HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

RELIAS MEDIA

JANUARY 2019 Vol. 27, No. 1; p. 1-12

In-house Physician Advisors Can Help Case Managers

Advisors also can improve communication

By Melinda Young, Author

Health systems increasingly are hiring physician advisors to work in-house to assist with utilization management (UM) and collaborate with case managers in discharge planning. The physician advisor role has evolved in recent years to include mentoring and educating other staff.

The greatest impact of collaborations between physician advisors and case managers exists when the advisors are on-site, says **Bruce Ermann**, MD, internal physician advisor services (IPAS) at Catholic Health Initiatives (CHI) in Englewood, CO.

"Physician advisors have the ability to combine support, education, and efficiency structure to work within the framework of what case managers need to get through the day," he says.

> THE GREATEST IMPACT OF COLLABORATIONS BETWEEN PHYSICIAN ADVISORS AND CASE MANAGERS EXISTS WHEN THE ADVISORS ARE ON-SITE.

External vendors have used physician advisors to remotely review clinical documentation and charges. But some organizations have found it more helpful to evolve from a fully outsourced and remote physician advisor program to an onsite physician advisor program.

Payers were the first to hire physician advisors to examine the medical necessity of procedures and services. Then, hospitals began noticing that this was a job position they needed

Financial Disclosure: Author **Melinda Young**, Author **Jason A. Smith**, Editor **Jill Drachenberg**, Editor **Jesse Saffron**, Editorial Group Manager **Terrey L. Hatcher,** and Nurse Planner **Toni Cesta**, PhD, RN, FAAN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

HOSPITAL CASE MANAGEMENT

Hospital Case Management™, ISSN 1087-0652, is published monthly by Relias Learning, 111 Corning Road, Suite 250, Cary, NC 27518-9238. Periodicals postage paid at Cary, NC, and additional mailing offices. POSTMASTER: Send address changes to Hospital Case Management, Relias Learning, 111 Corning Road, Suite 250, Cary, NC 27518-9238. GST Registration Number: R128870672.

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Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours or CMCC clock hours, $469.

Outside U.S., add $30 per year, total prepaid in U.S. funds.

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This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hour(s).

The target audience for *Hospital Case Management*™ is hospital-based case managers.

This activity is valid 36 months from the date of publication.

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to fill to help their physicians improve documentation, says **Lisa Flynn**, MD, MS, FACS, CHCQM, executive of clinical innovation and documentation integrity at Tenet Health in Dallas.

Working for hospitals is rewarding for physician advisors, Flynn says.

"I worked for an external vendor company that did remote review, and so I saw it from that perspective," Flynn says. "When I'd do the work, I was frustrated; I'd review the case and call physicians who were busy and might be in patients' rooms, and it wasn't a great way to educate them."

Physicians were resistant to hearing ideas from doctors who were not on their medical staff and who didn't know their health system's culture and demographics, she adds.

"We need someone onsite who is respected by peers and knows the culture," Flynn says. "We need someone who can sit in the doctor's lounge and educate them on regulatory rules, and that was one of the big drivers for us to bring this position in-house."

There are three chief focus areas for physician advisors, says **Linda Van Allen**, RN, BSN, CPUM, ACM, vice president of case management and continuing care at Tenet Health:

- **Is the clinical review for medical necessity?** "Based on the patient's status, observation, length of stay, and level of care, is the patient appropriate for the intensive care unit versus med-surg, etc.?" Van Allen says. "Those are included in the medical necessity bucket."
- **Is clinical documentation complete and accurate?** "In reviewing a case, sometimes there's a question about medical necessity and if the documentation is complete and timely, supporting medical necessity," she says. "We're looking to make sure our documentation accurately reflects what's going on with the patient."
- **Is the patient's progression of care timed efficiently?** Patients need to be in the hospital for specific services, and physician advisors can help with sequencing and timing patients' progression of care to optimize quality of care, Van Allen says.

If there is a question or problem with a patient, case managers can go to the physician advisor for coaching and answers, Van Allen says.

"The clinical picture of a patient is different from the case management or social work view, so the physician advisor helps us know what questions to ask, what we need to address with the physician," she explains. "They're not only coaching our physicians — they're coaching our staff, as well."

For example, Van Allen observed

EXECUTIVE SUMMARY

The physician advisor role, once associated primarily with payers and external vendors, now is seen more in hospitals. These experts can help case managers and other physicians with utilization management, discharge activities, and documentation accuracy.

- Physician advisors can mentor, educate, and support case managers.
- The job of a physician advisor includes ensuring documentation is accurate and complete.
- Physician advisors can meet daily with case managers to discuss priority issues and to help resolve crises.

a case at daily rounding where a physician wanted a patient discharged and transferred to inpatient rehabilitation, but the patient didn't meet criteria for such care.

"So the case manager talked to the physician about it, and he still was very insistent," she recalls. "We submitted the request to the payer and got a denial, and we asked the physician advisor to talk to the physician."

The physician advisor explained the alternatives to inpatient rehab and helped the physician understand that the patient would get the care needed elsewhere. "How do we manage to make sure that patient in a nursing home will get the care he needs? That's the concern, and the physician advisor was helpful in resolving that."

The physician advisor discovered that the patient's doctor wanted the patient to receive daily physical therapy and thought the rehabilitation setting was appropriate. An alternative was to transfer the patient to a nursing home that provided weekend physical therapy, she says.

"Case managers can have that conversation with physicians, but if the physician advisor also has that conversation, it helps," Van Allen says.

Ermann found that his role as physician advisor works well when he meets each morning with case managers after they have handled the early crises and new admissions.

"I make sure they had an adequate opportunity to be prepared for me," he says. "I ask about their most crucial needs, picking the hottest topic off their plate, and then I find a resolution to that."

Once Ermann resolves the chief concerns, case managers are more receptive to his priorities, such as handling observation cases or new admissions with questionable diagnoses, he says.

Meetings with case managers help inform Ermann's later huddles with hospitalists.

"The case managers know a lot more about discharge barriers than hospitalists usually do," he says. "Case managers may have had conversations with the doctor and may know the patient's story, but by my knowing that story, I can help the hospitalists."

Ermann's involvement often stimulates early conversations about palliative care and goals of care expectations. Instead of waiting until day six of the patient's hospitalization to bring up palliative care, physicians — encouraged by Ermann — can bring it up on day two.

"Those things improved communication between hospitalists and case managers," Ermann says. "That improves efficiency — bringing up the issue earlier on."

Physicians that move to physician advisor roles typically need training and specific education on regulations, documentation, and coding.

"A lot of what we teach is leadership skills — how to effect change management," Flynn says. "We collaborated with an advisory board to create education and hold full-day orientation sessions for physician advisors."

At Tenet Health, physician advisors meet daily with the case management director to get an overview of patients' symptoms and where help is needed, Van Allen says.

"We have daily rounding at all hospitals on every unit that discharges patients, and the physician advisor will attend some of those to address any barriers that come up," she says. "They intervene and help us get things — physician sign-off or orders for the next day — done."

When Van Allen reviews cases for medical necessity and encounters problems with payers, the physician advisor might look at the case and contact the payer's medical director to talk about reaching an appropriate agreement.

Flynn says her role includes educating hospital physicians on how to better document cases.

"We don't correct their mistakes," she says. "We educate them on documenting to fully represent the acuity and illness of their patient."

For example, a doctor may write that a patient is experiencing congestive heart failure (CHF). This is not sufficient for documentation. The physician should note which type of CHF the patient has.

"We teach them to be more specific," Flynn says. "Chronic CHF is treated differently than acute. So we help educate them to document with the most specificity the acuity and illness of the patient."

When a payer says the patient is not meeting inpatient criteria, even when the physician knows the patient needs to be in the hospital, it often is because the doctor had been too general and nonspecific in documentation, Flynn adds.

Having a physician advisor there while the patient's case is being discussed and documented is an effective way to educate doctors, she notes.

Flynn will explain how the doctor's documentation could be improved, even as she and the physician are standing in front of the patient's room.

"It sticks with them more than if they heard this in a lecture," Flynn says. "It's much more effective to do the education that is just-in-time." ■

Case Managers Can Help Patients Improve Health Outlook

Develop functional stories

Each time a case manager visits with a patient, the patient's story about his or her illness is developed. This is true when patients are in despair or are feeling anxious and fearful — or the patient's story might include optimism and hope.

What case managers often do not realize is that they can help patients shape these stories into more hopeful and positive narratives.

"The idea of narrative theory is addressing the way we talk to ourselves and others about ourselves and our experiences," says **Janice Gasker**, DSW, LCSW, ACSW, professor, bachelor of social work program director, and director of the department of social work at Kutztown University in Kutztown, PA.

Gasker provides this example: "You get hit by a car and go into the hospital. You can talk about how awful your life is with the example of being hit by a car. Or you can talk about how great your life used to be, and then you got hit by a car," she explains. "Or you can talk about how you were very busy in your life, and this accident has forced you to be still and think and be mindful about your life and relationships with others."

In other words, the car accident and injury were a forced rest — not a tragedy or example of the universe thwarting one's life plans.

Case managers should know that as these stories are told and developed, their shape and how people react to their illnesses, injuries, or circumstances are developed through their interactions with others, Gasker notes.

"It's like you walk into a room and you say, 'Is it cold in here? Or is it just me?'" she says. "We're constantly doing that, checking with other people to see if they're experiencing things the same way we are."

In the car accident example, if the injured person called a friend to report the accident, and the friend's reaction was "That's terrible! Your life is over," then the injured person will feel worse.

But if someone, such as a case manager, instead says, "Tell me more about how you feel about that" and helps the person get to a place where he or she can look at the injury in a more positive way, it will help the patient get to a better mindset, Gasker says.

"The idea is to create a story about either your whole life or small bits of your life that leaves you with the conclusion that you're a healthy, happy person," she says. "One thing that's attractive about this is it's something you can use in your own life, sharing elements of the theory with people you work with."

Gasker sees these life stories as helping people move from identifying as victims to identifying as survivors — or as thrivers.

Survivors see themselves as overcoming adversity through resilience. Thrivers are people who move to new and better levels in their lives, partly because of how they dealt with adversity, she says.

Case managers and others can have profound impact on helping patients survive and thrive.

"There is one abuse story where a child was constantly being punished in inappropriate ways; one thing he had to do was stand on the stairs for extended periods of time," Gasker says. "What was most troubling to him was there was no acknowledgement that the abuse was happening. No one said, 'That's horrible' or 'You can deal with it.'"

It was as though the boy's abuse wasn't happening. He was not able to begin creating a positive story because he received no validation.

But then something happened:

EXECUTIVE SUMMARY

Some patients suffering from a serious illness or injury may suffer more than others. They express fear that they will never recover and can no longer enjoy their lives. Case managers can learn skills to help them change these concerns through developing a functional life story that teaches optimism.

- Using narrative theory, case managers can teach patients how to talk to themselves in ways that will improve their outlook.
- The main idea is to provide validation to the patient's story and help the patient see things a little more positively.
- Case managers can help patients shift from victims to survivors, or even thrivers.

"The family had a housecleaner who would walk by him and make eye contact with him," Gasker says. "She would acknowledge that he was suffering, and that one small piece of light was able to help him talk about it, years later, that his life was not horrible."

This is what case managers can do for patients: They can acknowledge that they heard the patient's sad story. They do not have to say they believe the patient's version of events, only show that they care enough to listen, she says. *(See story on how to hear patients' stories, below.)*

"The most important piece of this is letting a person know that you heard their story and acknowledge the way they might be feeling," Gasker says. "You can do more than that. But you can also stop there, and you would have made a great intervention because they need that validation before they can go on to change their story and have a survivor mindset." ■

Strategies for How Case Managers Can Truly 'Hear' Patients' Stories

Listen, validate, be silent

Case managers have the power to help their patients change their own narratives about their illnesses and injuries. They can achieve this through helping patients develop more functional stories about their situations in the following ways:

• **Make empathetic statements.** "Empathetic statements are nonjudgmental comments that help a person continue and talk some more," says **Janice Gasker**, DSW, LCSW, ACSW, professor, bachelor of social work program director, and director of the department of social work at Kutztown University in Kutztown, PA.

These can include the following:

- "You're feeling sad/bad/unhappy/etc.?"
- "Could you say that again?"
- "Tell me about…"
- "I would feel sad/bad/unhappy in your situation. Do you feel that way?"

It is important to make a comment that helps the patient feel validated, Gasker says. And be specific: "Don't just say, 'I hear you,'" she says. "Say, 'I hear you that the nurse has been showing up late.'"

• **Fixing problems isn't everything.** "It's not that you don't fix their problems," she says. "It's that you can begin to hear them talk, and maybe there's nothing you have to fix."

It could be the patient just needs to start thinking about problems in a positive way, she adds.

"Remember, this story gets told in interaction and developed in interaction, so you need a trusted person to talk with so you can start shaping that story," Gasker says. "Say, 'I want this story to have a happy ending, so let me tell you what happened.'"

• **Find the right person.** Patients, case managers, or anyone looking to write a more positive story need to find someone who will validate their feelings and not try to fix them immediately, Gasker says.

It also is not important to make a person feel better immediately. "Many of us who do this kind of work want to help people get rid of their pain right away, when what they need is a new way to think about this," she says.

The listener does not have to believe everything the person says, but the listener should not demonstrate a lack of trust in the narrative. This means the best listeners will not be people who look at life through a negative lens, she adds.

• **Memory is malleable.** It is possible for people's memories to change over time. They might even believe something occurred that never happened.

For example, a study of people's memories after the 9/11 terrorist attacks showed that people's memories of specific details of where they were, who they were with, etc., when they first heard of the attacks deteriorated over time. They remembered details incorrectly, including even how they first heard of the attacks and who they were with when they found out. *(More information on the studies is available at: http://bit.ly/2zA8TZ9 and http://bit.ly/2qsehZT).*

"This points out that it's not your job to believe or disbelieve a person's memory," Gasker says.

The key is to listen and validate. If the person reports something disturbing, such as abuse, the case manager should report it to appropriate authorities. It is up to experts to investigate it. But for other

memories and stories, the goal is just to acknowledge that the person is being heard.

• **Ask how the patient feels.** The next step is to ask patients how they feel about what they are discussing.

"Then you talk about their story as they talk about it, helping the person see there's another way to look at things," Gasker says.

For example, the case manager dealing with a car accident patient could say this: "I hear you say the car accident was very troubling for you. Tell me more about that. How are you feeling about that?" she says.

The patient might be sad or angry, and the goal is to acknowledge the person's emotions.

"Say, 'I hear you say you're sad/angry/etc.'" Gasker says. "But don't settle for the word 'upset.'"

When patients say they are upset, the case manager can ask them whether they are mad or sad or something else. By digging a little deeper, the patient might open up and share more.

"If you say, 'Tell me what that means for your life?' the patient might say, 'Well, I can't move my legs, and it's over,'" she explains.

"So you can say, 'OK, let's think about that in a different way. You have told me that you're an artist. And it's true that it's bad for an artist not to go around and see things. But, on the other hand, you will have time to let the artist come out in you,'" Gasker says. "And you ask, 'Can you think about some ways you can find some things you can do when you're here that you have not had a chance to do if you were not here?'"

Likewise, if a patient shares that she is sad that her daughter never visits her, then the case manager can suggest that the daughter could visit more now that the patient needs more help to manage at home.

"You have to hear the person first to know where to go with it," Gasker says. "Just be careful to not invalidate what they're feeling. So if they're saying they are very sad, don't say, 'Really, it's not that bad.'"

"Instead, ask, 'Is there a different way we can think about this?' Gasker says. "Maybe this is something that stays a sad story for a while, but the person gets the idea they can think about things differently."

• **Use silence strategically.** Empathic statements help to build trust. Silence provides the space for the patient to tell his or her story.

"People need to know that the most important gift you can give someone is silence," Gasker says. "We do not allow silence in conversations. Someone always jumps in to fill that gap."

And when people have suffered a trauma or illness, others may be unwilling to hear about it. They cut the patient off when they start to talk, she says.

The silence might last 30 seconds, which will seem like an enormous amount of time, she notes.

"You say, 'Can you tell me more about that?' Then let them sit with that. Just let them talk first," Gasker says. ■

Age-Friendly Health Systems Initiative Improves Delivery, Quality of Care for Older Patients

By Jason A. Smith, Author

With thousands of people across the United States reaching age 65 and older every day, hospitals and health systems are looking for ways to improve care for these patients and better suit their needs.

Terry Fulmer, PhD, RN, FAAN, is the president of The John A. Hartford Foundation (JAHF), which has worked extensively in addressing the healthcare needs of older patients. Fulmer touted the success of the Age-Friendly Health Systems program as a way to meet those needs.

"The Age-Friendly Health Systems initiative is really a movement to transform healthcare so that each of us reliably gets the best care possible as we age that reduces harm, increases our satisfaction, and creates value for everyone from the patient to the health system CEO to the bedside nurse," says Fulmer.

The initiative was launched in 2015 with JAHF's partners at the Institute for Healthcare Improvement, in collaboration with the American Hospital Association and the Catholic Health Association of the United States.

"Our goal is to develop an Age-Friendly Health Systems framework and rapidly spread to 20% of U.S. hospitals and health systems by 2020," says Fulmer. "The heart of the initiative is what we call the '4Ms' bundle, which we distilled from the evidence about the best care of older adults."

The 4Ms bundle centers on implementing effective strategies of care for older patients:

• **What Matters:** understanding and aligning care with what is most important to each patient;

• **Medication:** using appropriate prescriptions that do not interfere with What Matters;

• **Mentation:** preventing, identifying, treating, and managing delirium, dementia, and depression;

• **Mobility:** promoting safe and regular movement to preserve function.

"Together, addressing these 4Ms across all care settings can measurably improve the experience and outcomes of care for older adults and their families," says Fulmer.

In 2017, five health systems adopted the Age-Friendly system: Anne Arundel Medical Center in Maryland, Ascension network, Kaiser Permanente, Providence St. Joseph Health system, and Trinity Health in Michigan. Fulmer says the initiative has yielded positive results.

"More than 100,000 patients have received age-friendly healthcare at 26 sites within those systems in seven states," she explains. "We are seeing examples of improvement and continue to collect data to show outcomes."

For example, at Anne Arundel Medical Center, "staff integrated the 4Ms into shift reports, incorporated 'What Matters' into the electronic health records and whiteboards in hospital rooms, and began daily exercise sessions for their older patients," Fulmer explains. "In their pilot, they reported reductions in length of stay and increases in patient satisfaction."

Overall, Fulmer says the healthcare community has responded with a "groundswell of interest and buy-in" to the strategies involved in this initiative. "More than 250 organizations have joined quarterly 'Friends of Age-Friendly' update calls," she adds.

Fulmer explains that as recently as September 2018, more than 120 teams from 69 health systems have joined an Age-Friendly Health System Action Community in a collaborative effort to learn how best to implement the 4Ms.

"The concept of age-friendly care is something that everyone understands and sees its value," she says.

In addition to positive reaction from those in the healthcare field, Fulmer says the initiative from patients has been "validating" as well. Patients and their families have expressed higher levels of satisfaction regarding their care since the initiative was implemented.

"We have patient representatives who have been helping design the initiative," says Fulmer. "They often talk about how incredibly different care is when their healthcare team is focused on what matters to them as people, rather than only focusing on what's the matter with them as patients."

Fulmer also laments the rising cost and demand of healthcare for people age 65 and older, citing a need for a system that creates value and continuity for patients.

"By focusing on what matters and preventing harm by using the 4Ms as a guide, we can reduce waste and inefficiency in our system," she says. "Simultaneously, this can increase patient and family satisfaction and bring more joy to members of the healthcare team who want to see their older patients, and all of their patients, have positive outcomes."

Fulmer says the John A. Hartford Foundation, established in 1929, has played an essential role in helping to improve care for older adults for more than three decades.

"Through our grants and programs, we've helped build a field of experts in aging and health, and today, we're focused on replicating their innovative approaches and achieving measurable impact."

Along with its work in age-friendly health systems, Fulmer says the foundation has maintained a focus on "supporting family caregivers of older adults and improving serious illness and end-of-life care."

Practicing the 4Ms

Lillian Banchero, MSN, RN, senior director at the Institute of Healthy Aging at Anne Arundel Medical Center in Annapolis, MD, says working to meet the needs of older patients is an increasingly important issue due to the changes in demographics across the country.

"There's 10,000 people who turn 65 every day," says Banchero. "We as healthcare providers need to understand that our population is changing to age 65 and older. Older adults have different medical needs and social needs."

Anne Arundel Medical Center signed on to the Age-Friendly Health System Initiative nearly two years ago. Banchero says JAHF and IHI have teamed up in recent years with organizations across the country with the goal of improving the level of patient care.

"Age-friendly healthcare is all about giving people the best care we can give, without harm, and reducing costs," says Banchero.

She points to elements of the 4Ms bundle to illustrate the priorities of the Arundel health system as a means of patient care.

"The most important 'M' to us is What Matters," says Banchero. "Once we understand what matters to them in their care, we can provide the best individual care for them."

Banchero also emphasizes the Mobility and Mentation components

of the 4Ms as crucial elements in caring for older patients. She says patients who exercise and interact with their peers have a greater likelihood of better health.

"Sometimes with older people, we think they just need to stay in bed. It's just the opposite," says Banchero. "If you're locked away in a room for two or three days and nobody's talking to you, that's no good for you. You need to get up and walk, say hi to somebody, have interaction with each other. It's just as important as any medication or treatment we can give you." ■

Efforts Underway to Reduce Medicare Spending, Meet Standards for Spending Per Beneficiary

With the healthcare industry's increased focus on value-based purchasing, debate continues as to whether hospitals are meeting standards for total Medicare Spending Per Beneficiary (MSPB).

Janelle Shepard, MBA, BSN, RN-BC, senior director and system officer of care transitions/utilization management/care continuum management at Texas Health Resources (THR) in Arlington, revealed her findings in a presentation titled "Get More Bang for Your Post-Acute Buck," during the American Case Management Association's Leadership and Physician Advisors Conference Nov. 6, 2018, in Huntington Beach, CA.

Shepard notes that North Central Texas — an area with more than 7.4 million people and growing — does not require a certificate of need to build a medical facility.

"The Kaiser Foundation ranks Texas number three in the nation for high Medicare spending," Shepard says. "In the Dallas/Fort Worth area, we are well known for overutilizing all sorts of healthcare."

Shepard says the MSPB measure is the Center for Medicare & Medicaid Service's way of gauging a hospital's financial efficiency. THR's goals are to analyze and critique current MSPB; to develop and implement a standard for appropriate and efficient post-acute care placement; and to build and support a network of post-acute providers.

"The mathematical formula averages the amount of Medicare dollars each hospital spends per patient on Medicare Part A and Part B benefits," she explains. "They then compare that number to a risk-adjusted national average across all hospitals for a Medicare-spending episode."

Shepard says value-based purchasing currently measures and can penalize hospitals for the MSPB. She notes that a Medicare spending episode begins three days before hospital admission, continues through hospitalization, and ends 30 days after hospital discharge.

Shepard adds that THR continues to see increased populations for risk management, with high volumes of patients being sent to post-acute care.

Categories where such episodes occur include: acute hospital admission; long-term acute care hospitals (LTACHs); hospice services; outpatient services; physician services; skilled nursing and acute rehabilitation facilities; Medicare home health agencies; and durable medical equipment services.

"While hospital administrators have voiced concerns about the 'fairness' of making hospitals accountable for spending they have no control over, CMS responded appropriately with 'perceived fairness is not the point,'" says Shepard.

"CMS believes that including Medicare payments paid to all providers during the Medicare spending episode encourages hospital case managers and physicians to evaluate closely the medical necessity of every service ordered. Their logic is that it should reduce Medicare spending and delivery system fragmentation."

During her remarks at the conference, Shepard outlined THR's processes for patient care. She says a care continuum system officer leads care transitions, with UR departments reporting to the chief medical officer.

Each facility in the system, says Shepard, contains two physician advisors who are responsible for handling physician education, case escalations, denials, and appeals. Other provisions within THR include: a physician advisor in revenue cycling for coding, clinical documentation improvement, a central business office, and appeal oversight.

Shepard says that thirteen THR hospitals feature care transition departments with more than 250 RN case managers, and social workers known as care transition managers.

"Due to an oversaturation of IRF and LTAC beds, the DFW market has historically pulled patients inappropriately to the higher levels of care. Patients would bounce from hospital to LTAC to IRF. Medicare patients became 'unfunded' because they used all of their acute Medicare days."

Shepard adds that skilled facilities struggled to develop staff with comprehensive skills to care for the patients with more intense medical needs.

"THR began seven years ago to work with SNFs to increase their ability to take sicker patients and provide more appropriate care at the skilled level," she says.

Shepard emphasizes that healthcare providers can control costs without causing harm to their patients.

"When true clinical criteria are applied, you are doing the right thing for the patient," she says.

"Physician advisors were especially helpful with physicians accustomed to overutilizing resources.This is not the 'Easy Button' for discharge planning, but the right thing to do." ■

Some States Provide Funding When SDOH Used to Improve Quality

One health system is finding that the state it operates in is willing to support the use of social determinants of health (SDOH) to address health issues affecting the community.

Spectrum Health in Grand Rapids, MI, is applying SDOH in two major projects. The first is called Strong Beginnings and includes a contract with the state that focuses on reducing risk factors for racialized infant mortality.

Spectrum was prompted to address the issue when a report showed that the African-American infant mortality rate was six times the Caucasian rate in Kent County, MI, notes **Jeremy Moore**, director of Community Health Innovations. He also is a Robert Wood Johnson Culture of Health Leader studying health equity and social determinants and looking for ways to resolve the inequities.

Initial efforts to address the problem showed some success, but scaling up those efforts was made possible by an opportunity with the state of Michigan paying for Spectrum to address risk factors for infant mortality. Spectrum determined that the key risk factors were preterm birth and rapid, repeat pregnancies, Moore says.

"The state pays on those outcomes — about $60,000 for each avoided preterm birth and $15,000 for each avoided rapid, repeat pregnancy," he explains. "They only pay on that as we reduce from the baseline infant mortality in the community, and it requires a baseline volume of 350 women. We also have to get a capital structure to put some of our own money and some foundation money."

Spectrum launched that program about 18 months ago with a rigorous data component, Moore says. The hospital uses a third-party evaluator, Michigan State University, and the state uses the University of Michigan to validate the data, also.

Another Spectrum project emerged a few years ago when Spectrum identified a significant number of uncontrolled asthma cases presenting to the ED and researched the causes. Some of the common findings were home conditions such as old carpeting and bug infestations, Moore says, so Spectrum launched another program for home remediation aimed at reducing overuse of the ED for asthma cases. The state also pays for improvements in that area.

Obtaining data for such projects can be a challenge for hospitals and health systems, Moore says.

"Hospitals usually aren't set up with that kind of data. We do have demographic data through insurance companies, but that data is very protected, and it's not easily used," Moore says. "None of these data systems talk to each other. Being able to translate all the vital records, Medicaid data, social determinants, and geographic census data is challenging because there are a lot of legal barriers and expertise barriers, and often, it doesn't easily translate into finance."

Any project involving SDOH will require bringing together a large number of professionals who speak different languages and organizations that have different priorities, Moore says. A first step will be identifying the people who have access to the necessary data, followed by trying to make that data user-friendly, he says.

New York state also is supporting the use of SDOH through its 1115 Medicaid Waiver, notes **Karen Meador**, MD, managing director of the BDO Center for Healthcare Excellence and Innovation. The waiver is aimed at improving access, quality, and cost-effectiveness of health services for needy and at-risk residents by allowing the state to implement a managed care program.

"There is a very strong emphasis on social determinants of health as a way to provide holistic healthcare. Each of the performing provider systems is incentivized to include in their projects, for which they are being

compensated, those initiatives that emphasize the importance of social determinants of health," Meador notes.

Meador notes the example of the growing use of community health workers to help reach the state's goal of reducing unnecessary ED visits and hospitalizations by 25% over five years.

"They have varying backgrounds, but they know their communities, the residents, and the resources. They know how to get people connected to resources that can make a difference in their health outcomes," Meador says. "Particularly in New York state, there has been a lot of effort put into training community health workers who can be available to patients, particularly those with complex medical problems and at highest risk. They can help these patients navigate their appointments and home management, watching for red flags that mean they need to see a clinician, so they can avoid an unnecessary hospitalization or ED visit."

Such efforts have been more difficult in the past because of the fee-for-service reimbursement system, Meador notes. A physician would be compensated for an office visit, and there was increasing emphasis on the physician discussing lifestyle and community issues that affect health, she says.

"Outside of that context, there hasn't been a way to reimburse providers or support personnel for assisting patients outside of that office visit," Meador says.

"But with the move toward value-based reimbursement and with physician practices increasingly taking on risk, there is financial value as well as overall social and healthcare value in providing resources and services that help patients be healthier at home and avoid unnecessary visits to the ED or hospital."

Maryland also has emphasized SDOH. In 2014, it revised its Medicaid system to become more of a global payment model in which hospitals could benefit from decreasing utilization, notes **Andy Friedell**, senior vice president of strategic solutions and public affairs with Maxim Healthcare Services, a provider of home healthcare, medical staffing, and wellness services headquartered in Columbia, MD.

There also were significant goals around reducing readmissions that could result in bonus payments or penalties.

"Hospitals had strong incentives to be involved with programs that targeted readmissions. We began working with the University of Maryland on a program that is very focused on the social determinants side of nonclinical barriers to nonadherence," he says.

"We started focusing on readmissions, but quickly realized that for a lot of patients, readmissions are only a symptom of these underlying problems. They're suffering from socioeconomic challenges that are preventing them from following the care plan you've outlined, so if you can address those, the utilization comes down as a byproduct."

Maxim's work involves looking for patients with challenges in four areas: medical complexity, functional status, psychological issues, and social determinants.

"When we find people with those four factors in their profiles being discharged, we reach out and schedule RN visits in their homes," he explains.

"They do assessments that focus on those four areas and build a care plan that can be used by a community health worker over 90 days to address those factors. They bring in a lot of coordination of social services."

The program has seen approximately 3,000 patients in four years, with good results, Friedell says.

"We started with a readmission rate for this high-risk population of 25%, and in the first year, we were able to bring that down to the 8-12% range. We've maintained it there over time," he says.

"The lesson from our experience is that you have to have a marriage of people and technology to see the good results," Friedell says.

"You have to get the data in the hands of people who can go out in the community and act on it, interacting directly with the patients who need their help." ■

Coordination Center Uses Real-time Data to Speed Collaborative Decision-making

As high-volume hospitals face continual overcrowding and ED boarding problems, leaders are recognizing that change is needed. To resolve logjams, some institutions are turning to a centralized command center model that relies on a nurse navigator to be the ED point person.

Yale New Haven Hospital (YNHH) in New Haven, CT, has adopted the model, centralizing operational decision-making in its Capacity Coordination Center (CCC). The CCC includes

representation from key hospital capacity decision-makers and hinges on the use of real-time data about incoming and outgoing patients.

The nurse navigator — representing the health system's two busy adult EDs — works with representatives from EMS, admitting, bed management, and other key operations to manage incoming and outgoing traffic optimally. This point person anticipates clinical services incoming patients may need further down the line and streamlines communication among hospital departments.

YNHH administrators note the CCC has changed the culture, eliminating the previous silo mentality that hindered efficiency. Essential to the hospital's model is a steady stream of real-time data flowing simultaneously to key decision-makers through the system's electronic medical record.

The hospital has a large inpatient service and an active ED. As providers struggled to deal with increasing volumes of patients, leaders recognized that they needed to bring key resources and people together under one umbrella, explains **Andrew Ulrich**, MD, operations director for the department of emergency medicine at YNHH.

Stakeholders in the ED have been big supporters of the approach, Ulrich observes. When the hospital is overcrowded, he says, "it all filters back down to us because we essentially are the front door to the institution."

YNHH encompasses two separate campuses and two adult EDs within one mile of each other, serving about 150,000 patients a year. Because the system has one major EMS provider bringing patients to the two ED ports of entry, "we were very interested in having improved communications," Ulrich notes.

Previously, the larger ED served a heavier load of patients while the smaller ED often took in fewer patients than it could handle. "As the whole discussion about the CCC was starting to take seed and blossom, we were working with our own group to develop a nurse navigator role," Ulrich says.

Originally, the nurse navigator worked alongside the prehospital provider agency to direct ambulance traffic to the facility best prepared to receive specific patients, based on capacity and services. The navigator worked next to the dispatchers, focusing on public safety and public health, explains **Thomas Saxa**, MSN, RN, patient services manager for the adult ED and supervisor of the nurse navigators at YNHH.

When the CCC opened in the Smilow Cancer Hospital, near YNHH's primary ED, the nurse navigator role expanded. Now the navigator and the EMS point person are housed together in the CCC. "That relationship is critical, so we moved both over," Ulrich says.

Besides EMS, the nurse navigator has direct access to staff handling bed management, admitting, environmental services, patient transport, and other operational services. "We understand what beds are coming open, what is being cleaned, and what is in the pipeline so that we know how to shift our patient volume," Saxa explains.

The navigator also anticipates services needed further upstream when determining which campus can better accommodate incoming patients with specific clinical needs. "For example, if there is abdominal pain in a young male that sounds like it could be appendicitis, the navigator now knows what operating room is open and where they can send that patient. For orthopedics cases, they know where these services are better equipped at certain times of the day to handle the patients coming in," Saxa observes.

Essential to the CCC's operations are rich operational data updated constantly. The hospital's electronic medical record vendor created dashboards that display available beds at both campuses, the time it takes to clean a bed, transport time, and quality and patient safety indicators. The dashboards also show patients en route, admitted, and being discharged.

The communications aspect is important, as YNHH has complex patient movement challenges. The navigator confers instantly with other operational decision-makers in the CCC and notifies the ED about incoming patients with specific needs. Typically, the navigator corresponds with the charge nurse in the ED or the nurse expediter, who manages flow from the waiting room, Saxa explains.

The full potential of the CCC has not yet been realized, according to Ulrich, although the system has seen some operational metrics improve. "The culture itself is the first big change," Ulrich observes. "We are light-years ahead of where we used to be because at least we have a shared resource and a shared approach." ■

SOURCES

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HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. **Which of the following is *not* a suitable focus area for the role of physician advisor?**

   a. Are clinical decision-making, medical interventions, and quality of care optimal?
   b. Is the clinical review for medical necessity?
   c. Is clinical documentation complete and accurate?
   d. Is the patient's progression of care timed efficiently?

2. **Which of the following best describes narrative theory?**

   a. Role-playing to heal emotional trauma
   b. The hypothesis of how storytelling relates to cultural groups' identities
   c. Addressing the way people speak to themselves and others about their experiences
   d. None of the above

3. **Focusing on what matters to patients can help case managers to:**

   a. eliminate risk of harm to patients.
   b. guarantee patient and family satisfaction.
   c. reduce waste and inefficiency within the healthcare system.
   d. cut down on the number of lawsuits brought by patients.

4. **Texas Health Resources' facilities feature each of the following *except*:**

   a. advisors to oversee education, case escalations, denials, and appeals.
   b. a focus on clinical documentation improvement.
   c. an emphasis on care transition managers.
   d. All of the above are features.

CE OBJECTIVES

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

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