HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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# Case Management in Hospitals Is Being Transformed to Care Coordination

*Focus on value-based care*

The hospital case management role that has been prevalent for more than three decades is transforming, hospital-by-hospital, into a value-based care coordination role.

"Hospital case management, primarily today, is pushing the role of case manager as discharge planner," says **Stefani Daniels**, MSNA, ACM, CMAC, president and managing partner of Phoenix Medical Management in Pompano Beach, FL.

"That was never the original intent," she says. "That occurred because of the hospital financial freefall after the introductions of DRGs [diagnosis-related groups] in the early 1980s."

> "THOSE THAT BARRELED THROUGH THAT TUMULTUOUS TIME BELIEVED THEY COULD MAKE MONEY IF THEY LOWERED THEIR LENGTH OF STAY."

When hospitals shifted to cost-based reimbursement to prospective payment, hundreds of hospitals closed, unable to adapt, Daniels says.

"Those that barreled through that tumultuous time believed they could make money if they lowered their length of stay," she explains. "As a result, in those hospitals where case managers existed, they became intensive discharge planners — get the patient out."

Hospitals changed case managers into discharge planners and utilization reviewers, she adds.

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Another seismic shift began with the Affordable Care Act. This time, the healthcare system is evolving from fee-for-service into a model that encompasses value-based care, population health initiatives, and care coordination across the care continuum. These changes have resulted in community case managers visiting some hospital patients and working with them on transitions to the next level of care or to their homes, Daniels says.

Hospitals that are evolving more quickly with this change are developing a second generation of hospital case management. "In this new marketplace of the accountable care organization, an at-risk payment model of population health, all is dependent on the outcomes achieved — not the value of tasks completed," she says.

This next generation of healthcare is about care coordination for high-risk patients. The successful care coordination strategy is a complex blend of activities, relationships, and identifying resources that influence the patient's successful navigation through the system, Daniels explains.

"The transformation of the traditional functional discharge planning-utilization review model is simply an evolutionary adaptation to the new marketplace," she says.

Hospitals in which executives understand this transformational change will be the 21st century survivors of the shift.

"We need a program that supports the cost-efficient navigation of high-risk patients through the hospital and high delivery system," Daniels says.

"We need to change from a department to an enterprisewide program," she adds. "The case management department implies boundaries and specific roles inside that department, while this is a hospitalwide concept — a hospital vision that we're all responsible for patient care coordination through that hospital system and beyond."

Hospitals should make this transition soon because community providers are filling the gap, and hospitals' survival will depend on it, she predicts.

For example, primary care clinics, insurance companies, self-insured employers, and others are hiring case managers to help high-risk patients with care coordination.

"Everyone is jumping on the care coordination bandwagon," Daniels says. "There is no coordinated effort to make sure we have a single vision for patients. There are patients who report phone calls from three to five different care coordinators, and the care coordinators go into the hospital, working around the hospital coordinators."

Hospitals are leaving consequential opportunities unanswered.

For instance, the hospital case manager might spend hours on the phone, trying to find a nursing home for patients when this role could be handled more efficiently by someone without a nursing degree. Meanwhile, physicians are ordering duplicate and unnecessary tests for patients, sometimes counter to evidence-based guidelines and the patient's family's wishes. This is the type of care coordination situation in which hospital case managers could be of service to patients and actually help to reduce healthcare costs, Daniels says.

Transformation is survival, Daniels explains:

• **Reveal the vision.** "If you really want to begin the transformation process, you must have a vision first," she says.

The vision can answer what the hospital means by care coordination.

"You can't just change the

structure and operations unless you have a vision for the future," Daniels says. "What do you want it to look like?"

When Daniels explains this to health system boards of directors or executive teams, she asks them to envision what they would want for their mother if she were diagnosed with cancer. "What do you expect the healthcare system to do for your mother over the next 60 to 90 days? Do you expect someone to help her understand her diagnosis? Do you want her to know why she gets one treatment and not another? Do you want her to understand what her medications are about?" she says. "Do you want her to understand the choices she has to make?"

The person who can help a patient answer all of these questions is the case or care manager.

The vision is how the healthcare organization will have a single consistent resource for patients. This should be someone the patient can contact throughout the treatment process and while the patient is in the hospital, doctor's office, or oncology office.

"If this is what you envision, what do you do to make it happen?" Daniels says. "That's when you talk about structure and operation. I've learned that unless you have a consensus on what your vision of case management or care coordination is about, then you'll float up river against the tide."

• **Consider the culture.** "A health system might have an enterprisewide vision that extends across the continuum, but what if its culture is not conducive to teamwork, or what if it does not encourage individuality or decision-making?"

A hospital could have a culture that is so engrained that it is not open with working alongside a case manager. In such a setting, care coordination and teamwork might not work.

"You have to take this into consideration," Daniels says. "We have to think of the culture of the organization and how it takes a long time to change the culture — like a comic strip of a cruise ship trying to make a U-turn."

For example, Daniels once visited a hospital and spoke with many employees, including lab and radiology professionals. One person told her about how a physician had ordered 16 CT scans for a teenage boy within the past decade. The teenager had a chronic illness, but the CT scans were excessive and placed him in danger of developing cancer. The radiology professional said, "When I first started seeing a pattern and went to the director, he said that if the physician ordered it, you do it," Daniels recalls. "So the man learned to keep his mouth shut — no matter what."

"WE HAVE TO THINK OF THE CULTURE OF THE ORGANIZATION AND HOW IT TAKES A LONG TIME TO CHANGE THE CULTURE."

This is a culture of fear, and in this situation, an organization will never work together as a team, she says. "That's why culture has to be taken into consideration."

• **Adjust staffing.** Health systems that make this shift to value-based care with an emphasis on the care continuum often find that their existing case management staffing changes. They might lose one-third of their staff and have to reassign others.

"Most hospital case managers are women and nurses, and many have been enculturated to be deferential to the medical staff," Daniels says.

When the hospital's culture and vision change, some case managers might not be able to take on the role of entering a partnership with the physician. The new job requires finding someone who can call the physician's attention to unnecessary CT scans and serial testing, she explains.

"They have to understand the case manager's primary ethical obligation is advocacy, and that's why we lose 35% of incumbent staff," she says.

• **Build multidisciplinary teams.** Hospitals can change their structural framework and realign some of their traditional duties, including activities that existing case managers perform, Daniels says.

"We have to make sure the scope of case management services focuses on care coordination," she says. "That means finding new homes for other things on the case manager's plate."

For instance, instead of handling insurance appeals, case managers now work more closely with patients. Their attention goes to the care plan and what makes the patient responsive to therapy.

All of these changes take time and require regular team meetings in which each team member can talk with each other, Daniels says.

In the new accountable care organization marketplace, health systems will have at-risk contracts in which the focus is on outcomes, including patient-centered outcomes.

And one of the most efficient ways to improve outcomes is to have a consistent case manager follow the patient through the care continuum and serve as a single resource for the patient and communicator with the patient and care team, Daniels says. ■

# Optimal Case Management Leadership Requires Subtlety, Advocacy

*Self-examination is important*

Hospital case managers are leaders, whether they realize it or not. Their role in standing up for patients and speaking with other healthcare professionals about patients' needs provides case managers with leadership skills.

"You can hold a really powerful, even maybe subtle leadership to be able to help your patient," says **Lisa Lobdell**, RN, MSN, CCM, lead case manager at VA Long Beach Healthcare in Long Beach, CA. Lobdell speaks about case management leadership and patient navigation at national case management conferences.

"A good example is how you might not be able to fight for yourself, but if you see something that your patients need, then you are able to speak up for them and advocate for them," she explains. "To me, that's leadership, being able to have people who are not in a direct authoritarian leadership role coach people on how to do the right thing."

Case managers might not consider themselves leaders because it is not a role they sought. There is a difference between being a leader and being a supervisor, she notes.

"Some supervisors have very good leadership skills, but you don't have to be a supervisor to be a leader," she says. "It's often the people down in the trenches, so to speak, who are the leaders who can get people to do things that even someone at a much higher level couldn't get someone to do."

Nurses are able to lead physicians, residents, and fellows to what patients need because they are a stable source of information and experience. But it takes fortitude and persistence. For example, Lobdell once had to call a physician at home late at night. The doctor hung up on her.

"I called back to make sure he did what was needed for my patient," she says. "Often times, in the middle of the night, your patients still have needs and you're with them while they're dying and taking their last breath, and to get what you need for your patient takes a level of creativity."

Lobdell offers these suggestions for how case managers can exhibit and improve leadership skills:

• **Be a mentor or trainer.** Each case manager should aspire to be a mentor for others, being the kind of patient advocate they would like others to be, Lobdell says.

"If people see that you are a really good, caring case manager who knows your resources and works well with others, then you are a role model," she says.

"When I have an employee who shadows me and asks questions, and if I want them to be able to work with and communicate with different doctors and different staff members, then I model what good communication looks like," Lobdell explains. "It's being respectful, direct."

For example, Lobdell will not tell a doctor, "You didn't order this." Instead, she will wait until the physician is finished discussing the patient, and she recaps, saying, "These are the things I think you wanted."

The doctor might say "yes" or "no," but the point is to learn how to communicate with people in respectful ways so it is much more likely the case manager will achieve the best outcome for patients.

"It's all about, at the end of the day, serving our best," Lobdell says. "We work in different kinds of areas and work with different personalities and temperaments and people who are at different stages of learning."

• **Lead for patients.** Working with patients in their most vulnerable state requires subtle leadership.

"You're trying to direct them to resources and be a leader for your patients," Lobdell says. "You have to find out what their values are and what's important to them and how you can get them to stop smoking to align with their values."

Ask patients questions about what they want and need, including the following:

- What would you like to do?
- Have you heard of that resource?
- Are you ready for a change?

"I've had people come back to me and say, 'I'm ready now.' They weren't ready before," she says.

"For me, it's always been about building trust, doing what you said you'd do, and doing it when you said you'd do it," Lobdell adds. "If you tell patients you'll call at 3 o'clock, and you don't call them, they're probably sitting at home waiting for that call."

The goal for case managers is to empower and educate patients, working with them until they do not need case management anymore, she adds.

• **Supervise others in case management.** Case managers

sometimes will be asked to move into the role of a supervisor. When this happens, they could embrace those leadership qualities that helped them land this responsibility.

As a supervisor, make communication a priority.

"When you're supervising people, they don't always know why you make decisions the way you do," Lobdell says. "I'm big on communication."

Supervisors cannot always share their decisions with people, for a variety of reasons. But they can engage in nudging people to an understanding of the supervisor's and other organizational leaders' goals and actions.

"As a supervisor, you have the authority to tell people what to do, but that doesn't mean they'll do it or do it at their best," Lobdell says. "Being a supervisor doesn't necessarily mean you are a leader; a leader is an informal authority."

Supervisors who have good leadership qualities and traits make for the best leaders, she adds. "Good leaders are people who know who you are and are in the trenches with you."

• **Engage in self-examination.** Case managers who aspire to be better leaders might start with self-examination.

"Look at what your own biases are," Lobdell suggests. "We each have areas where maybe we think we're better at doing than we are."

Aspiring leaders also can explore their potential through a leadership program. Lobdell attended a leadership program in which one of her peers answered questions about her.

"I found that very enlightening," Lobdell says. "One of the ways to develop your leadership style is to look at the person you are and take constructive criticism from people, so you know where your blinders and weak spots are."

Public speaking and building support networks with other leaders also are ways to improve leadership skills.

Case managers can think of leadership skills development as similar to nursing or other training.

"I've had to learn how to speak with data, be heard, and take the emotion out of my voice," Lobdell explains.

"I've learned how to put together a presentation. You may have great ideas, but if you don't know how to do those things, you won't get very far getting your point across with people in higher positions."

A case management program also could go through a self-examination process. For instance, the program could bring new and experienced case managers together to discuss what they think should be included in training.

"We got input from case managers about what they would have liked to learn when they first came there, but that no one showed them," Lobdell says.

• **Learn people management skills.** As a supervisor, case management professionals might learn how to listen to employees and see circumstances from their perspective.

Staff will seek out a good leader, looking for help with their problems. When they stop knocking on the supervisor's door, it might be time to find out why they have decided they no longer need the supervisor's help, Lobdell says.

When an employee is performing a task incorrectly, the supervisor's role is to sit down with the person, listen, find out what the person is trying to accomplish, and then lay things out step by step to help the employee succeed, she says.

"If someone is going down the wrong path, you sit down and say, 'Where are you trying to go? What do you think would be best?'" she says. "A lot of times, people can figure it out for themselves if you give them the right tools."

Creating a team and soliciting ideas, input, and creativity is how to get the best out of everybody, she adds.

The roles of manager and leader both are important, Lobdell says. "But when we lead or focus on leading, you really get greater results." ■

# Patient and Family Councils Make a Difference

A strong quality improvement infrastructure can be the perfect setting for developing a patient and family advisory council (PFAC), says **Libby Hoy**, founder and CEO of Patient and Family Centered Care Partners in Long Beach, CA, which works with hospitals to encourage patient and family participation.

"Some organizations have a very strong QI [quality improvement] infrastructure and that can be the most appropriate way to engage patients and family, by welcoming them into that structure," Hoy says. "The goal is to create consistent messaging and to create some guardrails around the effort, so that everyone comes in with consistent messaging and common goals."

Recruitment is especially important for PFAC because the members should accurately reflect the population served by the organization, Hoy says. She has served on a hospital's PFAC herself.

"It's a top area for opportunity in this work. Most councils are not hitting that diversity profile yet, and that is an important thing to strive for if you are developing a council," she says.

A common recruiting mistake is to ask leading physicians to recommend someone who would be a good patient or family volunteer, Hoy notes.

That is an easy way to recruit and can yield a good number of participants, she says, but it does not always yield the best results.

"After a honeymoon period of three to four months, we find that a lot of advisors who came to the council that way fall off. That is because if a physician is treating my family and comes to me asking me to be part of this council, what am I going to say?" Hoy asks. "I'm going to say 'yes' because he's treating my family and I want to maintain a good relationship. But three months down the line when I'm not seeing that doctor so regularly anymore, I'm going to find a way out because I didn't have any intrinsic commitment to the idea."

Staff members may be reluctant to suggest potential advisors because they worry about being held responsible if the volunteer does not work out, Hoy says. The best approach is to allow patient and family members to self-select but to manage the council membership so it has the right diversity, she says.

## Train Volunteers Properly

Training and educating PFAC members also is a key concern, Hoy says. Failing to provide proper orientation is a common pitfall and undermines the overall effectiveness of the council, she says. It can lead to volunteers becoming frustrated or losing interest, and staff members can be skeptical of the volunteers' motives or lose patience with them not knowing the hospital's basic functions, she explains.

"The orientation to the advisor role is a key piece that I see get dropped pretty often. People are brought in, and they stay in that mindset of being a previous patient or family member, rather than joining the hospital and being part of that team," Hoy says.

"If we can move people from their roles as patient and family members into the advisor role, we can get them to see themselves differently in terms of what they can do. That's when we get what we call high-impact advisors."

Integrating the volunteers into the quality improvement structure can address many of those potential pitfalls and help draw out the most meaningful information, Hoy says.

Too often, she says, hospitals use a customer service approach and ask patients and families questions like "What do you think of this?" and "How could we do better?"

"That opens up a whole dialogue that may or may not be relevant to the organization. We find it's much better to put that into the QI context and tell them you're working on improving admissions, specifically these parts of the process, so what do they see that maybe you're not seeing?" Hoy explains.

"Narrow the conversation so that you can get the most useful information and not have them feeling like they're being asked to think of a lot of different things that may be unrelated."

## Educate About QI

Many patients and family members will not be familiar with the concept of quality improvement within a healthcare organization or that a specific department exists. Hospitals establishing a PFAC should include education about how quality improvement works within the organization and introduce quality leaders.

Hoy became involved with a PFAC after her son was treated in a hospital, and at that point she had never heard of a quality improvement department.

"I just knew my son's physician and care providers. The idea that there was an entire department dedicated to

improving quality at the hospital, and that there were people who made this their profession, that was a new idea to me," she says.

The potential benefit from a PFAC is significant, Hoy says. PFAC members can provide a perspective that is unique to the organization, making their input useful in ways that more generalized advice cannot match, she says.

Hoy notes an example in which she was working with a hospital's PFAC, as a family member, to address the facility's ED outpatient clinic wait times. She did not know what to expect from the experience, especially what the eventual outcome might be.

"That's also key for PFAC participants: getting comfortable with the idea of not knowing the outcome. Quality improvement people are probably more comfortable with that, having used the PDSA and continually improving," Hoy says. "Being comfortable with not knowing the outcomes means you're getting the highest level of value out of your advisors because you have not predetermined the outcome. You have left room for that patient and family voice to inform and guide you."

She had another experience in which a physician was meeting with the PFAC and expressed frustration with parents who do not follow up with appointments and test results. Hoy told the physician that, as a parent, she also was frustrated with the difficulty of reaching someone to discuss those issues. She was frequently sent to voicemail and had other difficulties communicating with the physicians.

"We had a discussion with the administrative team and the front office staff, and together we were able to identify that the phone tree was set up so that when parents called in they were being routed to message boxes of staff members who weren't with the clinic anymore," Hoy says. "We looked in one message box and there were a hundred messages in there from patients and family. I think that highlights the partnership, because you can't get to that without every perspective in the room joining the conversation."

The use of PFACs has increased exponentially in the past several years, Hoy says. Hospitals and other healthcare organizations are embracing the idea as a useful quality improvement tool, she says, with about 54% already using patient and family advisors in some capacity.

"The idea of having advisors is taking hold in the healthcare community, but it's spreading now beyond the idea of having one council for your hospital or health system," Hoy says. "We're seeing councils developed for research, measurement development teams, and quality improvement organizations themselves. That is continuing to spread."

Hoy recently met with a major health plan that is developing a PFAC to help design benefit packages.

## Watch for Pitfalls

There are potential pitfalls when establishing a PFAC, Hoy notes. To get the most value from a council, the hospital should take it on as a serious endeavor and not merely a casual nod to listening more to patients and family. An organization can start slowly, but still, a council is more than just having a few volunteers in for lunch a few times a year and asking them for suggestions, she says.

"There is a risk of not being intentional enough up front, not understanding for the organization what the specific value is to them and how to best implement this plan, which often means working through your quality improvement framework," Hoy says. "It can start as a small test of change and develop organically from there, rather than jumping in all at once with a full council. But some organizations are ready to move forward in a deliberate way. The important thing is to know what you want from this effort and being intentional about that from the start."

When you do not establish the council with that mindset, it can become only a reactive resource. The council might provide feedback, but that information is provided to the organization without structure, Hoy says. The recipients do not know what to do with it or how it fits into the hospital's quality improvement efforts. "That's when things get really loose, and the value just diminishes," Hoy says.

Another pitfall is not closing the communication loop. It is discouraging for council members to discuss an issue or policy and see no evidence that their input was valued or led to any changes, she says. Volunteers do not expect the hospital to accept and act on all of their suggestions, Hoy says, but they do need to hear that the information was received and considered.

"It's very important for organizations to close that loop by telling them that their information went to the appropriate committee, and for this reason and that reason, the committee decided not to alter the policy, or the decision is on hold for another six months," she says. "Whatever the explanation it is, it's important to pass that on to the advisors so they don't lose momentum."

Hoy's center offers online resources at: https://bit.ly/2v69W1m. ■

# Emergency Clinicians Steer Patients With Substance Use Problems Into Effective Treatment

Baltimore has struggled mightily with substance misuse, and much of this burden has fallen on EDs in the region. Indeed, statistics from 2014 suggest that the city registered the highest rate of ED use due to opioid use disorder in the country, and the volume has not let up.

This has prompted hospitals and public health authorities to create innovative solutions to address the problem in a comprehensive way. For example, two years ago, the ED at University of Maryland Medical Center (UMMC) in Baltimore decided it needed a fresh approach toward connecting patients with effective treatment. The impetus for action on this front stemmed from the realization that substance use was a key contributing factor to a growing number of diagnoses.

"Many of the patients ... were coming in with a medical complaint, but really when we got studies done and [figured out] why they were there, we recognized that substance use was ... at the heart of whatever their medical issue was," explains **Andrea Smith**, DNP, CRNP, the director of urgent care and advanced practice emergency services at UMMC.

**Eric Weintraub**, MD, director of the division of alcohol and drug abuse and co-director of adult psychiatry at UMMC, notes that some of these patients presented with psychiatric issues while others arrived with medical concerns, but they were not treated for substance misuse.

"They were getting patched up and sent on their way, and we were seeing high rates of recidivism," Weintraub says.

Part of the problem was that many of these patients were reluctant to discuss their issues around substance use with the emergency clinicians. "When I would try to approach this subject with patients, they just weren't opening up to me, and I wasn't able to build that relationship," Smith observes.

To get around this barrier, UMMC became the first hospital in Maryland selected to pilot the idea of leveraging peer recovery coaches — people who are in long-term recovery themselves and have received training in how to assess the readiness of patients to consider treatment. Peer recovery coaches work with patients to find a solution most likely to succeed, and facilitate patients' transition into an appropriate program.

"I was able to secure funding for our hospital to hire three peer recovery coaches, and that is how [the program] started," Weintraub observes. "They have been working here for two years now, doing SBIRT [screening, brief intervention, and referral to treatment]. [Coaches] see anybody in the ED who screens positive for substance misuse, and it has worked pretty well. We have seen thousands of patients and gotten people into treatment, which has been really helpful."

Meanwhile, the need for such services has only grown. "As a university-owned medical system, we have gone from a couple of years ago seeing an overdose every other day to having two overdoses per day now," Weintraub laments.

In the beginning stages of this effort, the focus was on embedding the peer recovery coaches into the emergency team.

"When [coaches] came in to train and orient, one of the things I did strategically ... was have them shadow a resident, a nurse, and an attending [physician]," Smith shares. "This was to have a walk-through so that they could see the workflow, but also start to ... build the relationships so that the clinical team understood what the peer coaches were all about and vice versa."

Still, it was challenging to integrate the peer recovery coaches and their work with patients into the overall flow of the ED.

"That was difficult because this is a fast-paced environment," Smith explains. "You've got a million things going on at once, and a lot of times [in the past] ... substance use was something we would maybe bring up once and then not talk about [again], but we really put that [issue] at the forefront."

Now, every patient who comes through the door of the ED undergoes a brief screening at triage that includes four questions regarding drug and alcohol use.

"Based on the responses, if a patient's score is above seven, then the peer recovery coach will get a flag to go see that patient," Smith says. "About 25% of the patients we see in the ED in Baltimore have a positive screen, and that means their substance use or their risk of harm is so great that we need to [have them seen]."

**Archie Rhyne**, a peer recovery coach at UMMC, notes that a flag that indicates that a patient needs to be seen appears on a computer screen in his office.

"That is when I will first talk to the nurse [caring for the patient] and find out if there is anything [he or she] needs to let me know about the patient," he explains. For example, the patient may be sedated or irritable, or it may be best to wait a few minutes

because the patient is about to go to radiology for X-rays. The nurse will convey any information that can help the peer recovery coach engage in a more productive discussion with the patient.

"Also, the nurse will always let the patient know the hospital has a peer recovery coach that would like to come around and talk to them and may be of some assistance," Rhyne says.

Typically, Rhyne will introduce himself to the patient and ask if it is acceptable if he provides the patient with some self-disclosure. "That is my door in because I start disclosing that I have been exactly where they are. It loosens the patient up a little bit, and they will start talking," he says.

Rhyne explains that his conversation always has to be about what the patient wants, but he will guide the patient toward questions relating to what his or her life might be like without the drugs or alcohol that the patient is misusing. "A lot of times patients just take a moment to think," he says. "Me being in recovery myself, I know that when I was caught up, there were moments I couldn't have ... because it was always about where I was going to get my next [fix], and I was always filled with shame about what I did to get one."

When patients hear about Rhyne's experiences, he says they tend to relax and share more information with him. "I will find a patient who may have been in treatment four or five times, and then gave up on himself. Then, I will disclose that it took me 40 [attempts], and we talk," he says. "When I get that one moment when a patient starts to feel something for himself again, that's when I will [ask] what was the last type of treatment that he had."

Rhyne will explore with the patient how the treatment worked and whether an alternative approach might be worth a try. "A lot of times, for a person who has been in and out of treatment, and has tried the same thing over and over, a different approach will work better," he says. "Basically, though, it is always about what the patient thinks will work for them because [treatment] is not being imposed or forced on them. If it is what they think will work ... I know from experience they will give it their best shot."

Rhyne emphasizes to patients that there are many resources available to them — a reality that many patients have not experienced.

"Most addicts are out of touch with what is going on as far as what is available to them," he says. For example, they may have called treatment centers in the past and learned that they would be put on a four-week waiting list. But for this program, UMMC has connected with treatment facilities throughout Baltimore, including 11 fast-track treatment providers that will accept patients right away or the very next day.

Consequently, once Rhyne and a patient have decided on a treatment path, Rhyne will leave the room and start making calls.

"Sometimes, we can get the patient into treatment as soon as he or she is discharged from the ED," Rhyne observes. "We have funds here at the hospital where we can send them by Lyft or Uber because a lot of times, if we put them on public transportation by themselves, they will change their mind before they get there. If we can get [patients] right there and sign them up, they will stay."

Before taking any action on treatment, Rhyne always confers with the patient's emergency providers to share what he has learned from the patient and offer his recommendations.

"I may have been able to get more information from the patient than [the clinicians] did ... and then they are able to understand the patient a little bit better," he says. "They work right along with us. The physicians, nurses — everybody. It is like one big team now. And we have a great relationship with the outside providers — the treatment centers and the IOPs [intensive outpatient programs]."

Among the treatment options available to appropriate patients is ED-based induction of Suboxone, a prescription medication that includes buprenorphine and naloxone. Under this approach, patients receive their first dose while they are still in the ED, and then they are connected to a treatment facility for subsequent doses. In fact, Weintraub obtained a grant for UMMC to train emergency physicians throughout Baltimore to provide this intervention, and he is trying to get the approach expanded to EDs throughout the state.

"Part of it depends on the willingness of emergency physicians to follow the protocols," he says. "And it is work trying to destigmatize and encourage physicians to do this type of treatment."

Smith observes that peer recovery coaches can connect on a deep level with patients who have substance use problems.

"They can get from these patients in five minutes what it would take me hours to get just because of the lived experience that they share with them," she says, adding that there is constant demand for their services. "It is not uncommon to have 10 to 15 patients on the board that the peer recovery coaches need to go see. We have three peer recovery coaches on staff in the ED, and one peer recovery coach is in our psych ED."

The peer recovery coaches cover the ED from 6:30 a.m. to 1 a.m. Monday through Friday, and from 11 a.m. to 9 p.m. on the weekends.

"They work in 10-hour shifts, and

we are actually in the process of hiring more individuals so that we can offer 24/7 coverage," Smith adds. "The peer recovery coach in the psych ED covers 8 a.m. to 5 p.m., Monday through Friday."

However, for patients who have been brought to the ED because of an overdose, it is often difficult to engage them in discussions regarding treatment while they are in the hospital, Weintraub explains. "They have received Narcan [naloxone], and it will wake them up and reverse the overdose, and it frequently puts them into pretty severe withdrawal," he says. "They are very angry and irritable, and oftentimes are not that interested in talking to anybody."

Consequently, in cases in which these patients decline interactions with the ED-based peer recovery coaches, they are referred to an outreach worker who is part of the Overdose Survivors Outreach Program (OSOP), an effort supported by the Maryland Department of Health's Behavioral Health Administration. *(For more information on the program, visit: https://bit.ly/2J0b13U.)*

The OSOP workers have a similar background and similar responsibilities to the ED-based peer recovery coaches, but will primarily follow and work with overdose survivors who have been discharged.

"We provide a spot for [the outreach workers] in the hospital, and they are employed by the hospital ... but most of their time is spent out in the community," Weintraub shares.

The goal of the outreach workers is to stay in touch with overdose survivors and eventually link survivors into needed treatment for their addiction. The outreach workers also follow up with overdose patients originally referred into treatment by the ED-based peer recovery coaches.

"Anyone who overdoses is automatically transitioned to the outreach worker," Weintraub notes. "If you have someone who is actually cooperative and feels like they want treatment after the overdose while they are still in the ED, then our in-house peer recovery coaches can refer the person for treatment, but the follow-up is done by an outreach worker."

However, many overdose patients initially decline any discussions about treatment, leave the ED, and then the outreach worker tracks them down in the community. There is some blurring of the responsibilities between the peer recovery coaches and the outreach workers, Weintraub acknowledges.

"We try not to be too rigid. We just want to make sure the patients get the treatment they need."

Usually within 30 days of discharge, an outreach worker is able to link overdose survivors with some type of assistance, whether that involves transitional housing or another appropriate program, Smith says. "The program has been very successful."

Smith acknowledges that she was initially very concerned about the prospects of integrating the peer recovery coaches and the outreach workers into the ED. "Being involved in emergency medicine for almost 15 years, I knew how difficult it is to say that, 'oh, by the way, we are now going to be adding [something] else to the care of patients,'" she says.

However, Smith's concerns were dispelled quickly. "We were very strategic and very careful in how we implemented the program, and it was well-received almost immediately, because there was such a need," she says, adding that collaborating with the peer recovery coaches and the outreach workers has delivered dividends over time.

Smith says that emergency staff members have seen the difference the program has made in patients, including some who have been coming in for years and are now in long-term recovery. "The peer recovery coaches and outreach workers are part of the medical team now, and if they are not there for some reason, it is noticeable." In fact, Smith says providers sometimes ask for peer recovery consults for patients who have not screened positive during triage. In the past year, peer recovery coaches have seen just shy of 30,000 patients who have presented to the ED. Roughly 3,000 of those patients have gone on to receive some type of intervention.

"We have confirmed entry for 433 patients ... which means they are active in recovery," she says, adding that at least one of the patients who has been referred into treatment through this program has become a peer recovery coach himself.

While peer recovery coaches have worked well in the ED at UMMC, Smith notes that other EDs interested in implementing a similar approach should first consider some of the hurdles involved.

For example, hiring recovering addicts raises all kinds of red flags to the people in human resources, so the issue must be addressed beforehand.

"Usually, everybody goes through drug tests and things like that, so we had to be very sensitive to how we onboard these individuals and what that process looks like," Smith recalls. "Make sure there is a close relationship with your human resources partners in starting this program because [these individuals] are not going to look like your [typical] employees, and that is very important to understand at the beginning. It was a lesson learned for me." Further, Smith reiterates that it is hard work integrating the peer recovery coaches into the medical team to ensure there is effective collaboration.

"You have to embed these peer coaches as part of the team or it

will be just another service that is underutilized," Smith cautions.

Funding the peer recovery coaches is a challenge, too, and UMMC has not yet found a way to bill for their services, although treatment typically is covered by public and private payers. To date, the peer recovery coaches have been supported through grant funding.

Smith notes that any ED that implements a peer coaching model with the idea that it will reduce readmissions should not be looking for quick returns.

"When we initially brought this program on, we thought it would help us reduce our readmissions," Smith says. "What we found is that if patients were seen by our peer recovery coaches, they were actually three times more likely to return to the ED."

Investigators discovered the reason for the return trips was simply that the patients had received help in the ED for their substance use, so they were returning to the same place for help with their other health issues.

"Once patients are engaged, they will come back to you," Smith says. "What we found is that after the third visit, generally, there is a steep decline in the number of times the patient will return to the ED."

Now, ED staff are working toward connecting patients with a primary care physician and other needed social or behavioral health resources as part of the initial recovery piece, so that they will not feel the need to come back to the ED for subsequent healthcare needs. "That was a really important lesson learned for us," Smith adds.

Weintraub's advice to his emergency medicine colleagues is that before they implement peer recovery into the ED workflow, they first should consider whether the area has adequate resources for treatment of substance use disorders.

"It is all good and well to have an intervention ... but if you don't have anyone to refer patients to, that is a problem," he says. "We have a fair amount of treatment in Baltimore, so getting someone into treatment is generally doable."

Weintraub adds that it is important not to oversell the potential benefits or outcomes from a peer recovery coach program.

"The literature on the effectiveness and outcomes of peer recovery coaches in severely dependent opioid use disorder patients is pretty weak or nonexistent," he says. "There is a general sense that this is effective, and that it helps get people into treatment, but I don't think there is a good study on economic outcomes and things like that ... so you don't want to oversell what you are going to get."

However, the peer recovery coaches at UMMC have made a positive impact on morale in the ED, because staff see patients getting help for their substance use disorders when they have not been able to help those patients before, says Weintraub. ■

## CE QUESTIONS

1. **Health systems are undergoing a major change because of the Affordable Care Act. Their financial model is shifting from a fee-for-service model to what type of model?**
   a. Value-based care
   b. Prospective payment
   c. Diagnosis-related groups
   d. All of the above

2. **Which of the following is a good question for case managers to ask vulnerable patients in order to assess their needs?**
   a. What would you like to do?
   b. Have you heard of this resource?
   c. Are you ready for a change?
   d. All of the above

3. **Why does Libby Hoy say it often is not a good idea to ask physicians to recommend volunteers for a patient and family advisory council?**
   a. They are not sufficiently familiar with the hospital or organization.
   b. They may volunteer to please the physician but then drop off the council in a few months.
   c. They often are parents who do not have enough time to serve on the council.
   d. Physicians usually are reluctant to recommend their own patients or their family members.

4. **Two years ago, the University of Maryland Medical Center decided it needed a fresh approach toward connecting patients with effective treatment. The impetus for action on this front stemmed from the realization that:**
   a. substance misuse was a key contributing factor to a growing number of diagnoses.
   b. ED patients referred to treatment facilities were not satisfied with their care.
   c. physicians and nurses demanded help with the issue of substance misuse.
   d. patients with substance use problems were becoming hostile and violent.

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