HOSPITAL CASE MANAGEMENT

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INSIDE

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Case Managers Can Help With Overcrowded EDs and Hospitals

Problem common, especially during flu season

By Melinda Young, Author

Hospital and ED overcrowding can be especially problematic during flu seasons — like the especially deadly season experienced last winter.

The 2017-2018 flu season resulted in more hospital crowding than the previous record during the 2014-2015 season when more than 700,000 Americans sought medical care for the flu (https://bloom.bg/2OkDh3J).

Some hospitals had so many ED patients waiting for inpatient beds that people would sleep on beds in hallways for days (http://bit.ly/2RGKwB7).

Seasonal and infectious disease trends like this can strain hospitals' resources, particularly if they already are operating at nearly full capacity. This highlights the need for strategies that improve bed flow and help to admit and discharge patients more efficiently. Targeting early-day discharges could be one solution.

> SEASONAL AND INFECTIOUS DISEASE TRENDS LIKE THIS CAN STRAIN HOSPITALS' RESOURCES, PARTICULARLY IF THEY ALREADY ARE OPERATING AT NEARLY FULL CAPACITY.

Hospitals can improve morning inpatient bed access through a program that involves hospital case managers, social workers, physicians, and others working together, says **Teresa Jacobs**, MD, medical director of care management and professor of

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neurosurgery and neurology at Michigan Medicine at the University of Michigan in Ann Arbor.

"We had a culture of discharges happening much later in the day, throughout the system," Jacobs says. "Before noon, less than 4% of patients were discharged."

After rolling out a process to increase morning discharges, the health system's morning inpatient bed access improved. Among its highest performers, more than 24% of patients were discharged before 11 a.m.

Overall, the percentage of morning discharges has nearly quadrupled from 3% before the program to 11% now, says **Josh Thielker**, MPH, senior project manager, care management, at Michigan Medicine.

"This certainly has improved our patient throughput and wait times for patients to get beds," Thielker says. "And we know it's also enabled us to grow our discharge volume within pretty tight capacity constraints, and this has all been during a period of pretty rapid change for the health system."

The gap between available beds and patients being admitted has improved significantly. This is important because the hospital often has patients waiting in the ED for an inpatient bed, Jacobs says.

"There is increased demand on our hospital system," she notes. "When the hospital is this full, you don't know if you have a bed to put someone into, so having bed availability in the morning hours is better."

The goal is to achieve an overall 20% of discharges occurring by 11 a.m., Thielker says.

"We're still striving toward that, although the goal is something we continue to monitor and update as part of the dynamic of health system and flow changes," he adds.

"It's hard to get a 1,000-bed hospital and all of its employees to move in a different direction," Jacobs says. "You have to have a plan that gives reasonable change, so you can accomplish the goal incrementally."

Everyone has to be involved in the process. But three groups are the ones that should be focused on first: physicians, care management, and nurses.

Physicians give orders for earlier discharges. Care managers facilitate communication between providers and make sure everything is in place, and nurses plan patient discharges.

The program involved nine

EXECUTIVE SUMMARY

For some hospitals — especially during the flu season — ED overcrowding and inpatient bed waits are common. The key to improving bed flow and efficiency is to implement a program that increases morning discharges, freeing up space earlier for additional patients.

- Targeting early-day discharges is one solution to admitting and discharging patients more efficiently.
- Increasing early-day discharges requires a culture change led by project team managers and case management teams.
- One health system went from 3% of discharges before 11 a.m. to 11% of discharges before 11 a.m.

steps to educate staff, clinicians, and patients, and changed standard processes and culture to shift toward a priority list of patients in need of a morning discharge. *(See story on the nine steps, below.)*

Project team managers help facilitate staff education and culture change.

"These are people like me," Thielker says. "When we were rolling out the program in new areas, project team managers were on hand and on the units to follow through with the process and reinforce the project by helping to solve any new or unforeseen issues that might come up."

The mere presence of project team managers helped reinforce the importance of the change.

"Before rolling out the change in each new area, we sat with bedside nurses on the unit and provided them with the resources they needed," Thielker says.

The education included strategies for shifting discharge tasks earlier. For example, nurses were told to start discharge education the day before, including the following:

• Explain that the goal was to have the patient discharged by 11 a.m. the next day.

• Tell patients to arrange for a ride the next morning.

• Coordinate with security to have the patient's personal belongings brought from storage to the patient's room first thing in the morning.

• Work with nutrition services to get the breakfast brought up early and prepare a packed lunch.

• Work on order reconciliation in the health record.

• Discuss the patient's status changes that might affect the early discharge at handoffs or shift changes.

• Tell nurses at handoffs what tasks the incoming nurse would need to complete to keep the patient on track.

These kinds of changes take time, continual focus, and patience.

When the health system first rolled out the program to improve morning inpatient bed access, only three units were high performers, Jacobs says.

"That's out of 21 top discharging services. So we sat down with all 21 different services and talked about what was working out for those groups of high performers," she says. "We shared ideas and showed an action plan."

The next data showed that eight were high performers, a definite improvement.

"We had one more cycle where we brought in a chief clinical officer and chief nursing officer and had a meeting, broke into groups, and went over practices that worked," she adds.

This resulted in 12 high performers, and the health system has been able to sustain these results over time, Jacobs adds.

"Every time we did one of these action plans for performance, we made an improvement," she says.

The change pleases patients and providers when it works correctly, Thielker says.

"In general, operationally, it has also helped us to flatten our discharge curve a little more and shift discharges from the afternoon to early in the day."

This redistribution of work volume improves efficiency, reducing the spike of activity in the late afternoon, he says.

"It's been a great experience to work on this and see changes occurring and moving in the right direction," Thielker says. ■

Best Practices in Improving Morning Inpatient Bed Access

Case managers are key to success

Case managers are a crucial component of programs to improve hospital discharge and bed flow efficiency.

One hospital has developed a nine-step program involving case managers to improve patient flow and discharge efficiency.

Here are the ways Michigan Medicine in Ann Arbor has improved its patient flow:

1. Case managers round with teams.

Case managers hold a daily conversation with members of the discharge team.

"They talk about which are the one or two patients that will be discharged tomorrow," says **Teresa Jacobs**, MD, medical director of care management and professor of neurosurgery and neurology at Michigan Medicine, University of Michigan, in Ann Arbor.

Case managers always have been involved in this conversation of what a patient needs at discharge, but they

now ask whether particular patients could be discharged in the morning, she adds.

"We now say, 'Who can we realistically discharge tomorrow morning and get everything the patient needs by 11 a.m.?'" Jacobs says. "We didn't change the amount of work everyone has to do, but we changed the times that they do the work."

The rounds involve logistic discussions, including setting up lab orders for patients who will be discharged by 11 a.m. "We want those labs done first, making them available for the physician to evaluate in the morning," she says.

"Instead of putting all labs in one giant order, we reprioritize the queue, and we talk with pathology and the lab to find a way to get a flag on those labs," Jacobs adds.

2. Note changes on the progression board.

Case managers use a simple, color-coded system in the electronic health record to flag patients for discharge by 11 a.m. the next day, says **Josh Thielker**, MPH, senior project manager of care management at Michigan Medicine, University of Michigan.

For example, physical therapy staff might see 10 orders for physical therapy evaluations on any given day. Of those 10, three could be priority discharge patients. Physical therapists will prioritize their work to allow for rounds on those three patients first, he says.

Physical therapy evaluations were one of the most frequent barriers cited for an early discharge, Thielker notes.

Once physical therapy staff had access to the progression board and color-coded system, they were able to adapt easily to the change in priorities, he says.

"There was an adjustment period when we rolled it out, but the progression board helped them visualize the patient," he adds. "And we found, quickly, they were taking care of those priority patients' needs first without much difficulty."

Before the change, various departments might prioritize patients arbitrarily, Jacobs says. "Instead of doing it alphabetically or by room — which is an arbitrary designation — we now have a priority list of how they get their work done."

3. Ancillary services use list of priority discharge patients' needs.

"The priority list is in the electronic health record with a visual indicator," Thielker says.

Ancillary services, including physical therapy, occupational therapy, lab, social work, and others, use the list as early as 2 p.m. the day before the discharge.

"Case managers and their care teams are educated to identify appropriate patients for the morning discharge, and they can make the list no later than 2 o'clock," he says. "We want to give our ancillary partners the maximum amount of time required so they do not delay discharge the next morning."

It will not help to create a priority discharge list that is not available until early on the morning of discharge, Thielker notes.

"If we don't get the order in for physical therapy evaluations until 9 the next morning, then it doesn't give physical therapists adequate lead time to evaluate the patient," he explains.

Making this cultural change required significant staff education, Jacobs says.

Nurses approved the education plan, which involved going to various units to help people understand the concept of discharging more patients in the morning.

"It's a new way of thinking," she says.

"We're forcing teams to have conversations proactively the day prior to discharge," Thielker adds.

4. Social worker and nurse meet in the afternoon to discuss the early discharges.

Nurses do not always agree with the physicians' ideas of which patients could be discharged the next day before 11 a.m. Nurses can discuss specific concerns with the social workers.

"If there's a barrier to the early discharge and the social worker tries to fix the barrier, but cannot, then the social worker will talk with the case manager and medical team," Jacobs explains. "The patient might have to be taken off the list."

But this scenario happens less frequently as the program evolves. "It doesn't mean we don't have priority discharge patients drop off the list, because we do, but the main reason is a medical status change, such as the patient overnight developing new nausea or vomiting or gastrointestinal bleeding," she says.

Once everyone understands which patients will need the early discharge, nurses take charge of educating patients on what they will need to do when they return home.

"There is an end-of-the-day discussion to make sure there are no barriers to the early discharge," Jacobs says. "In our system, the case managers are assigned by service, and the social workers are assigned by unit."

So case managers have patients on six different units and cannot be at all final discussions. The social workers, who are part of the care

management group, are there to discuss discharges with nurses.

5. Physicians give discharge medications to the pharmacy the day before discharge.

The pharmacy is part of the discharge discussion, so the pharmacy staff knows about these priority discharges.

Physicians write their medication prescriptions by 2 p.m. the day before the morning discharge, and this gives pharmacy staff enough time to prepare the medications by 8 a.m. the next day, Jacobs says.

"So after we identify the patient for an early discharge, we have a list made, talk about barriers, and get the medications ready," she adds.

There was another efficiency change with pharmacy and prescriptions: "With the outpatient pharmacy, we found that certain discharge medications that providers were sending to the pharmacy prior to discharge were medicines that could be filled in the patient's own pharmacy in the community, and the patient might prefer that," Thielker says.

This highlighted the need for more robust communication between the care team and the patient to see how his or her medications should be filled. Although the discharge team assumed it was more convenient for patients to pick up their medications at the hospital, this was not true for some patients, he says.

Providers and care teams were educated to ask patients whether they wanted their medications filled at their home pharmacy. Complex medications could be filled at the health system pharmacy, which would have access to more of the complex drugs than would a community pharmacy.

The complex medications could be filled prior to discharge. The more common medications could be sent to the patient's community pharmacy.

"We can get the pharmacy prescriptions for priority medications filled early," Thielker says. "We've heard that this does reduce the volume of unnecessary medications being filled at the pharmacy. It's a more appropriate use of pharmacy resources."

6. Doctors complete the chart's list of chief complaints or diagnoses.

Prior to discharge, physicians need to complete the patient's chart. Depending on the clinical situation, the patient might suffer from hypertension, chronic obstructive pulmonary disease, or other conditions that need to be documented and updated.

"They prepare the discharge summary, do order reconciliation and medication reconciliation — all of the stuff the provider has to do to prepare the chart for discharge," Thielker says.

This information tells the story of the patient's inpatient stay, he notes.

"That's a fundamental part of our process, and it falls under the banner category of things providers should be proactively trying to work on the day before discharge," Thielker says.

The goal is to not wait until the morning of discharge — get the chart information updated the afternoon before discharge.

"They have to finish the things that need to be done for the next day," Jacobs says.

7. Complete patient education the night before discharge.

"We ask the bedside nurses to complete all patient education the night before the discharge," Jacobs says.

For example, a patient might need education about changing his or her wound dressing. The nursing staff will need to provide that education the night before discharge instead of in the morning of the discharge, Jacobs says.

"What we're trying to do is make this change staffing-neutral," she adds. "We tell everyone that it's not more work because they're always discharging patients anyhow, but the flow of work will be progressively in a different pattern — rather than heaping more work on them throughout the day."

The nurse-patient ratios are the same for both morning and evenings, and the night nurses know how to provide patient education. The biggest change was to set the expectation of when the education should be provided.

8. Physicians write discharge orders by 9:30 a.m.

The usual pattern is that doctors would handle their surgical and other work early in the morning and write discharge orders in the afternoon. Now, physicians are asked to write the discharge order in the mornings.

This created a logistical conflict for some doctors. For instance, the medicine service might not have rounds until 8:30 a.m., and they will see their acute patients first. Acute patients are not the ones who will be discharged in the morning, Jacobs explains.

"So they have to let a resident skip rounding to do the discharge, or they can take the computer with them as they round," she says.

9. Patients are discharged early.

Each unit discharges the early patients and confirms that they have exited the hospital. This information is collected for metrics about how well the early discharge program is working. ■

Case Management Program Helps Cancer Patients Navigate Care

Program also helps with research decisions

Cancer patients and their families experience day-to-day challenges that often are not addressed when the patients return to the hospital. Patients with high-acuity needs require 24-hour assistance every day, and families can easily become burned out from filling this role.

"I've worked with folks in oncology settings, and this is where we are looking at high-speed, high-intensity care and need support for families," says **Jennifer Wenzel**, PhD, RN, CCM, FAAN, associate professor in the school of nursing and school of medicine at Johns Hopkins School of Nursing, division of cancer prevention and control within the Sidney Kimmel Comprehensive Cancer Center in Baltimore. Wenzel also is principal faculty at the Center for Innovative Care in Aging, and dissemination director for Johns Hopkins Alliance to Advance Patient-Centered Cancer Care, which is part of the Merck Alliance.

Case management is a natural fit for these goals.

"Being a case manager, you have a certain perspective on things," Wenzel says. "It pushes you to look at how things work, how they come together, and to learn what the gaps are."

Wenzel's experience as a case manager and discharge planner led her to understand patients' and their families' needs after discharge, and it helped to direct her research in this field.

One thing case managers, clinicians, and researchers might learn about cancer patients and other patients with chronic illnesses is that their caregivers often are not family members, she notes.

"I spend a lot of time talking with families, and it's not always the nuclear family that is working with patients," Wenzel explains. "In a lot of communities, it might be someone outside the family who is engaged in the care, and in low-resource communities it might be a pastor or friend or co-worker who is helping the person through the day-to-day realities of their diseases."

Her experience as a case manager and nurse influenced Wenzel's clinical research into the daily challenges high-acuity patients face.

For instance, high-acuity cancer patients require considerable care, but they still are sent home and into the community. This is what Wenzel wanted to study: How did they cope with the daily medical care needs?

"We did focus groups, data collection, and we realized we were seeing a lot more care needs and requirements for support outside our care facilities," Wenzel says.

Also, these cancer patients were living longer than in previous decades. Their disease increasingly was becoming a chronic illness. "Like HIV, cancer is a disease that initially was fatal, and people didn't live long after diagnoses," she says. "But thanks to improving treatment, we have folks living much longer, and the majority of their care does not take place within an institution."

This is why it makes sense to combine case or care management with community health workers and nurse navigators.

"Here in Baltimore, people have been doing work in hypertension and cardiovascular care, using lay health workers or community health workers [CHWs] to work with low-resource, high-need communities," Wenzel says. "We asked, 'How can we use this growing population of health workers in the context of cancer treatment?' And that's how we started our intervention: using health workers to provide navigation."

CHWs and nurse navigators work together. Nurses can answer questions and serve as liaisons between formal healthcare and the community.

"Also, community health workers answer nurses' questions," she says. "They provide information and relay questions from patients. They are a channel for more communication, helping nurses and providers understand the day-to-day needs of patients and their care partners."

During data collecting, Wenzel asked cancer survivors in the clinic what financial concerns they had.

"We understand cancer is a high-cost diagnosis, and there are a lot of out-of-pocket costs as we move from in-care to outpatient to home," she says.

"It shifts a lot of the costs to patients and the family, and it shifts not just tangible costs in terms of coinsurance or deductibles, but also a lot of the costs relating to time and effort," she adds.

Wenzel learned that cancer patients were not discussing the financial challenges with nurses, even when they saw nurses regularly. There often were experience/cultural barriers. But with CHWs, patients

were more open about their financial issues.

"Because they are from the community, they have a better understanding," she says.

Working together, CHWs and nurse navigators can find patients local resources for transportation, respite care, and other things they might need but cannot afford.

One project involving CHWs, nurse navigators, and cancer patients was designed to work with clinical trial enrollment of minority patients.

"One group I'm engaged with is enhancing minority participation in clinical trials," Wenzel says. "So navigators talk with patients about the importance of participating in clinical trials and what barriers might exist."

Only 3-5% of patients eligible for cancer research actually do participate, and some groups are particularly unlikely to participate, she says.

"These are the people we need to understand the most, and our community health workers and our navigators help patients and families with the decision of whether to participate in a study," Wenzel adds. "It's important for patients to speak with someone who is not providing direct care and who is not running the research study they want to consider."

Community health workers help patients and their family or decision-makers better understand what their participation in research means. They help patients with the decision-making process and provide support for anything they decide.

"Our community health workers are great at working with patients and families," Wenzel says. "They're looking for more tools to use to be helpful to patients and families, so we take these decision-making tools and allow community health workers to deliver these to patients, providing navigation for clinical trials."

Another decision-making example involves cancer patients presented with the choice of starting treatment to increase their survival or treatment to manage their symptoms, she says.

In one pilot study, patients had to choose whether to start a treatment that would make their quality of life worse but improve their survival/longevity. The other option was to not take that treatment but to receive palliative treatment that would improve their quality of life.

"Or there could be a third decision to stop treatment altogether," Wenzel says.

"Choosing between improved survival vs. quality of life is difficult," she adds. "So community health workers delivered decision interventions that were part educational and partly supportive and also included real-time data related to symptoms to patients and their decision partners."

In this example, CHWs facilitated communication between patients and decision partners. Sometimes the decision partner would be available only by phone. The community health workers would ask patients to share their feelings about the choices and to talk about their values as they reviewed the estimates of their survival odds and quality of life over time.

The pilot study found that CHWs could perform this work as well as nurses. Decision partners reported that the intervention was useful, Wenzel says.

"What patients and their care partners tell us is they feel like they have more access to support, and they feel better supported in what is a very challenging time in their lives," she adds. "We're still analyzing particular outcomes on health data." ■

Motivational Interviewing Gains Strength in Patient-centered Care

By Jason A. Smith, Author

As healthcare professionals continue moving toward a patient-centered model of treatment, certain practices have taken on a greater role. One increasingly prominent practice centers on motivational interviewing as a way to help patients change behaviors, with a focus on helping them understand why those changes are needed.

Motivational interviewing was developed in the early 1980s by Stephen Rollnick, a professor of clinical psychology at Cardiff University in Wales. It was initially designed as a way to help patients with substance abuse issues. In recent years, motivational interviewing also has been used to help people manage their own health behaviors, says **Jayne Josephsen**, EdD, RN, CCCTM, CHSE, CHPN, professor of nursing at Boise State University in Idaho.

Josephsen has worked in the nursing field for 15 years, following her previous career in social work.

She says she sees a significant overlap between those two areas from a patient-perspective model, particularly when it comes to motivational interviewing.

"The patient is the expert on themselves, and the patient has to be part of the healthcare team and the decisons that are made," she says. "Even if we are an expert in medicine or nursing or something else, we have to have that patient perspective in all of our decision-making. Otherwise, our plan of care won't be effective."

At Boise State, nursing students are trained in motivational interviewing to help patients self-manage their conditions. "In our behavioral health nursing class, they have to do a simulation with standardized patients. We also go over it in our care coordination class because motivational interviewing is a competency for national certification as a care coordination and transition management nurse," she says.

Motivational Strategies

Josephsen notes that a number of techniques are used for motivational interviewing and points to Elicit-Provide-Elicit as one of her go-to strategies.

"That strategy is where you elicit what a patient already knows about a topic, and then you ask them if you can give them additional information once you have a baseline of what they already know," she says. "The important part of that is to ask permission, because part of motivational interviewing is to help the patient remain autonomous in the process. The last part, after I provide more information, is that I ask the patient what that would mean. It really makes it a patient-centered conversation."

Josephsen notes that a commonly used element in motivational interviewing calls for healthcare professionals to direct conversations with patients through OARS: Open-ended questions, Affirmation, Reflective listening, and Summary.

"You start with the open-ended question so that you can elicit the patient's perspective," she says. "Then, you also want to have affirmation in the conversation because that will build on the strengths the patient already has. We want to affirm that."

Reflective listening, Josephsen adds, provides a way to further direct patients and to motivate them toward making positive changes.

"Then, the summary is kind of wrapping up the conversation," she says. "But you can have many summaries with the conversation if it's a lengthy one."

Another increasingly used technique within the patient-centered perspective focuses on agenda-setting.

"You're asking permission: 'Joe, can we talk about your diabetes today?' and 'What would you like to talk about?'" she says. "That lets them set the agenda for the conversation."

With the advent of motivational interviewing as a strategy of patient care, healthcare professionals have reported both positive and negative results in recent years. One example of positive results from motivational interviewing, she says, can be seen when talking to patients about smoking cessation.

"What really happens in that process is that people kind of identify what their values are," says Josephsen. "They discover that they really want to stop smoking. They want to spend more time with their grandchildren and the rest of their family. Sometimes with small children, people don't want to smoke around them."

Josephsen says that such realizations help patients to identify what is most important for them regarding their overall health and quality of life, thus getting them more involved in the direction of their care.

However, she says, motivational interviewing also carries the risk of negative results if a patient and the provider are not on the same page in determining a course of action.

"A key concept with motivational interviewing is ambivalence," says Josephsen. "As with everyone, if we want to change behavior, sometimes we're ambivalent about it. They haven't really decided if they're ready for change or if they want to change their behavior. That can be frustrating as a healthcare provider."

Josephsen notes that key elements in overcoming such ambivalence are to help patients determine what they want, to be empathetic as patients work toward change, and to be as nonjudgmental as possible if a patient takes more time than others to decide on the next phase of his or her care.

"Our role as healthcare providers or case managers is to provide consistent support so that the client does have the ability to change when they choose to," says Josephsen. "In any conversation with a patient, ask what they know about their disease. What additional information do they need?"

Getting Patients Activated, Engaged

Another crucial element of motivational interviewing centers on patient activation and engagement.

"An activated patient is a patient who understands their role in their own health," says Josephsen. "A hospital case manager does need to understand how activated a patient is because a patient who is not

activated likely won't participate in self-management post-discharge, which can result in readmission and ER visits."

Josephsen points out that with an increased focus on the patient-centered perspective in recent years, doctors — particularly those who have worked in the healthcare industry for a long time — have experienced difficulty adapting to the patient-engagement model of care management. For this reason, she advocates that healthcare professionals use a holistic approach to engage their patients.

The transition to a value-based payment system will require that healthcare professionals engage patients in the process, she says.

"In the old model, a patient going to the doctor and doing whatever the doctor says doesn't work anymore," says Josephsen. "Doctors need to focus on patient-centered care because we need to understand why patients don't follow through with the directions their healthcare provider gives them. To do that, we have to provide a holistic patient assessment so we can understand how best to support them in managing their own health."

Motivation Can Help Difficult Patients

Ken Resnicow, PhD, notes that most addiction counselors now incorporate motivational interviewing in treating their patients.

"Most practitioners are exposed to MI in their training. Some use it with everyone because they use it as their primary approach," says Resnicow, Irwin M. Rosenstock Collegiate Professor at the University of Michigan's School of Public Health. His research on motivational interviewing has resulted in numerous articles on the topic.

He says that other counselors use motivational interviewing to address the needs of their more difficult patients.

"It can be a tool in their back pocket or in their primary operating system," says Resnicow. "It's not quite the standard of care for primary care medicine. For addiction, it's a standard of care, but for managing primary care medicine or chronic disease, it's only used moderately. It's certainly not universal, and there's in some cases a lack of evidence to support it."

He adds that in some instances, there is a "lack of will" among healthcare providers to implement motivational interviewing as a method of patient care. Exceptions to that rule can be found in the Aetna, Blue Cross Blue Shield, and Kaiser Permamente systems, he says.

"They've invested a great deal of resources into training providers to learn motivational interviewing," explains Resnicow. "It goes back at least 10 years, with generally positive results."

Resnicow notes that physicians and counselors have used motivational interviewing to assist patients in changing their behavior in areas beyond smoking.

"It's used for chronic disease, blood pressure, blood lipids, diabetes, sexual behavior like condom use, and taking HIV medications," says Resnicow. "The question is not so much where it's been used so much as where it's *not* been used."

Resnicow says motivational interviewing has helped to address a majority of the CDC's top 10 preventable causes of death.

"With the exception of maybe asthma, MI has been tested in at least one randomized trial," he says.

Resnicow echoes Josephsen's sentiments regarding effective strategies for employing motivational interviewing with a plan of care. He says "slight changes" in the theory of motivational interviewing have occurred over the years, with a greater emphasis on helping patients to identify the meaning of their behavior change.

He says one method uses a combination of "visualization and verbalization," asking patients to look forward and see how their life would be different if they made necessary changes to their lifestyle.

"It's part of a tool called 'pulling change talk from the patient' — another concrete strategy in reflective listening," says Resnicow. "Rather than responding with advice or questions, in MI we encourage clinicians to use reflective statements like, 'You're starting to wonder what life would be like without smoking' — restating what the patient said and understanding the feeling and meaning behind it."

Resnicow points those seeking to help patients change their behavior to a three-pronged method of motivational interviewing that focuses on exploring, guiding, and choosing.

"It's derived from Christian theology, but it turns out to be effective in addiction counseling and behavior change in general," he says. "It's still an active framework to teach providers how to conceive the sequence of behavior change counseling.

"It's a sequence of what to do and when," adds Resnicow. "We want to start with draining the swamp — to let the person express their fears and their resistance so their fears have been neutralized. Then you go to 'guide,' which is getting more change talk, getting the person

excited about change, and moving them in the direction of change. The final step is 'choosing,' which is the planning phase."

Resnicow adds that strategies for effective motivational interviewing are evolving and are continually being developed to engage the skills necessary to maximize their effectiveness.

"For example, we're starting to use e-health and artificial intelligence to both train practitioners and to deliver the intervention to patients," he says. ■

Bundled Payment Program 'Changed the Landscape of Case Management'

Healthcare professionals are continuing to evaluate the progress of bundled payments as a way to manage the care received by patients.

The Centers for Medicare & Medicaid Services (CMS) launched Bundled Payments for Care Improvement (BPCI) in 2013. The program "changed the fundamental payment for care delivery from a prospective system to one dependent on cost and quality outcomes" while also driving physician and post-acute care provider behavior, explains **Beverly Cunningham**, MS, RN, ACM, partner and consultant at Case Management Concepts in Tulsa, OK.

Assume Risk to Improve Outcomes

Cunningham says that with the advent of changes in discharge planning requirements in recent years, case management departments must be staffed appropriately to minimize delays.

"The answer to that is bedside rounds every day when the physician, the nurse, the case manager, and the social worker are available," says Cunningham. "At bedside rounds, the team can give the patient the plan and their estimated day of discharge. That way, there's a one-time discussion. That's how you keep the patient in tune with what's going on."

BPCI, she says, started out as a voluntary program with several diagnoses for providers to assume "a little bit of risk."

"By assuming risk, they improve outcomes," says Cunningham. "Then the provider increases their revenue and provides better outcomes for patients as well. When the risk goes to you, you begin to look at how you can more effectively manage patients while achieving the optimal outcomes."

She notes that BPCI started out with four types of initiatives, with providers identifying which group they would be in.

"The CMS really had not allowed the BPCI initiatives to run their course," says Cunningham. "They decided that they would take lower extremity joint replacement and make those mandatory bundled payments. In doing that, they selected geographical areas where any hospital in that area would have mandatory bundled payments."

The program, she says, was successful in many hospitals in those 67 mandatory geographic areas, with a focus on hip and knee replacements for patients with Medicare Part A and Part B.

"It's a five-year program where the first year, there's no payment reduction at all," she continues. "As you go through the remaining years, that's when you have the payment reduction or the increase in payment. They were extremely specific in how they would pay and how they would evaluate. It's very complex, but in order to receive additional payment, you had to meet certain criteria. It really incentivized providers to be organized in the care of these patients."

"Commercial and state payers alike adopted bundled payment programs," adds Cunningham. "Ohio, for example, introduced 10 mandatory bundles in 2015 with a plan to expand to an additional 20 episodes of care in 2019."

Cunningham says hospitals began identifying the most cost-effective place after discharge from the hospital to ensure optimal outcomes for patients.

"That's when they began to identify that if they increased the complexity of care provided by home care, they could bypass the skilled nursing facility and/or acute rehab," she says.

Cunningham says CMS expanded the mandatory model with additional diagnoses and procedures in 2016. However, in early 2017, the expanded mandatory model was canceled, and the number of hospitals in mandatory geographic areas decreased from 67 to 33, she says.

The new and voluntary Advanced

BCPI Model was introduced in November 2017. The program includes procedures, medical diagnoses, and outpatient episodes.

"Many hospitals have evaluated collaborating with the CMS in many, or all, these bundles," she says. "As a result, 832 hospitals are participating in this new bundle initiative."

Cunningham notes that at skilled nursing facilites, patients are at risk for readmission, infection, and falls, and there is a higher sick population at such facilities.

"That increases the cost of care," she says. "It's a bad outcome for the patient, it's not optimal, and it increases your cost. For the appropriate patients, they're providing appropriate care in home as opposed to transferring to a skilled nursing facility if it's not needed."

CMS did not expect that the majority of total knee replacements would be performed as outpatient procedures, Cunningham says.

"The government added more bundled payments and increased the number of diagnoses that would fall under bundled payments," she says. "That changed the kind of patients that were in the mandatory program. Hospitals were really working diligently to figure out how they would manage patients when they had no idea what was going on with the patient before admission."

Under that system, she says, there was no plan of care in place because there was no patient at all.

"Planning starts on the day of admission, but you're kind of behind the eight ball on that, and that increases your cost," says Cunningham. "It requires adequate staffing and effective focus by everyone in the healthcare team."

She says when a new Department of Health and Human Services secretary was appointed, mandatory bundled payments stopped, thus opening the door for voluntary payments.

"Right now, where we sit, there's a whole list of bundled payments, and hospitals can elect to be included in this," says Cunningham. "What I am seeing in my consulting is that some hospitals are embracing this because it's an opportunity to increase revenue. That surprises me."

Cunningham says that for hospitals, the attractiveness to this development lies in the ability to increase revenue.

A New Landscape in Case Management

Bundled payments have "changed the landscape" of case management in recent years, says **Toni Cesta**, PhD, RN, FAAN, owner and consultant for Case Management Concepts, LLC, in North Bellmore, NY.

"RN case managers and social workers can no longer focus only on the inpatient setting but rather must incorporate across-the-continuum strategies into their daily workflow," says Cesta.

She says that such changes include a greater emphasis on care coordination and transitions in care.

"In terms of care coordination, hospital-based case management professionals must complete comprehensive assessments and daily reassessments of the patient's ongoing needs while hospitalized and after transition to the community."

Cesta adds that care coordination is an essential role of the hospital case manager and that it has a direct impact on length of stay, cost of care, patient satisfaction, and patient outcomes.

"Each day of the hospital stay must be optimized in order to ensure third-party payer reimbursements and to reduce nonessential patient care days," she says. "At the same time, the hospital case manager and social worker must keep an eye on the patient's post-acute needs and provide written and oral information about the patient during all transitions in care."

Creating linkages across the continuum between healthcare providers, patients, and families is a core responsibility of case managers and social workers, both in the community as well as in the acute-care setting.

By keeping the patient at the center of the process, case managers can ensure that his or her needs are met at all touchpoints across the continuum, rather than based on specific providers.

"There's a nurse navigator who follows people telephonically for up to 90 days to make sure there are no gaps in care and to follow up with the patient and see if they have any questions or need further intervention," says Cesta. "The other type would be a nurse navigator who is based in the community rather than the hospital and who has a longer-term relationship with the patient, following their care and monitoring their lab results or other diagnostic tests, physician appointments, or other care needs."

It helps the patient to manage and navigate the complex healthcare system and to reduce ED visits or readmissions to the hospital.

"It gives them a name and a face that represents the healthcare system to them and someone they can go to if they have questions or concerns," says Cesta. "It's a win-win for the healthcare providers. Nurse navigators serve as an intermediary between the patient and the physician." ■

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. **What are some actions that hospital nurses can take to help with shifting some patients to a discharge before 11 a.m.?**
   a. Explain to the patient that the goal is to have him or her discharged by 11 a.m. the next day
   b. Coordinate with security to have the patient's personal belongings brought from storage to his or her room, first thing in the morning
   c. Discuss the patient's status changes that might affect the early discharge at handoffs or shift changes
   d. All of the above

2. **Which of the following best describes how case management can help cancer patients when they are discharged home?**
   a. A case management team, including a nurse navigator and community health worker, can help cancer patients and their families find resources.
   b. A case management team can provide eight-hour shift respite care for cancer patients' families, who are under considerable stress.
   c. A case management team can handle cancer patients much as a hospice or AIDS home care team would help those patients.
   d. None of the above

3. **Which is not an effect that can result from motivational interviewing?**
   a. Patients can better identify what is most important to them with regard to their care.
   b. A healthcare provider can become frustrated by a patient's ambivalence.
   c. It guarantees that patients and doctors will be on the same page in determining a course of action.
   d. A patient is more likely to improve his or her self-management after being discharged.

4. **A bundled-payment system results in all of the following except:**
   a. a greater focus on effective care coordination.
   b. comprehensive assessments of patient needs during and after hospitalization.
   c. a nurse navigator helping to monitor the patient's needs following discharge.
   d. Minimal impact on a patient's length of stay.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

What Does Population Health Really Mean for Case Managers and Social Workers?

By Toni Cesta, PhD, RN, FAAN

Introduction

Population health is the new buzzword in healthcare. Often misused or misunderstood, it is an important concept that applies to case managers and social workers across the continuum of care. Population health is now an integral part of what we do and how we think about our patients. No longer can we manage our patients "out the door" of the hospital and into the community with little thought as to what will happen to them once they get there — we must think about our chronic and high-risk patients beyond the walls of the hospital. So many of our reimbursement penalties and rewards have driven us in this direction, and if performed correctly, case management can steer our health systems and patients toward better health and outcomes. This month, we will discuss what population health is and how case managers play a strategic role in these emerging models of care.

THE POPULATION HEALTH CONCEPT REPRESENTS A DEPARTURE FROM MOST OF MAINSTREAM MEDICINE IN THAT IT IS FOCUSED AWAY FROM THE INDIVIDUAL PATIENT LEVEL.

Defining Population Health

Population health has a fundamental goal to help high-risk individuals with chronic conditions to remain as healthy as possible for as long as possible. A recent study indicated several determinants that are the foundations of a healthy population. These include health-related behaviors (30%), clinical care (20%), social and economic factors (40%), and physical environment (10%). Although as case managers we tend to focus on clinical care, it represents only 20% of the problem. In an effective population health model, we must provide ever greater attention to the other factors that clearly have much more to do with socioeconomic issues. While population health aims to reduce disparities among different patient populations, this concept still is not well understood. And despite the fact that these determinants have the greatest impact on how well a patient does in the community, healthcare commonly provides minimal — or none — of the resources necessary to address and manage them.

So, what is population health? It is an approach that aims to improve the health of an entire population. The population health concept represents a departure from most of mainstream medicine in that it is focused away from the individual patient level. It seeks to manage patients before they get sicker. It is a big concept to define and a bigger concept to implement.

In a population health approach, vast populations of patients are segmented, meaning that the healthy are separated from the patients who are chronically ill, frail, at end of life, or unable to manage their own health adequately.

These factors represent risk for these patients. They are at risk for poor outcomes, admissions and readmissions, and institutionalization. Population health strives to provide a greater focus on wellness and preventive services by staying ahead of problems. The concept is to risk-stratify the patients and focus resources toward those who score at greatest risk.

Components of Population Health

Fundamentally, population health is designed to coordinate care delivery across a population to improve

clinical and financial outcomes. Three sets of tools are used to coordinate this care:

- disease management;
- demand management;
- case management.

Disease management evolved out of managed care principles. It provides a system of coordinated healthcare interventions and communications for populations with complex conditions.

Access is an important component of disease management. It is the process in which patients with long-term conditions, along with family and caregivers, share knowledge, responsibility, and care plans with healthcare practitioners and/or peers.

Demand management is another component of population health that empowers patients to make wiser healthcare decisions. The goal is to engage patients in the quest for appropriate care.

The terms "adherence" and "compliance" often are used interchangeably in demand management. Adherence refers to the patient sticking to the proper practices of the care plan. Compliance occurs when the patient follows the instructions of the doctor. Adherence is a term that is commonly used in medicine to refer to the act of the patient, by him or herself, adhering to the proper dosage of medicine, proper practices of hygiene, or practices of well-being. In adherence, the patient is empowered and takes healthcare practices into his or her own hands via therapy sessions, self-care, or self-directed exercises.

Compliance, on the other hand, is defined as following the doctor's instructions or recommendations in the care plan. It can seem like a paternalistic, uncaring, and condescending sort of medicine where the patient plays a passive role. Barriers to compliance include complex care management plans and poor health literacy.

In summary, adherence empowers the patient to become a co-equal to the healthcare providers, whereas compliance is believed to promote a paternalistic attitude toward healthcare. It is believed that adherence has more advantages than compliance.

Case management is the third tool in population health. Community case management incorporates both disease and demand management. It targets high-risk, high-cost subgroups in a population-focused framework. Community case management staff assist in managing and coordinating care for specific individuals across the continuum. These individuals are at greatest risk for suboptimal outcomes and typically cannot manage their care without the assistance of a healthcare professional, such as an RN case manager or social worker.

Case management provides a system of care that is used to oversee the care processes for these vulnerable populations. It also provides a linking mechanism to ensure that these patients are not lost to the healthcare system.

The first strategy is to keep patients connected to the healthcare system. Case management staff monitor and engage with the higher-risk patients as needed to ensure that appointments are kept, medication adherence is maintained, diets are well-managed, etc.

Problems patients face include the following:

- missed treatments;
- prescriptions not filled, not taken, or taken at the wrong dosages or frequencies;
- missed medical or other healthcare appointments;
- frequent ED visits or admissions;
- frequent readmissions;
- poor healthcare behaviors;
- busy healthcare staff missing patterns or trends in these patients;
- lack of systematic ways to assess and proactively deal with issues that affect adherence, quality of life, and outcomes.

Secondly, healthcare resources are matched to the patient's needs. For example, a patient with greater behavioral health, financial, or social risk factors may have a social worker assigned to his or her case. A patient with a chronic and complex medical condition may have an RN case manager assigned to him or her. In some cases, extremely complex patients may require both disciplines working together to facilitate the best outcomes.

How to Develop a Population Health Strategy

Development of a population health strategy requires planning. Even before the program can be developed, your organization must be sure that it has the correct structural components in place.

- **Provider networks.** A comprehensive provider network that can support a population health strategy must include partnerships with care providers across the continuum, including ambulatory, hospital, and post-acute care. The best approach is to have a series of providers who are fully contracted with your health system. By contracting with providers across the continuum, the patient transitions can be performed seamlessly and without delays. Strong coordination of care and alignment of resources are critical and are foundational

components of an effective plan. There is greater risk to a health system when employing population health, but this risk can be reduced through the use of a strong provider network.

• **Provider compensation.** Dovetailing with the need for a provider network is the need for a provider compensation structure. In the more traditional provider payment models, providers are compensated solely on the volume of work they perform. This model lacks incentives for providers to spend additional time with patients, provide education, or conduct patient outreach.

Even the notion of coordination of care gets short shrift in the traditional payment models for providers. A forward-thinking provider payment plan should include rewards to providers for meeting specific quality and cost measures. These incentives should include metrics for all specialties, including primary care.

• **Payment models.** There are a variety of payment models that will work effectively in a population health strategy. The systems with the greatest return include capitation and partial capitation payments. These mean that on a monthly basis, payment is made to the health system for services provided across the continuum of care. Capitation includes some amount of risk, as the monthly payment amounts must be carefully determined based on the population being managed. Bundled payments through the Medicare programs provide such payment models but are limited to a handful of diagnoses.

Value-based payment elements, such as the Spending per Medicare Beneficiary, require that resources and coordination of care are well-managed across the continuum. As these various payment models tend to collide in any health system, it becomes imperative that the fundamental infrastructure for the population health model supports all of them through care coordination, management of resources, and quality of care.

• **Clinical informatics.** Population health management of large numbers of patients would be impossible without information technology. The need for integration of clinical information across the continuum of care has never been greater. The first need is to establish a single electronic medical record that can be accessed by providers regardless of where the patient is receiving care across the continuum. This single medical record allows for better coordination of care, management of healthcare resources, and improved communication among providers. It is an essential component of population health.

UNDER A POPULATION HEALTH MODEL, THE PATIENT IS THE CENTRAL PLAYER IN THE PROCESS, AND ALL CARE PROVIDERS COORDINATE THEIR CARE TOGETHER AND AROUND THE PATIENT.

Other important IT tools include patient registries. Registries are electronic systems that give providers and case managers methods to identify patients at high risk, who may need more intensive case management. They alert providers to abnormal test results and/or when tests, treatments, or procedures are due. Registries also alert case managers and support staff when a patient needs, or has missed, an appointment. With the large volume of patients that need population health, it would be virtually impossible to track and manage the copious amounts of patient information in any other way.

Risk stratification is best performed using clinical information systems that allow organizations and providers to understand the highest-risk populations they serve and to also report the quality and cost outcomes.

• **Care models.** As we discussed, care models such as community case management are important components of the successful population health program. Effective and efficient care models promote coordinated care across the continuum. These models should be designed to focus on those patients who are at greatest risk for poor outcomes and/or high resource utilization.

When we think of traditional models, we think of patients seeking healthcare services only when they are sick and seeking that care within the physical setting of healthcare. If patients are seeking care at multiple locations with multiple providers, it becomes the patient's responsibility to ensure that all providers are receiving up-to-date and appropriate information.

Under a population health model, the patient is the central player in the process, and all care providers coordinate their care together and around the patient. The team usually is led by the primary care provider with supporting staff, including staff RNs, behavioral health

providers, and others as needed. For those patients at higher risk, case management professional staff such as social workers and RN case managers, as well as other support staff, is added.

Team roles and functions also are critical in ensuring an effective population program. The multidisciplinary team must be involved in risk assessment, guidelines implementation, coordination of care, and self-management support. The primary care providers work to assist patients in optimizing their self-management when appropriate and/or referring to case management professionals when necessary. Educators and educational programs can help patients with these processes as well.

The Case Manager's and Social Worker's Role

The case manager's responsibilities include the following:

- advocacy and education;
- clinical care coordination and facilitation;
- continuity and transition management;
- utilization and financial management;
- outcomes management;
- psychosocial management and support.

As advocates and educators, case managers and social workers ensure that the patient receives the services he or she needs, as well as any needed education. Patients will be more participatory in their care regimen if they understand the ramifications of not adhering.

Case management professionals coordinate the patient's clinical care regimen and ensure that the patient is receiving those services in a timely manner. They work with the care team to update the patient's care plan as needed and intervene when changes are necessary.

Case managers and social workers make sure that their patients have continuity in their care and that things are explained to them in a consistent manner. In addition, should the patient require services such as admission to the hospital, home care, or rehabilitation, the community-based case manager and social worker communicate with other care providers along the continuum to verify smooth transitions, that all providers are well-informed, and that the patient does not fall through the gaps as he or she transitions from one care setting to another. Transitional planning has become a key role for case management professionals as driven by bundled payments, value-based purchasing, and accountable care organizations.

Another key role for case management professionals is utilization and financial management. Managing resources has become an important component used to ensure that patients are not overtreated or undertreated. Managing resource consumption also helps the organization, as the use of limited resources is optimized.

Outcomes management is the next role for our professional staff. Case management professionals monitor and, if needed, intervene to achieve the desired outcomes for both the patient and the healthcare system.

One of the emerging issues is the concurrent management of medical and psychosocial issues. Because of this need, most community case management departments use both RN case managers and social workers to ensure that both sets of needs are met. These might include individual needs but also the needs of the family and home.

Summary

Population health is much more than just placing a case manager in a clinic or other setting. It requires an infrastructure of support that includes staff, information technology support, outcomes management, and strong communication across the continuum of care. While still in its infancy, it has many exciting features that will become more and more important in the years ahead. ■