HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Health Systems Should Stay on Top of Longitudinal Care Curve

Train, educate, use tech, focus on value

By Melinda Young, Author

One way to view the healthcare industry's transformation from fee-for-service to value-based care is to think of it as a change from the episodic model of care to a new model of longitudinal accountability across the care continuum.

At least, that is what hospitals should be thinking about. "Hospitals are a little behind on the concept of longitudinal care management," says **Kathleen Ferket**, MSN, APN-BC, senior consultant with Ferket Advisory Services in Chicago. Ferket speaks about longitudinal care at national case management conferences.

"Hospitals have been long rooted in the episode of care, and they're doing a good job with discharges to the next setting," Ferket says. "But it's really saying, 'We're done with that patient and on to the next.'"

> "SLOWLY, MOST OF THE SYSTEMS ARE COMING TO THE REALIZATION THAT THEY HAVE TO GET THIS RIGHT, THAT THIS IS AN IMPORTANT PART OF CARE PRACTICE ACROSS THE HOSPITAL."

By contrast, payers have been attending for a long time to longitudinal care management with chronically ill and complex patients. They are ready for this transition, waiting for health systems to catch up.

"There are a lot of disrupters in the market," Ferket says. "So those areas across the business sector that have embraced the disruption have done a better job."

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Accountable care organizations (ACOs) are one way that acute care hospitals have moved into the longitudinal care management arena. This is especially true for health systems involved in the Medicare Shared Savings Program, called Pathways to Success. *(See story about Pathways to Success in the April 2019 issue of* Hospital Case Management.*)*

Some physicians, EDs, and hospitals are committed to the process of reducing costs for Medicare patients.

Those involved with Pathways to Success do their best to navigate patients to the best level of care and to keep patients out of the hospital, Ferket notes.

There mostly is a wide variation where health systems are transitioning to longitudinal care management.

"Everyone is in transition; there are huge variations in philosophies around patient care management," says **George Mayzell**, MD, MBA, FACHE, vice president and chief clinical officer of Vizient Southeast in Tampa, FL.

"Folks have dedicated different amounts of time and resources to thinking about this," Mayzell says. "Slowly, most of the systems are coming to the realization that they have to get this right, that this is an important part of care practice across the hospital."

While some hospitals still focus on utilization review and discharge planning, others are moving to a clinical case management model that includes care coordination, he says.

"Case management is an incredible asset to health systems," Mayzell notes. "There are few people who get to see the patient at the bedside and follow them through the hospital so they can identify risk issues, quality issues, and social-economic issues of patients."

The case management team should be clinical, but it also should integrate social workers and other disciplines, including pharmacists, nutritionists, and physical therapists, Mayzell says.

For hospital case management programs, a first step is to teach staff the definition of value-based care and longitudinal care.

"Value-based care initiatives are driving a lot of work being done right now, so make sure folks understand what we mean by value-based care," Ferket says.

They also need to know the drivers behind longitudinal care, including the United States' financial and clinical outcomes.

EXECUTIVE SUMMARY

Payers are moving toward longitudinal or value-based care across the care continuum, but health systems are lagging in building an infrastructure for this newer model.

- Hospitals and case management departments too often operate under the philosophy of discharging patients and finishing those cases.
- There is wide variation in where health systems are on the continuum of change to accountable care, longitudinal care, and population health initiatives.
- Value-based care provides quality care at the right place with optimal patient satisfaction.

"Healthcare in the United States is more expensive than any other industrialized nation, and yet our outcomes are not as good," she says. "We rank in the second tier."

Value-based care provides quality care at the right place and ensures patients are satisfied with their care. It also means making sure all of a patient's care providers have access to the same medical records, Ferket says.

"Care managers and case management divisions within health systems are coming to the forefront," Ferket explains. "It's no longer, 'I'm going to worry about your length of stay and whether your hospitalization is going to be covered.'"

Instead, the focus is on transferring patients to the next level of care and keeping them within the system as much as possible, she adds.

"Case managers will look at a patient as someone they will keep on their caseload for the patient's lifetime," Ferket says.

Another strategy is to recognize that the patient leaving the hospital is transitioning to another setting and his or her care is ongoing, Mayzell suggests.

The case manager's job is to educate patients and their families about their transition and the case managers, care coordinators, or transition coordinators who might be helping them along the way.

Directors also should select the best staff for case management in the new era.

"Some of the older models of case management emphasized nonclinical people, although they always had some clinical staff," Mayzell explains. "But the new models — and I'm preferential to these — are a clinical process."

The new case management role will be challenging because each hospital case manager will need to understand payment models and how to work with hospital physicians, outpatient providers, and payer case managers, he says.

"It requires extensive knowledge to do this role, and you have to understand clinical expertise and the disease process," he adds. "Case managers now need more skills than utilization review and discharge planning; it's a very difficult job."

For a long time, healthcare organizations were siloed in their focus. Acute care staff would only learn how to handle patients in acute care and not necessarily understand what happened when a hospital discharged a patient to ambulatory care, Ferket notes.

"Case managers might not have known about resources in the community," she adds. "Now, the opportunity to build those relationships across the continuum of care is key; case managers need to know the handoff is safe and they're including the patient's goals of care in that transition."

It is about breaking down the silos in the ED and hospital and understanding the entire health system and community points of contact, she says.

Case management directors will need to hire staff who possess the right personalities and skill sets, and invest in training.

"There has to be integration of these roles with all key players in the hospital, including integration with nursing, physicians, and other hospital teams," Mayzell says. "Establish a rapport with physicians so they can see case managers as assets and help them and their patients in the care process."

It's also crucial for directors to show their hospital leadership how important case management is as the health system transitions to longitudinal care.

"Make sure they understand the benefit of this," Mayzell says. "It takes additional resources, and leadership has to buy into the model and provide enough staffing and training resources for it to be successful."

The ultimate goal is for case management to be linked to quality initiatives and help the hospital reduce length of stay and readmissions, he adds.

The shift to longitudinal care management also requires leveraging technology, Ferket says. Some electronic health records have identified the importance of connecting ambulatory settings to acute care settings, she says.

With up-to-date technology, there are ways to make sure everyone who sees a patient is in the loop and understands where the patient is in the continuum of care, Ferket says.

By leveraging the electronic medical record, case managers can stay on top of what is happening in the acute care episode and in the skilled nursing facility. New technology enables bi-directional communication with patients, she adds.

This move toward longitudinal and value-based care is a trend that will continue regardless of what happens with the Affordable Care Act, Mayzell says.

"Most people agree that our current healthcare spending is unsustainable, and most people agree there is a lot of waste in our system. Clearly, there have to be some new payment models," he says. "Value-based care will continue and not just in Medicare-driven arenas; this train is not going to stop."

Hospitals that work now to establish infrastructure and strategies

to handle these changes will be in better shape when the change is forced on them.

"You have to have some infrastructure things in place, including a good data and analytic system, as well as the right payment model and culture in the organization," Mayzell explains. "Those are things you cannot pull together at the last moment, and making changes now will make you more successful in the current fee-for-service model, as well as in the future." ■

Patient Reassessments Help Hospital Reach Top Goal of Patient Safety

A children's hospital targeted seven-day readmissions, successfully reducing the rate after instituting a patient safety case management program.

In a value-based healthcare culture, ED and hospital readmissions for preventable health issues are considered a failure.

"With pediatrics, we focus on readmission within seven days," says **Patty Huddleson**, RN, BSN, CPHQ, clinical quality manager at the Children's Hospital of Orange County (CHOC Children's) in Orange, CA. Huddleson and CHOC received recognition for their patient safety efforts in January 2019 by the Children's Hospitals' Solutions for Patient Safety (SPS), a collaboration that focuses on strategies for hospitals to improve safety and quality while reducing readmission rates. *(See story about SPS in the April 2019 issue of* Hospital Case Management.*)*

"The intervention that this collaborative decided to focus on had to do with keeping patients out of the hospital," she adds. "Our readmission rate was 3.8 readmissions per 100 hospital discharges, within seven days, in 2015."

Three years later, that seven-day rate was 3.2 readmissions per 100 hospital discharges, she says.

The hospital conducted a pilot program in 2016 with a case manager and social worker rounding with the physician medical-surgical teams. They were dedicated to that team, looking for case management and social services issues as they rounded, says **Karen Pugh**, MSN, RNC, director of case management and social services at CHOC Children's.

Part of the hospital's evolution was to change the case manager role. It had been a combination of case management discharge planning and utilization review (UR), Pugh says.

"Around 2017, we split up that role to make it distinct," she explains. "We have utilization review nurses and discharge planning nurses, so it's the discharge planning nurses that round with med-surgical teams."

The UR nurses can work from home, using evidence-based guidelines and giving insurance payers all necessary information to expedite payments.

While rounding with physicians, case managers can send the UR nurses emails to answer questions about the physician's discharge plans and timing. They keep communication flowing.

Here's how the case management program works:

• **Use team-based case management.** Case managers touch base with patients' families and connect them with needed services, making sure they are well-educated on what patients need at home, she adds.

"A year later, we attempted to spread that to more teams, meaning more teams in the med-surg unit, to have a case manager or social workers rounding with all the different teams — and the doctors loved it," Pugh says. "They liked having the case manager and social worker there to bring up concerns they might not have thought about with the patient and family."

• **Assess risk.** The next step is to

EXECUTIVE SUMMARY

The Children's Hospital of Orange County (CHOC Children's) in Orange, CA, has been recognized for its patient safety efforts that also have led to improved readmission rates.

- The hospital reduced its readmission rate from 3.8 readmissions within seven days per 100 discharges in 2015 to 3.2 readmissions per 100 hospital discharges three years later.
- CHOC Children's divided the case management role between utilization review nurses and discharge planning nurses.
- Discharge planning nurses/case managers round with medical-surgical teams.

develop a risk stratification tool that could identify patients who would most benefit from case management to prevent readmissions.

"Our organization hired a scientist a year and a half ago, who developed a tool to predict risk," she says. "It puts patients in high, medium, or low categories to predict whether the patient would be readmitted."

The tool was embedded in the electronic medical record. Initially, its goal was to categorize patients and look for reasons why patients were returning to the hospital.

At first, the case management team worked with the high-risk patients. But they found that most of those patients already were connected with the outpatient case management team, Pugh says.

"Now, we're more focused on patients that are moderate risk," she says. "We thought those kids could be prevented from coming back to the hospital."

• **Find out why patients return to the hospital.** One strategy is to ask families questions from a reassessment tool, including

- "Why are you coming back to the hospital?"
- "When you left the hospital, how did you feel? Were you comfortable, slightly comfortable, uncomfortable?"
- "Were you prepared?"
- "Were you able to get your medications?" If the person says "no," the case manager can ask whether the patient participated in the medication-to-bed program, which gives them medications to take home from the hospital.
- "Do you need help taking care of yourself?"

• **Find solutions.** One strategy for preventing readmissions is to ensure patients and families schedule medical appointments before leaving the hospital, Huddleson says.

Not all patients make these appointments, Pugh notes.

"We have a dedicated case manager to that process, to set up appointments at discharge, and we're not at 100%," Pugh says. "Sometimes they don't want the appointment."

Another strategy is to provide timely follow-up to discharged patients.

> "WE'RE MORE FOCUSED ON PATIENTS THAT ARE MODERATE RISK. WE THOUGHT THOSE KIDS COULD BE PREVENTED FROM COMING BACK TO THE HOSPITAL."

"We developed a post-discharge follow-up call with nurses," she says. "Within 48 hours of discharge, we call to see if they have any questions, to reinforce the discharge instructions, and to make sure they have an understanding of what they're supposed to be doing."

The most frequent questions patients and families ask involve medical concerns. In some cases, nurses refer them to the right providers or advise them to return to the ED, Huddleson says.

• **Collect metrics.** "We keep metrics on whether patients completed their appointments after discharge," Pugh says. "We have a dashboard and can show our team the work they are doing."

The data include how many patients kept or did not keep their appointment.

"About 50% do not go to the appointment, and we're trying to work with the team to figure out exactly why they don't," Pugh says.

"Some of the things we've heard back from families is the kid gets better and they don't feel like they need to go to the primary care provider appointment," she adds. "We're working on a plan to increase the percentage of patients who keep their appointments, and case management is working on that, as well."

Case managers also need to know why patients returned to the hospital. These readmissions and ED visits could be the result of worrisome signs and symptoms, such as being unable to obtain medication and schedule follow-up appointments, and not being comfortable with home care.

"Some would rather be at the hospital than at home," Pugh says. "Or maybe their home health nurse didn't show up or the durable medical equipment they needed was never delivered."

• **Provide telehealth as needed.** Hospitals can schedule a post-discharge telehealth visit for patients who are discharged at high or moderate risk.

With telehealth, case managers and social workers can see patients in their homes. They can answer questions, ensure families understand the discharge instructions, and reinforce the importance of making it to a follow-up appointment, Pugh explains.

The case management program's outcomes in reducing unnecessary readmissions have been positive, and there are other benefits: "Case managers love it because they feel their work is more streamlined without having to worry about the utilization review part; they're more focused on the family," Pugh says. ■

The Case Manager's Role in Palliative Care

By Jeanie Davis, Author

For patients with serious illness, mortality can range from weeks and months to years. Patients with dementia and metastatic cancer may live with their illness for many years.

Palliative care often is essential in the care of patients with serious illness, says **Allison Silvers**, MBA, vice president of The Center to Advance Palliative Care (CAPC), part of the Icahn School of Medicine at Mount Sinai in New York City.

The big questions: How can healthcare systems improve the lives of people living with serious illness? How can they help doctors and other caregivers learn the skills they need to give patients better quality of life in the final weeks, months, and years?

After all, a patient is a person — and that person might decide to travel the country for fun and adventures instead of pursuing aggressive treatments, says Silvers.

For many patients, symptoms such as severe pain, fatigue, reduced functional ability, and shortness of breath are debilitating, yet go unaddressed. "Patients may think it's just part of the illness, that nothing can be done. They don't think to mention it," says Silvers.

When pain is the issue, patients may be reluctant to take opioids, fearing addiction. Clinicians may be afraid to prescribe opioids — and they often are unaware of all the pain management options.

"Opioids are an option but there are others as well — it's just that nobody asks," says Silvers.

CAPC's mission is to increase the availability of quality palliative care services for all people living with serious illness. That includes improving the knowledge and skills of all clinicians, case managers, and team members who serve seriously ill patients and their families.

At the heart of this problem is communication, says Silvers. "Patients and families aren't really getting information they need about what to expect with their illness, about their prognosis. And clinicians aren't asking about their goals of care … what's important to the patient."

> "IT'S TRUE SHARED DECISION-MAKING WHEN YOU CLARIFY THE PATIENT'S GOALS. THAT'S WHEN YOU LEARN WHAT'S MOST IMPORTANT TO THAT PERSON."

It's all about asking and finding out what's important to the patient, says Silvers. What do you want to be able to do with your life? "It's true shared decision-making when you clarify the patient's goals," she explains. "That's when you learn what's most important to that person. Then, you build the treatment plan around that."

If aggressive treatment is the decision, that is fine, Silvers adds. "But it's a decision that must be made consciously. Right now, people are not making conscious decisions because in many cases they don't have full information about their diagnosis, their prognosis, or any trade-offs."

Patients deserve to receive full information if they want it, says Silvers. "It's not the case manager's role to deliver serious news or prognosis; that should be the treating clinician. However, the case manager can act as an intermediary to facilitate these conversations."

Case managers are ideally positioned to help these patients live their best quality of life, says Silvers.

In coordinating treatment, case managers can ask questions about pain, fatigue, breathing, and other issues. Can patients make their own meals? Do they have trouble walking or getting ready for the day? That kind of feedback can be shared with other team members.

Caregivers should get similar attention, Silvers adds. How are they doing? Feeling stressed? A 2008 NIH study found that family caregivers have a 63% higher risk of early mortality compared to noncaregivers. *(The study can be found at: https://bit.ly/2YoWSRA.)*

Case managers have many opportunities to start these conversations, says Silvers. "They are talking to patients with serious illness anyway during the course of the day. My mantra is, if you're talking to them, you might as well have a meaningful conversation."

How to initiate the difficult conversation? "It is teachable, and it's really not that difficult," says Silvers.

She suggests starting with, "Tell me what you know about your illness" or "Is there anything more you want to know?" That simple question can be a springboard to help the patient open up and talk about their goals, values, and wishes.

Silvers shares a story about a man

caring for his wife, who suffered from advanced cancer, at home. He never knew she was actively dying. No one ever asked either of them what a good quality of life would be for her — and as a result, no one helped to make that happen.The patient spent her time cycling between hospitals and rehabilitation facilities.

In that situation, a case manager can be very helpful in speaking with the physician. The case manager can help the caregiver get support. The entire treatment team, including social workers, can get involved to improve quality of life for both patient and caregiver.

Standardized assessment tools are available to help case managers understand the patient's quality of life and symptoms. These help gauge pain level, functional ability, fatigue, and other symptoms. There also are tools to help initiate the important conversations.

Communication skills can be taught, Silvers adds. Certain key phrases help to stimulate conversations include: "Tell me more about what is happening at home. Tell me more about what concerns you. What are some things that make your life meaningful that you really find essential to your happiness?"

Physicians can use the "Ask, Tell, Ask" formula: "Can I explain what I think might be going on from a medical perspective?" and "What did you understand from what I just said?"

"There are not enough of those meaningful conversations going on," says Silvers. "Certainly, doctors, nurses, and case managers are talking to patients about treatment options. But are they tying patients' values into that context?"

This key communication isn't happening often, she explains. "Physicians aren't taught how to do that. We're trying to teach case managers to be the intermediaries who elicit those values, who elicit that very critical information from patients." ■

Case Study: New York Hospital Meets a Palliative Care Mandate

End-of-life discussions with patients and families can be difficult. It's the elephant in the room that physicians, case managers, and other healthcare professionals hesitate to discuss, says **Antonia Ferrer**, MPA, BSN, assistant director, Supportive Care Program at NYU Langone Health System in New York City.

In New York state, these discussions have become mandatory. New York's Palliative Care Information Act of 2011 requires that every physician or nurse practitioner discuss palliative care and end-of-life options with every patient with terminal illness. *(For more information on the law, visit: https://on.ny.gov/1rXS15e.)*

As part of that process, every physician must indicate whether the patient's death might come within six months. If the answer is "yes," that prognosis must be shared with patient and family, and offer palliative care services.

"The law ensures that physicians are being honest with their patients," explains **Christine Wilkins**, PhD, LCSW, who leads the Advance Care Planning Program at NYU Langone Health. "In the past, doctors didn't routinely tell patients; they weren't up-front. It's never easy, but this legislation obliges providers to have these important conversations."

"The worst thing is to hear a patient say they would have done things differently if they knew they had such a short time to live. Instead, they can decide what they truly want to do," she adds.

Physicians and nurses receive little or no training in delivering the "bad news," so the discussions can be difficult for all involved. Things can get complicated quickly: A patient might not want his or her spouse to know.

Ferrer's team has developed a program to teach palliative and hospice care to case managers and social workers and to assist them in handling these situations. Their program gives team members a chance to practice these difficult interactions via role-playing.

Ferrer and colleagues have produced two videos to illustrate best practices for healthcare staff in facilitating these discussions. These videos are shown in a workshop for nurses and social workers.

In the videos, physicians (actors) are shown asking patients (also actors) the tough questions to learn their patients' personal values, end-of-life preferences, goals of care, and more.

Then, the participants take turns role-playing as clinician and patient. "It's an opportunity for staff to practice using these skills so they feel more confident in these situations," says Ferrer.

Each participant receives a communication guide with specific

language tips that will help. Simple statements like "Tell me more," for example, can yield a "richer conversation," Ferrer says. "These conversations aren't easy; they take time, and you can't do them in one or two meetings. You gather information over time."

Case managers and clinicians must learn about cultural views that should be respected and provide clarification about the diagnosis, expectations, and hopes and goals.

"It's important to ask questions like 'What did you understand from what I just told you?'" says Ferrer. "We need to make sure they know exactly what's going on so they can make informed decisions."

Wilkins recommends that hospitals build out their electronic medical records systems to include note types that focus on advance care planning.

The hospital's system features a "very robust" Advance Care Planning Navigator for documenting and retrieving advance care planning information, Wilkins says. This helps promote person-centered and coordinated care

For all their programs, the Langone team draws from an internationally recognized, evidence-based program that promotes person-centered, shared decision-making. "This program helps guide patients toward examining their own goals, beliefs, and values," says Wilkins.

Asking questions like, "What is a really good day like?" helps a patient recognize what matters most to them, she says. "That helps them make these serious decisions."

Talking to patients about their care and their options leads to improved quality of care — and quality of life, says Ferrer. Clinicians are better equipped to assess a patient's care goals and develop a plan that honors those goals.

"This process gives patients a voice and a sense of control over what happens next," she adds. "Often, this leads to more conservative, less costly treatment choices. We've found it reduces overall costs in end-of-life care." ■

Loneliness Prevalent Among Older Adults, With Negative Effects on Health

Loneliness is a health risk factor that hospital case managers might overlook, and it is prevalent among older patients.

About one in four older adults say they are socially isolated, and one out of three lack companionship. Loneliness is reported more frequently among people in the 50- to 64-year-old age group than people who are 65 to 80 years old, according to the National Poll on Healthy Aging, conducted by the University of Michigan Institute for Healthcare Policy and Innovation.

"Chronic loneliness can have major effects on the overall well-being for older adults and all adults," says **Preeti Malani**, MD, MS, MSJ, professor of medicine at University of Michigan Medicine and director of the National Poll on Healthy Aging, Institute for Healthcare Policy and Innovation at the University of Michigan.

The poll found that women, people with lower annual incomes under $60,000, and who lived alone or had children in the home were more likely to report a lack of companionship.

Loneliness and social isolation can impact people's life expectancy, physical and mental health, and memory, and can lead to worse health outcomes, she adds.

One poll finding was that people who reported a lack of companionship were twice as likely to report fair or poor physical health as those who rarely lacked companionship. For the lonely, 26% reported poor or fair health vs. 13% of those who did not lack companionship.

Also, people who said they were isolated reported poor mental health: 17% of those who felt isolated rated their mental health as fair or poor while only 2% of those who rarely felt isolated reported fair or poor health.

"If someone is isolated and no one is looking in on them, then a minor health issue can go unnoticed and unchecked," Malani explains.

The person might have been able to resolve an infection or wound with a primary care visit, but because the issue was unnoticed, it might become a major problem requiring a hospital visit, she says.

"People who are lonely are more likely to engage in unhealthy behaviors," Malani adds. "They may not cook for themselves or shop for healthy foods or engage in physical activities."

By contrast, a person who is socially connected might take walks with a neighbor instead of watching TV and web-surfing.

"Everyone knows that smoking is not good for health, and being sedentary is not good for your health, but I'm not sure people recognize how

loneliness is the same way," Malani says. "Physical issues can result from loneliness."

Knowing there can be a problem is a first step. Case managers can ask patients questions to determine whether they are lonely or isolated.

"Ask, 'Who is around to help you?' or 'Who checks in on you?'" Malani suggests. "These are surrogates for isolation."

Screening for loneliness/isolation should be viewed as part of the case management job — just like asking patients questions about their safety, she says.

"We should ask about social connectedness," Malani says.

Screening questions might include:

- "How often do you feel lonely?"
- "How often do you have contact with others?"
- "Who helps you drive?"
- "Who lives around you?"
- "How often do you see other friends or other people?"

When women report a lack of companionship, it could be the result of their neglecting themselves after spending their lives taking care of other people.

"If there are children living in the home, people are more likely to report a lack of companionship," Malani says. "If you were screening people for loneliness, you would look for the older woman living by herself or taking care of a grandchild: 60% of them felt a lack of companionship, and 41% felt isolated."

When patients appear to suffer from loneliness, case managers can find out if the problem might have a solvable cause. For example, some people experience undiagnosed hearing loss that can isolate them.

Malani recalls her 96-year-old grandmother's recent hearing loss and the problems this causes in social settings: "She says, 'I don't even try to bother following the conversation if multiple people are talking,'" Malani says. "Those who reported their hearing was fair or poor were also more likely to report they were socially isolated."

The poll found that 18% of people who lacked companionship reported impaired hearing, vs. 11% of those who rarely lacked companionship having the same concern.

There are some low-cost answers, such as pocket talkers that act as amplifying devices. "They work like an old Walkman, a microphone," she says.

Malani bought her grandmother a small hearing device, allowing her to have conversations she previously struggled through.

"For someone else, loneliness might be the result of a physical barrier, and you need to bring resources to help them," Malani says.

Hospital case managers might encounter patients who are new to the community, having followed their adult children and lost their long-time friends in the process, she says.

"You can give them suggestions on how to build new friends and make new connections," she suggests.

Social media can help some people stay connected, but it also can isolate people who rely solely on electronic forms of human connection.

Another solution is to connect older patients with Meals on Wheels and other meal delivery services in which they see someone each day.

"For vulnerable, older adults, that ability to be checked in on is helpful and can prevent issues," Malani says. "People are not just dropping off a meal, but are sharing a part of their day. While it's not ideal for everybody, it's an important option."

Case managers also could create a guide of community social resources or borrow one from local geriatric clinics. When patients appear to be lonely or isolated, case managers could offer them the resource guide, she adds.

Health systems might even have opportunities for older adults to interact with youth and younger adults. These inter-generational friendships are special and can help everyone involved. Some hospitals have volunteers who range from teenagers to 90-year-olds. This solution typically is more of a grassroots kind of thing, Malani notes.

"Since we did this study, I started

EXECUTIVE SUMMARY

Hospital case managers should be alert to the risk of their patients suffering from loneliness and social isolation. These conditions can worsen mental and physical health outcomes for patients and are fairly commonplace among older populations.

- The National Poll on Healthy Aging shows that one out of three older adults report they lack companionship, and one out of four say they are socially isolated.
- Seventeen percent of survey respondents reporting feelings of isolation also reported that their mental health is fair or poor, compared with 2% of those reporting rare feelings of isolation also reporting fair or poor health.
- People who report being lonely or isolated also are less likely to engage in healthy eating and activities.

paying more attention," Malani says. "I walked into a neighborhood coffee shop, and the place was filled with 65-year-old to 70-year-old men, having discussions over newspapers and coffee."

People experiencing loneliness need more of that face-to-face interaction, she adds. ■

Building Resilience and Gratitude in Case Management Practice

In healthcare, life comes at you fast — and case managers may struggle to handle it all. That is when it pays to bring up the adage, "Control what you can, accept the rest."

But that's not always so easy, says **Joan Brueggeman**, RN, BSN, ACM-RN, director of care coordination at Gundersen Health System in LaCrosse, WI.

"Healthcare has gone through a lot of changes," she explains. "There's been a lot of growth in uncharted territory. Case management has been an integral part of that. But we feel like we're being pulled in different directions. It throws us off balance; it's decentering."

This leads to discord, as team members react with their default behaviors — impulsive and reactionary responses. This is similar to the fight-or-flight response, says Brueggeman. It is a normal human failing, but not always effective.

Instead, we need to learn resilience, she explains. Resilience is defined as an ability to recover from or adjust easily to misfortune or change.

"Resilience is also a component of mental toughness, a way of reacting to a difficult situation in a disciplined manner," she says.

In every difficult situation, it is mental toughness and perseverance that will predict the level of success, Brueggeman explains.

One must learn to quickly "hit the big pause button" in the middle of the difficult moment, she says. "Hitting the pause button buys you a little time. You can then think about the situation and make a thoughtful response." That is what she calls a "disciplined response."

Of course, if it's an emergency, it must be handled immediately. "But most things are not emergencies," she says.

Developing resilience can help with the following:

- listening more carefully;
- purposefully trying to understand the facts;
- responding in a disciplined, purposeful, controlled manner.

When this becomes your new default behavior, you will have a better outcome in these tense situations, she explains. Like emotional intelligence, you can develop mental resilience.

Mental resilience requires being accountable for actions. If you've made a mistake, you need to hold yourself accountable, then fix it.

A mentally resilient person also realizes he or she can't control other people's opinions and thoughts. You can only control your own attitude and response. "It takes effort," says Brueggeman. "And you must remember to forgive yourself, as you won't do it perfectly. That's OK."

Case managers also should remember the gift of gratitude. The next time you have a difficult discharge, challenge, or other difficulty that went well, it is important to acknowledge that moment of success, she says.

Let yourself feel gratitude that things went well. "We move so fast, we forget we did this great thing. We don't take time to say, 'Wow, we did it.' Gratitude helps you move on to the next challenge. Gratitude helps us build resilience," Brueggeman says. ■

Dynamic Dashboard Gives Bedside Case Managers Ready Knowledge

Case managers often encounter inefficiencies in their daily work due to poor communication and lack of actionable data. As one health system has learned, this obstacle can be eliminated with the right data metrics and dynamic dashboard.

It is frustrating for case managers to know that everyone possesses the skills and are doing the best job they can, but they are unable to set optimal priorities because they lack vital information, says **Todd McClure Cook**, MBA, MSW, EdD, vice president of integrated care management

with Sharp HealthCare in San Diego. Cook led the creation of the Sharp HealthCare actionable dashboard.

Bedside case managers in particular need up-to-date information at their fingertips, Cook says. His leadership team created an actionable dashboard to identify core and critical indicators.

"These are indicators that would be important for case managers to watch," Cook says. "It gives them data upfront on where they should put their priorities, and it engages them in the mindset of using and managing metrics."

The metrics include patients' length of stay, based on how many midnights they've spent in the hospital, and their status — inpatient or observation, he says.

Other dashboard data include whether the person had been hospitalized within the past 30 days. The hospital assesses whether patients are homeless, per a new California state requirement.

"We added homelessness to the dashboard. If an individual triggers as homeless, then they'll show up on the dashboard and we can engage them in care planning," Cook says.

The chief trigger for additional case management scrutiny is whether a patient has had four or more midnight stays in the hospital, he adds.

Once patients are identified as needing additional help, the goal is to set them on the best course of action:

• Collect data and create an actionable dashboard. A dashboard that case managers can access is only as useful as the timeliness and accuracy of its data.

If case managers do not have access to the most accurate data, then it's not actionable, Cook says.

The question case management should ask about data is: "Can I go in at any moment, any time, and run this report, and it would have an immediate update so I know where I stand at that moment in time?" Cook suggests.

The dashboard should be continually updated, showing the newest high-priority case and eliminating the cases that have been resolved.

Case managers work to create a smooth transition and to remove all barriers to achieving that level of success. They usually check the dashboard at the beginning of the day and again after rounds, Cook says.

"They can print off a copy of their dashboard so they have it and use it as they work through their daily activities," he says. "The dashboard is dynamic. There is new information all the time."

Case managers can check midway through their day to see any dashboard updates, he adds.

• Identify patients in need of case management. The dashboard provides readily accessible data on patients' length of stay, payer, admit date, etc.

"If you had been admitted to the hospital within the past 30 days, no matter what payer group, you'd be triggered on the dashboard," Cook says. "Your type of visit would be on the dashboard: Was this an inpatient visit or observation status or emergency department visit?"

The dashboard also has a column for whether a discharge order is available.

"Similar to the initial assessment, the discharge order is a plan made at the end of each individual's stay," Cook explains. "It outlines what the care transition process looks like and what it will be in terms of supplies, resources, referrals, and what we have laid out as the plan of care necessary for the patient to be safe and sustainable."

• Conduct initial assessment. There is a goal of completing initial assessments within 24 hours or one business day, he says.

The dashboard has a column that notes whether a patient's initial assessment was completed. If not, then it becomes a priority.

The goal of the assessment is to collect data and provide a roadmap for what happens next with the patient. The dashboard highlights information that suggests issues for the case.

• Create discharge plan. Case managers also work with patients to determine what they are capable and willing to do in their own follow-up and self-care.

Clinicians can list a variety of actions the patient should take after leaving the hospital, but it is a waste of ink and paper if the patient is not able or motivated to follow through, Cook says.

"We center on not only what I want as a clinician but what the patient will agree to follow-up on — and that's a big deal," he adds.

An even bigger problem is if there is a discharge order but no discharge plan. The dashboard includes a column for these cases.

"If I have someone who will be exiting the board real soon and there is no plan written, then it means the individual will be at high risk of return or failure," Cook says.

The goal always is to ensure a patient's hospital stay is no longer than is absolutely necessary. Patient safety is at risk the longer a patient stays in the hospital, he says.

"If a patient's stay is greater than four days, we typically want to know what the plan is, what the barrier to discharge is, and what is keeping them here," Cook says. "How are we executing on that plan so we can get them to a safe environment, which is more appropriate for long-term care and recovery?" ■

HOSPITAL
CASE MANAGEMENT

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CE QUESTIONS

1. **To reduce unnecessary readmissions, which of the following questions should be asked of patients who return to the hospital?**

   a. "Did you like your home care nurse?"
   b. "Were you able to get your medications?"
   c. "Why do you think your symptoms worsened?"
   d. "Will your insurance cover this hospital stay?"

2. **According to the National Poll on Healthy Aging, what proportion of older adults say they lack companionship?**

   a. One in three
   b. One in four
   c. Two in five
   d. Three in eight

3. **Which of the following physical problems could contribute to social isolation, according the National Poll on Healthy Aging?**

   a. Diabetes
   b. Gastrointestinal pain
   c. Melanoma
   d. Hearing loss

4. **Sharp HealthCare in San Diego developed an actionable dashboard that case managers can use to prioritize at-risk patients. Which of the following is a metric collected and shown on the dashboard?**

   a. "Does the patient have a significant other?"
   b. "Is the patient homeless?"
   c. "Does the patient have congestive heart failure?"
   d. "Does the patient have chronic obstructive pulmonary disease?"

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.