and come up with several possible choices. Many decisions can lend themselves to different solutions, so explore what those are. Look at your options and determine if they are compatible with your values, goals, and abilities.

The next step is to weigh the probabilities of the potential outcomes. Ask yourself what is the worst that can happen. If you pick one potential solution over another, can you live with the consequences of that decision?

Take the time to write a list of pros and cons. Prioritize which considerations are more or less important to you. If time allows, solicit feedback from those you trust or those who may have had experience with your problem. By gaining feedback, some factors that you had not considered may come to light.

Once you have made your decision, monitor the results and check that your desired outcome was achieved. Remember that hindsight is always 20-20. Some people become paralyzed with the fear of making a mistake. If you make a mistake, think of it as an opportunity to learn, and do not second-guess yourself. At the

end of the day, all you can do is the best with what you have.

Also, do not underestimate the power of intuition, or your gut feeling. After all the facts are weighed and evaluated, it can be the final determinant. Quite often, it may be all you have to go on.

Trait 9: Being a Trusted Leader

When all is said and done, the vast majority of employees want to do a good job. Very few people go to work saying, "I'm going to do a bad job today." People also want to follow and accomplish great things. Your staff knows that you are their link to senior leaders and that you are their face and their voice. They need to trust that you will protect them, advocate for them, and fight for them when necessary. If they lose their confidence in you, their morale and work will suffer.

A trusted leader will get more from their staff and have a strong following. Think about leaders you have known over the course of your career. What made you want to do your best for them? What were the traits that elicited your trust and confidence? Was it their support, their charisma, their ability to teach you, their kindnesses, or their fairness? It was more than likely all of these. You knew in your heart that your leader had your back. He or she told you the truth and followed through on promises.

It also is important to remember that trust is earned. You do not gain trust simply by being hired into a position — it is a fragile thing that can be earned and lost. Once it is lost, it will be much harder to earn it again. Trust will build over time as you work on making it happen.

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When you first take a new leadership position, your staff may challenge you in a variety of ways. They may push the limits of the rules to see if you will let things go or hold them accountable. As a leader, you are not the staff's friend. If you approach your role as a friend, you will have trouble when there are issues that need to be addressed — or you may be tempted to ignore the issues altogether. This is dangerous and could ultimately lead to your own failure. Your staff wants a leader who sets rules and holds everyone to them equally. You must be diligent every day and never take your eye off the elements that will gain trust.

The four key traits of trusted leaders are selflessness, safety, service, and sacrifice. Real leadership, the kind that inspires people to pull together and achieve something great, can only be exercised when a leader is trusted.

Trust also arises when someone is seen acting selflessly. This may not sound like news; indeed, the centuries-old concept of servant leadership is based on it. But if it also sounds vague and hard to apply to your own leadership setting, let us break it down further: People in an organization perceive selflessness when a leader concerns him- or herself with their safety, performs valuable service, and makes personal sacrifice for their benefit.

Trait 10: Clear Communication

As you review all the traits discussed in our two articles on leadership, there is one theme that carries through them all: Communication. It has been said that communication is the glue that holds organizations together. It also is one of the fundamental leadership skills.

So much of our work is performed

through communication. It is how initiatives are launched, outcomes are reported, patients are case-managed, and teams are built. Interpersonal communication skills are what we use when we are engaged in face-to-face communication with one or more individuals.

These skills are needed to speak appropriately with a wide variety of people. They also involve maintaining good eye contact, demonstrating a wide vocabulary, and tailoring your language to your audience. As a case management leader, you must listen effectively, present your ideas appropriately, write clearly and concisely, and work well in groups.

Although presentation skills may be used infrequently, there will be times when you will need to present information to a group or committee, either in a formal or informal setting. Be sure to work on presentation and public speaking skills.

Communication skills are not limited to direct interaction with other people and the spoken word. Writing clearly and effectively is a skill that is not limited to journalists or professional authors. Poorly written communication can be frustrating for the reader and potentially damaging for you. Spelling mistakes, even in emails, can give a bad impression and may result in the reader not taking your message seriously. If you need help with your writing, there are many workshops you can attend to improve your skills.

Communication is a two-way street. As a leader, you are constantly giving and receiving information. It can be verbal or written. In fact, written communication has accelerated with the advent of electronic communication. Information is coming at leaders from all directions at all times. It is a lot to juggle for even the most seasoned leader. You must consciously remember to listen as well as to speak.

Listening is an active process that requires as great an effort as speaking, so do not give it short shrift. If you are not a good listener, practice honing your skills. When staff members speak to you, give them 100% of your attention. Do not read papers on your desk, respond to emails, or answer the phone. It is difficult for us to do two things at once, even though we think we can. While you are reading an email, you are giving your staff member the message that you are not completely present and that they do not warrant your full attention.

Summary

Leadership style sets the tone and approach for an organization. Think of it as the classic "follow the leader" situation: People will watch and mimic how things are done by their leaders. You always should lead in a way that you want to be copied — because you will be. I hope you will consider these traits so that you can be the very best leader you can be. ■