HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

RELIAS MEDIA

APRIL 2020 Vol. 28, No. 4; p. 37-48

Person-Centered Case Management Tool Improves Discharge

Electronic tool includes checkboxes

By Melinda Young

A patient-centered, collaborative case management tool can help hospital case managers anticipate patients' needs and ensure an appropriate discharge and transition of care.

Inadequate care coordination can lead to rehospitalizations and expensive care, says **Carol Manuel**, RN, BSN, CCM, inpatient RN care coordinator at Cleveland Clinic South Pointe Hospital.

"If we don't coordinate care and get patients to the appropriate level of care, that results in avoidable healthcare costs and unnecessary readmissions," Manuel says. "Often times, coordination of care is not handled appropriately, but proper care transitions will [prevent] some of the wasteful spending."

> "IF WE DON'T COORDINATE CARE AND GET PATIENTS TO THE APPROPRIATE LEVEL OF CARE, THAT RESULTS IN AVOIDABLE HEALTHCARE COSTS AND UNNECESSARY READMISSIONS."

The patient-centered case management tool can help ensure better care coordination by examining patients' current needs, potential of delirium and dementia, and social determinants of health.

Case managers check patients' potential barriers to maintaining their health in

Financial Disclosure: Author **Melinda Young**, Author **Jeanie Davis**, Editor **Jill Drachenberg**, Editor **Jonathan Springston**, Editorial Group Manager **Leslie Coplin,** 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.

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***Hospital Case Management™*, ISSN 1087-0652, is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Hospital Case Management*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.**

GST Registration Number: R128870672.

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Back issues: $78. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

ACCREDITATION: Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

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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the community. These might include financial restraints, transportation needs, and any other information that might help them transition the patient to a safe and appropriate community placement, Manuel says.

The tool assists case managers and other healthcare professionals in understanding patients' post-discharge needs. When these needs are poorly communicated and understood, patients are more likely to experience unnecessary hospital readmissions, she adds.

Also, the tool encourages making patients and their families a part of the discharge plan, giving them some control over it. "Patients need to have some control in order for it to be successful, and we want them to be compliant, so they will have some buy-in," Manuel says.

Patient satisfaction survey scores have improved since the case management tool was implemented. The hospital scored 100% on metrics related to information provided to patients and addressing patients' needs at discharge, she says.

The electronic tool includes checkboxes and drop-down box information. It includes these questions:

- What are your barriers to healthcare?
- Do you have a primary care provider?
- When was the last time you were in a hospital?
- Have you been in a skilled nursing facility within the last 30 days?
- What are your medications?

"The tool addresses medical and health literacy and patient needs prior to admission," Manuel says.

When patients answer a question, the drop-down box allows the case manager to individualize the information by writing additional observations or patient answers.

The tool also asks for information about the patient's prehospitalization mental status. "Was the patient oriented or disoriented? Are they confused?" Manuel says. "It will further drop down and signal to us to go to a delirium screen."

The tool is comprehensive and allows case managers to note nuanced information, such as "The patient had been managing well alone at home, but has progressively gotten worse," she adds.

As case managers learn to use the tool, they might bring it into the patient's room with them. Soon, they know which questions to ask patients, take handwritten notes of

EXECUTIVE SUMMARY

Hospital case managers can use a collaborative case management tool to improve care coordination and patient satisfaction.

- The Cleveland Clinic South Pointe Hospital uses the tool to collect information about patients' medical needs, social determinants of health, and cognitive status.
- Questions in the tool might include "What are your barriers to healthcare?" and "Do you visit a primary care provider?"
- Since using the tool, the hospital has scored 100% on patient satisfaction survey metrics related to information provided to patients and addressing patients' needs at discharge.

patients' answers, and then input those responses in the tool after they leave the patient's room.

"I've been doing this for over seven years, and I know what questions to ask," Manuel says. "I can go back to the tool at any time to update it as I learn new things or if something changes."

Manuel takes notes by hand, then enters the information into the electronic tool after leaving patients' rooms.

"We want people to complete the tool within 24 hours," she says.

Case managers introduce themselves to patients and explain that discharge plans are started at admission. "We say, 'We need your input. This is your plan, and we want it to be appropriate and safe,'" Manuel says. "I am sitting down with the patient, when I'm talking to them, and the family members might be there, too. It's a conversation."

For instance, the case manager will ask patients which home care agency or skilled nursing facility they prefer. If the patient has not yet been referred to a post-acute care setting, or has not chosen one, the case manager answers that question as "pending," Manuel says.

Case managers also assess patients' mental status, checking to see if patients are forgetful. "After gathering all the information, I say, 'I know you are having difficulty remembering everything. If it's OK with you, can I call your family member to get additional information?'" Manuel says.

The care coordination includes helping patients make follow-up appointments with primary care providers. Case managers also assist with medication reconciliation and linking patients to other post-acute care providers, as needed.

Part of their job is to ensure better communication between the hospital and all other providers, Manuel says. "We provide a summary of care to all community providers, including nursing homes, medical equipment sites, and home care providers," she says. "There is a summary of care in our case management tool."

When case managers work with primary care providers, that summary of care is sent to the patient's other providers. If the providers, including home care agencies and skilled nursing facilities, are within the health system's network, the information is sent electronically. For out-of-state providers, the information might be faxed. "The summary of care includes information about why the patient was hospitalized and what the patient was treated for," Manuel says. At discharge, they give patients information about their care plan and medications, she adds.

Case managers help patients contact post-acute care providers, pharmacies, and home care providers. "We want them to be safe, and we want them to go home and stay home without having to come back to the hospital," Manuel says.

The tool is popular among case managers because it has allowed them to individualize patient care coordination to a greater extent than before, she notes. For instance, the tool encourages case managers to look at delirium and dementia as separate conditions. Dementia is considered a chronic condition, while delirium might be acute, she explains.

"The tool helps us identify whether a patient has an acute issue, like delirium, which is treated differently," Manuel says.

Home care agencies and other providers rely on the hospital's care plan and medication discharge summary, she notes. "I used to be a home care nurse, and that information is crucial and essential," she says. "Patients can have 40 to 50 bottles of medicine, and if we didn't get a discharge form from the hospital, then we'd call them." ■

An Escalation Team Can Improve Care for Complex Cases

By Jeanie Davis

Patients with complex needs can stretch the resources of even the most experienced case manager. These tend to be patients who have been admitted via the ED, not elective admissions. They are ready for discharge, but various barriers can cause complications.

"These are folks who have really novel needs," explains **Geoffrey Lake**, MBA MSW LISW-S CCM, a manager of case management at Cleveland Clinic. "Whatever next step is, it is so far outside the norm, we have to figure out extra resources."

That is when an escalation team can help. This team of "the right people" can help find solutions for complex cases, says Lake.

This team does not usurp the case manager's role, he explains, but can be an adjunct resource during a stalemate. "Case managers are natural coalition-builders," he explains. "They know to take the patient's desires, interests, and goals to synthesize a medical team that will recommend appropriate resources. Case managers are experts at building an individual plan that meets the patient's needs and goals."

Because Cleveland Clinic regularly treats patients with complex needs, there is an escalation team that meets every two weeks to review cases presented by a case manager. "It's not the C-suite, although in small hospitals that might be necessary," he explains.

Escalation team members need broad control, he says. "In many hospitals, budgets are siloed. The escalation team must have the discretion to make decisions on spending hospital money and using hospital resources. They should have oversight over multiple budget lines."

This team approach has not only generated success for these patients, but also created best practices for handling future issues, Lake adds. He cites several cases when the escalation team has been instrumental in resolving complex patient cases:

THIS TEAM APPROACH HAS NOT ONLY GENERATED SUCCESS FOR THESE PATIENTS, BUT ALSO CREATED BEST PRACTICES FOR HANDLING FUTURE ISSUES.

• A patient arrived in Cleveland on a tourism visa, then unexpectedly became seriously ill. He had no traveler's insurance, and no insurance payer. "That always makes things more complex. He also was in a debilitated condition, which further complicated the situation," says Lake.

Discharge planning for this patient was proving difficult, as he could not care for himself. He needed rehabilitation to grow stronger, but did not have coverage. In the end, the patient entered a Cleveland Clinic-owned skilled nursing facility where he gained sufficient strength to return to his home country via a commercial flight.

• An international patient was morbidly obese, bedbound, and could not be transported via commercial plane or standard air ambulance. The escalation team worked with his home country's military to find a military flight that could accommodate him and medical staff.

• A sick, fragile patient could not accept the severity of her illness and the extensive treatment required. She did not want to be discharged to a rehabilitation facility; she wanted to stay in the hospital where she felt safe.

The escalation team put together an estimate of her hospital bill if she stayed. It described the medically necessary services her insurance would cover, and the amount it would not cover. Then, the team showed her a mockup of her bill if she went to the rehabilitation facility, where all her expenses would be covered. She decided to transition to rehab.

• A family refused to allow a patient to leave the hospital to return home. The team examined this case more deeply for abuse or financial gain if the patient stayed in the hospital. "We can get Adult Protective Services to establish a guardianship. The court then has oversight and monitoring of the patient's progress," says Lake.

• A patient was gravely ill, and the family had a difficult time accepting it. They demanded extended-level hospital care, with tracheotomy, which could become a long-term situation, Lake explains.

In trying to understand the

family's viewpoint, the escalation team asked the chaplain to join a meeting with the physician. The chaplain advocated for the hospital's position on the patient's care, and the family finally accepted the situation.

"In all these instances, the focus has to be on the patient's needs and getting those needs met," Lake explains. "The focus also is on ensuring the patient's safety at all times."

• An elderly woman was in the habit of visiting the ED several times every week with somatic medical complaints. This went on for several months. Over time, she formed a friendly relationship with the ED social worker. The person had no obvious medical need; she just liked visiting with the social worker.

The escalation team decided it was time to send the ED case manager to the woman's home to get a better sense of her needs. She is enrolled in a home care program, with a physician making home visits.

"That one case manager visit left this lady feeling so cared for, she quit visiting the ED so often," he says. "The ED staff became concerned about her absence and called to check on her, to learn all was well. In the end, it worked well for everyone."

Organizing an Escalation Team

By the time a patient reaches the escalation team, the issues keeping them in the hospital are not medical — they are related to finances, availability of services, and the agreement of the family, says Lake. "A patient being in the hospital because they need medical care is the right thing. If there is a different reason, that is not good for the patient."

The Cleveland Clinic's team has been in place for three years. The team is comprised of the chief nursing officer and six to 10 leaders from finance, patient experience, legal, case management, and other departments.

The escalation team's transition plans are presented to the medical team. After the physician agrees, the plans are implemented, Lake adds.

"I'm really proud of working with this team and this hospital because we really do put patients first," he says. "Obviously, meeting fiscal targets is important, but the team focuses on what is the right thing for this patient. The folks in that room really believe the first goal has to be what's right for this patient." ■

Pulmonary Maintenance Programs Reduce Readmissions, Lower Costs

Patients engage in supervised exercise

By Melinda Young

A hospital-based pulmonary maintenance exercise program can help patients with chronic lung conditions improve their exercise tolerance and regain some lung function, while reducing readmissions, according to the authors of a recent study. The potential cost savings are significant as well.[1]

"The most significant finding, based on three years of data of 20 participants who met all of the criteria, was 71% reduction in nights spent in the hospital due to pulmonary problems," says **Kim Crilly**, RN, MS, outpatient diabetes educator and coordinator of the pulmonary maintenance program at Holy Cross Resource Center in Silver Spring, MD. "We also had a 33% reduction in emergency department visits due to pulmonary conditions," she adds.

The Holy Cross Health Pulmonary Maintenance Program provides patients supervised physical activity and education about disease management to patients with COPD or other chronic lung conditions. "We usually enroll 32 to 35 people at any time," Crilly says. "We had 85 participants enrolled in the program during the three-year data period of April 2013 to the end of 2018." Participants stay in the program an average of 2.3 years, she adds.

The program provides tangible physical benefits to patients, but it also offers social benefits, says **Sarah McKechnie**, MA, MES, manager of disease management services at Holy Cross Health. "It prevents social isolation," she explains. "A lot of times, people with lung disease will stay in their homes and not go out much."

Patients bond with each other, and show up for the exercise sessions mostly because they want to see their friends in the program, Crilly says.

The pulmonary maintenance program fills a gap between patients' rehabilitation and living at home on their own.

"Patients get close to three months of rehab," Crilly says. "Then they graduate, and there's a big gap as far as whether they are going to be able to participate in community programs safely with oxygen or exercising on their own."

Patients feel better after pulmonary rehab, but they need a maintenance program to help them stay healthy, Crilly notes.

"Resources after rehab are limited," she says. "Patients need to continue to exercise after rehab to keep the benefits."

The one drawback to the program is its cost. Although it saves healthcare dollars through reduced hospitalizations, it lacks insurance support, Crilly notes. "We are an out-of-pocket program right now, and that's why we'd like it to get more attention," she explains. "Maybe if nationwide programs could roll out more maintenance programs, they could be supported by insurance because of their cost savings."

Without payer reimbursement, the program shifts a small fee to patients. They pay $70 per month for the twice-weekly, individual training and medical supervision, Crilly says.

This is how the Holy Cross Health's pulmonary maintenance program works:

• **Assign staff.** Program staff include a registered nurse, respiratory therapist, exercise physiologist, administrative assistant, and program coordinator. "It's overseen by medical professionals," McKechnie notes.

"It's critical to have such a knowledgeable staff because patients will plateau a little bit," Crilly adds. "They'll need to increase their exercise and duration."

• **Schedule patients.** The program assigns patients one-hour time slots to exercise twice a week. Six patients will exercise each hour of the program. Each patient uses an individualized workout plan, Crilly says.

• **Provide equipment.** Pulmonary patients have access to a variety of exercise equipment and medical supplies. They rotate between three machines: a treadmill, a recombinant stair stepper, and an upper body ergometer, which patients use to strengthen and condition their upper bodies. All three provide a cardiovascular workout.

"It's critical for people with lung conditions to increase their respiratory muscles," Crilly says.

Other equipment and instruments include weights, exercise balls, oxygen concentrators, pulse oximeters, sphygmomanometers, stethoscopes, nasal cannulas, oxygen tubing, and an emergency oxygen tank.

• **Set goals.** A primary patient objective is to achieve at least 40 minutes of cardiovascular exercise each hour of class, Crilly says.

Program goals include:

- Maintain oxygen saturation at greater than 92% pre- and post-exercise;
- Maintain blood pressure at less than 139/89 mm/Hg pre- and post-exercise;
- Keep hospitalizations at less than two nights per quarter per participant;
- Keep ED visits below one per participant per quarter;
- Reduce overall number of hospital admissions per quarter to fewer than three;
- Decrease or maintain the yearly number of nights in the hospital, compared with the prior year;
- Decrease or maintain the yearly number of ED visits compared with the prior year.

• **Assess patients.** Two members of the pulmonary maintenance program staff check patients at each exercise session for their vital signs, including blood pressure, heart rate, and oxygen saturation.

"With this population, sometimes they arrive and need to get their oxygen saturation stabilized before exercising," Crilly says. "During exercise, they may need breaks of one to two minutes for breathing, and they transfer from machine to machine between exercises."

Patients are not on a heart monitor because to be eligible for the pulmonary maintenance program, they must be considered risk-free enough to not need a heart rate monitor, Crilly says.

EXECUTIVE SUMMARY

Silver Spring, MD-based Holy Cross Resource Center's pulmonary rehabilitation program helps patients with COPD and other chronic lung conditions maintain their fitness and health post-rehabilitation care.

- Program goals include lowering hospitalization rates and ED visits.
- The program charges patients a small fee because it is not covered by insurance despite its economic benefits.
- People stay with the maintenance program for social benefits and camaraderie as well for health benefits.

• **Assist with exercise.** "We're standing next to the individuals, and with every piece of equipment they're on, we ask about their perceived trouble breathing," Crilly says.

They monitor patients' duration on cardiovascular equipment, their rating of perceived exertion, their miles per hour and grade.

"That's how we determine how they're doing," Crilly explains. "If I look at quarterly data and see their duration or intensity is decreasing, but perceived duration is increasing, then that's a sign the patient is failing in health, and this needs to be addressed."

When there is a problem, staff can call the pulmonologist for help. The patient might need a new appointment, six-minute walk test, and another evaluation and pulmonary function test.

Patients who are in better physical condition might exercise for 50 minutes. Those with more severe lung disease or shortness of breath might struggle to put in 40 minutes of exercise, Crilly notes.

After patients finish their cardiovascular workout, they may use weights and resistance bands.

"Half of participants have time for bands and weights, and spend five to 10 minutes on that," Crilly says. "Through our education session, we teach participants how to do resistance training at home. Our focus is cardiorespiratory endurance, so we save resistance for the end of the workout."

• **Motivate patients to participate.** "We play music in the background and take requests," Crilly says. "Our staff is amazing and upbeat, and we have fun parties and holiday parties."

For example, Holy Cross Health holds a summer in February party to help combat winter depression among patients, Crilly says.

"We bring out leis, hula hoops, and seltzer water with umbrellas," she adds. "It sounds silly, but they ask when the next party will be — they enjoy them so much."

The parties are held once a quarter. Also, each month there is a morale booster activity. Every other month, there is a support group or information-sharing session.

"I invite everyone to come together, and we have a topic — maybe related to physical health or mental health," Crilly says.

Crilly posts a flyer and sign-up sheet. "The respiratory therapist is amazing and will give educational tips," she adds.

Participants form lasting friendships, and sometimes meet with other participants outside of the exercise classes, McKechnie says.

"The social piece is very important to people, and it keeps them going; they motivate each other," McKechnie adds.

"We create positivity and support, and they thrive on that and on the dynamics with each other and their peers," Crilly says.

• **Keep participation open-ended.** Patients stay in the program as long as they desire or can participate. Most leave because of a fall, a hospitalization, or death, Crilly says.

"Some of the other reasons people leave is that some participants just get tired," she adds. "It can be absolutely exhausting to drive and get to class."

A few others left to join a gym because they do not need to be monitored as closely.

"We have participants we can refer to other programs, like a Senior Fit, which is an evidence-based exercise program for seniors," McKechnie says. ■

REFERENCE

1. Crilly K, McKechnie S. Improving outcomes, reducing readmissions: A case for pulmonary maintenance programs. *CMSA Today* 2019;7. Available at: http://bit.ly/38GS8f9.

Case Managers See an Influx of Elderly Patients in the ED

By Melinda Young

As baby boomers shift into their senior years, hospital EDs are seeing increasing numbers of older patients, a trend noted by a care coordinator at the Cleveland Clinic. These older, at-risk patients need case management services.

"Our aging population is an unprotected population of patients," says **Lauren Delaney**, RN, ACM, transitional care coordinator in the ED at Cleveland Clinic. "They don't have social support, and they have financial issues. Of those that come to the ED, we're seeing an increase in social issues with geriatric patients."

Some of these patients experience failure to thrive health issues. They might have problems with alcohol, or are not eating well. They might fall at home and lack family support. Even

if they do not need ED services, they can end up there, she adds.

"Some older patients are not able to maintain their physical health in the home," Delaney says. "Traditionally, at the ED, they'd be a soft admission. But with care transition services, we can help them with a multidisciplinary staff that includes dietary services."

The ED case manager's role is to help patients transition to a more appropriate level of care. "We work with other teams and offer alternatives to social admissions," Delaney says.

For example, an 80-year-old patient lives at home alone. Her family checks on her once a week, but they are busy. Over time, ED staff notice an increase in her falls and ED visits. She appears confused, and is not managing her medications or eating well.

"We bring in that patient and triage her to make sure she's medically safe," Delaney says. "If the patient has no fractures, labs and X-rays are OK, and there's no medical reason to admit that patient, then to admit the patient just for social issues places the patient at increased risk of infections, delirium, and falls," she explains.

Case managers are brought in to work with patients, families, ED staff, and the geriatric team. They assist with connecting the patient to physical therapy and medication reconciliation. Case managers also help patients transition to skilled nursing facilities (SNFs) for rehabilitation, as needed, she adds.

Physicians, nurses, or the geriatric team will refer patients to case management. Sometimes, case managers will find high-risk patients on their own.

"We're looking for any high-risk patient — someone who had a 30-day readmission," Delaney says. "I'd like to know why they're coming back to the hospital."

If a case manager identifies an elderly patient who is in the ED because of a fall, he or she will try to find out why the patient fell. Knowing whether it was syncope, a mechanical fall, or Parkinson's disease can help with a safe transition, she says.

"We had a case where a gentleman came in and had a catheter, and he wanted to be placed in an SNF," Delaney says. As case management worked with the patient, they found that sending him to a SNF would not be a good fit because he was not strong enough to handle rehabilitation.

"We started talking with him about end-of-life care or hospice, and the transition took a different direction," she explains.

"A lot of times in geriatrics, it's sitting down and having those difficult conversations, hashing out what's best for them and finding out what their goals are," Delaney adds. "And sometimes we come to the end."

Case managers can help patients with their transitions more effectively when they listen to his or her own goals of care and transition. They can work as a team to help patients receive in-home oxygen, hospice care, wound care, and other treatments.

ED case managers should be mindful of the hospital's resources. Case management services need to work within the ED workflow and not tax staff time.

"If I come in, as a case manager, and become burdensome to ED staff, and my interventions are so time-consuming, then I'm not going to be a popular person in the ED," Delaney says. "You need quick, thorough assessments, and you need to know the appropriate levels of care and be mindful of all the resources, the ED staff, nurses, and physicians."

Turnarounds should be quick and precise, she adds. "This really is a team approach," Delaney says. "You can't take one person out of that loop and be successful." ■

Case Managers Can Help Patients With Autism Spectrum Disorder

By Jeanie Davis

A hospital's strange sounds, sights, and people can be overwhelming for a child with autism. But a case manager who watches for behavioral cues — and listens carefully to parents — can help that child cope more easily, says **Caroline Cortezia**, MS, CCLS, supervisor of Child Life Services at UCSF Benioff Children's Hospital. She works with children from birth through teens, often following them into adulthood. The types of behaviors she encounters range from ADHD to anxiety, to the more intense autism spectrum disorder (ASD).

"Autism is the most difficult behavioral disorder that professionals have to deal with," says Cortezia. She emphasizes that not all children on the spectrum suffer from a mental

illness like schizophrenia, bipolar disorder, or depression. "But when there is a mental illness on top of the autism, that's the most difficult."

The trend toward openly discussing these disorders resulted in more resources. It is easier to find placement and support, she adds.

These patients present to the hospital for reasons outside these disorders. For example, a child with autism also may suffer a comorbidity like seizure disorder or gastric disorder, she explains.

"They may become combative and aggressive due to the anxiety and their inability to communicate," says Cortezia. "They may have trouble expressing how they feel, so they may act out physically or display self-injurious behaviors."

As a child life specialist, she is called to help a patient to cope in the hospital setting. But, too often, the situation has escalated — and the child is displaying undesirable and unsafe behaviors, she explains. Her goal is to help case managers and other staff recognize signs of ASD, and provide tips to help calm the child and prevent escalation.

Because there are limited psychiatric units for children and adolescents with ASD, most admissions are to general child and adolescent psychiatric units. Staff may have limited experience with ASD children, and may not be prepared.

She believes a psychiatric unit is not the best placement for patient with autism, as the environment typically is too "sterile," says Cortezia. "If they don't have a mental illness, a psych unit will be difficult for them. They're used to a routine, repetitiveness. If all their privileges are taken away, this will escalate their behavior."

However, there are difficulties placing a patient with autism in a general unit. The child's rigid routines and preferences will be disrupted, so any attempts at treatment will not be effective, she explains.

Cortezia advises helping parents plan:

- Provide all admissions forms early so they can be completed before hospitalization;
- Let the parents and child know what tests and procedures will be performed;
- Encourage parents to create a "social story" for the child, or provide caregivers with a social story they can use.

A social story can help familiarize children with the hospital environment. The story is comprised of words and pictures designed to help patients with autism know how to handle each situation. The picture book also helps them gain better understanding about how others feel, and why they should respond with a specific behavior.

The social story incorporates details to which the child easily relates, such as sequence of events, sensations they may encounter, length of events, and how to respond to their new environment.

"In a social story, you break down the scenario for the patient so they know what to expect," says Cortezia. "When you come in from the garage entrance, this is what the hallways look like, here's what the machine looks like, here are the sounds to expect, here's what the staff will do. This helps them know what behaviors are expected from them."

Take the young patient into a quiet room or space when they arrive. This will acclimate him or her to the hospital setting before entering a hospital room, Cortezia says. "Have the patient's preferred music and a preferred item waiting for them. That calm environment will be a signal they need to match their behavior and remain calm."

Parents and caregivers are ultimate experts, she says. "We don't always listen to them, but using the techniques they already know that work with the child can really help in the moment."

For example, the mom may suggest giving the child an item that reinforces the desired behavior, such as a food item, before a procedure. The nurse may resist, believing food is not appropriate. "But if the mom says the child is calm, and the patient does not have calorie or food restrictions, why would we not do something that will keep them calm?"

Cortezia advises hospital staff to find the trigger for any behavior, then figure out how to change the situation. "It's easier to prevent a meltdown by handling it while it's happening," she says. "Because at that point, the patient is in such a heightened level of stress that they're not reasonable anymore."

Think about it: "If I'm the trigger, what is it that I'm doing? What can I change about the situation?" are questions to ask yourself, she says.

Focus on one behavior at a time, Cortezia adds. "Perhaps every time you walk into the room, the child starts screaming. You're not there to give medication, but to coordinate care. But the child starts disrupting your conversation with the mother. You have to think about this: Is it something that I'm doing that causes this child to scream and interrupt the conversation? Could I ask the mom to step outside to talk instead?"

"Often, the behavior can be stimulant-induced, caused by white coats, the noise of machinery, or any repeated noises in the environment," Cortezia says. "Even within an ED's trauma room, you can bring down

your speaking tone, and eliminate as much harsh stimuli as possible, which can help the patient adapt to that chaotic environment."

If possible, eliminate continuous monitoring or take vitals less often, which will eliminate some of the touching, she adds. "Lower the volume on a monitor that keeps going off. Avoid changing to a hospital gown if possible," she advises. "Use a calm and soft voice — anything you can do that allows for the patient to warm up to you. The patient may not make eye contact, but that's OK."

The child's frustration can be caused by a trigger. "For example, if we have to keep the patient NPO [nothing by mouth] for an extended period, that may cause behavioral problems," says Cortezia. "Because the child doesn't have the ability to communicate their desire to eat or drink, they may resort to extreme behavior to get your attention."

Or, the reaction may be caused by necessary treatment. "Let's say we are putting a tourniquet on an 8-year-old's arm. The child may start kicking and screaming because it causes an undesirable sensation. Their behavior allows for them to do what they want to avoid that sensation," Cortezia explains. "The behavior can also be the side effect from a drug — causing delirium, hallucinations, or aggressive behaviors."

The earlier the behavior is de-escalated, the better, Cortezia advises. "Seek the support of a specialist in anticipation of behaviors. It's better to address the behavior as soon as it starts rather than to let it escalate."

Some patients with autism will benefit from pharmaceutical interventions to help them stay calm. But, generally, it is best to focus on controlling the child's environment and the staff's interactions.

"We're not here to change the child — just to make sure they get medical care," says Cortezia. "Why not do these things that help them with that? As professionals, we need to focus on getting our medical tasks done, and then refer to professionals who can help further."

When talking to a child with autism:

- Use concrete terms;
- Use a calm voice and low tone;
- If the child questions why everyone is calm, say "why not be calm? There's no reason for us not to be calm";
- Ask the child why he or she is not calm. If he or she says, "I'm scared," say "I've been scared. I feel scared sometimes when you raise your hand at me. But you can also be calm when you're scared."

This starts a whole new type of conversation, says Cortezia. "It can help them stay calm, because we're not shoving them into a room, and invading their space. We're helping them stay calm."

Set up patients for success when they leave the hospital, she says. "When you're setting up a clinic follow-up visit, anticipate what the patient will need for that visit. If they have trouble sleeping because of disturbed sleep cycles, and they're awake most of the night, make the appointment for a time that works with their sleep cycles. Think about this child's needs, and plan the visit accordingly." ■

Program Tailored to Reducing Senior Patient Readmissions

A program in the Chicago area is demonstrating the value of tailoring discharge plans to the particular needs of elderly patients with little support outside the hospital.

These "solo seniors" often face complex medical challenges after discharge and can experience high rates of readmission without help from family and friends. With hospitals facing significant penalties from 30-day readmissions, the program could be a model for hospitals to emulate.

Seniors Alone Guardianship & Advocacy Services is a not-for-profit program that works with Chicago-area hospitals to closely monitor elderly patients after their release from the hospital.

The group helps spot health issues as they arise and see that patients are treated before these issues become serious enough to require readmission.

The advocates supervise post-discharge care to ensure patients are receiving what they need, whether in a skilled care facility or receiving care at home, explains Founder and Board Chair **Teri Dreher**, RN, CCRN, iRNPA, who left hospital nursing after 40 years as an intensive care nurse.

In addition to the seniors program, she also is chief advocate and president of North Shore Patient Advocates, a Chicago company that provides assistance to patients who need help navigating the healthcare system. Dreher was inspired to form Seniors Alone as a result of the struggling "senior orphans" she has met through her advocacy business. She notes that

one out of every four seniors in Illinois must face healthcare challenges alone while surviving on less than $20,000 per year. The Seniors Alone assistance is particularly important for medically complex patients, which many seniors are, Dreher notes.

The Seniors Alone team includes experienced nurses, social workers, care managers, attorneys, and guardians. They work with healthcare providers, courts, and long-term care resources to ensure patients receive appropriate care.

If a hospital called on the program to assist with the discharge plan for a solo senior with a broken hip, the team would choose the rehabilitation facility and make post-rehab living arrangements, Dreher explains. This would include finding a skilled care facility or home healthcare agency, coordinating with Medicare and Medicaid, and monitoring the patient's ongoing health.

Seniors Alone's fees are assessed on a sliding scale, based on the client's ability to pay. The client readmission rate for Dreher's patient advocacy company has stayed under 1% for the last eight years, and she hopes to maintain the same rate for the not-for-profit Seniors Alone.

The American Hospital Association (AHA) reports that almost 20% of Medicare beneficiaries return for readmission within 30 days of discharge. Further, each readmission of a senior patient costs the hospital an average of $7,400.[1] The AHA profiled a program at Rush University Medical Center in Chicago that focuses on the post-discharge needs of seniors.[1]

Staff from the hospital's older adult programs and case management department created the Enhanced Discharge Planning Program in which social workers call senior patients after discharge to check on compliance with their discharge plans. The social workers also look for unmet needs and facilitate solutions to meet those needs.

In a pilot program on four units, the social workers found 67% of discharged senior patients were not receiving necessary services, following discharge recommendations, or coping with care demands.[1] Hospitals are interested in this type of support because many do not have the resources to provide this kind of support to solo seniors, even though they realize those patients can be in jeopardy after discharge, Dreher says. She encourages hospitals to consider developing similar programs because the need is significant — and so are the potential benefits.

"There are an awful lot of bad skilled nursing facilities, bad home care companies, and a lot of home care companies are going out of business because of new Medicaid guidelines," Dreher says.

"For seniors who don't have family to be their caregivers, they are really falling through the cracks, especially if they are starting to have cognitive issues," she continues. "They don't have someone to check on their medications, to oversee the care they're receiving from the skilled nursing facility or home care provider. You end up with them being readmitted to your hospital unnecessarily."

Addressing solo seniors with a post-discharge program can help reduce 30-day readmissions, improve patient engagement, boost patient compliance, and shorten hospital stays by helping families pick out a reliable rehab facility or home care company, Dreher says. "To us, it's a social justice issue. This country doesn't have a great way to take care of our seniors. With 10,000 people turning 65 every day, hospitals that can figure out how to best provide care management for these seniors without any support will serve their community better and reap benefits of their own, too," Dreher says.

"Hospitals sometimes keep patients for a week or two because they have no safe discharge plan, creating a pain point for the hospital that results in additional costs and burdens on your resources," she adds.

The costs for such a program, in-house or from an outside provider, should be offset by the savings in avoiding Medicare penalties for excessive readmissions and other losses that can come from treating solo seniors, Dreher says.

"Plus, [hospitals] have to carry the expense for the extended hospital stay of patients who are medically stable but can't be discharged without an adequate plan. They're sitting in a hospital bed that costs $3,000 to $4,000 a day," Dreher says. "When the insurance companies and Medicare say they're not paying for more days, the hospital administration is stuck. It costs too much money to keep them, but you don't want to discharge them and see them come back for readmission within a month."

Dreher says quality professionals can make a business case for providing special discharge planning for solo seniors, in addition to the improvement in community support for a vulnerable population.

"We can do it because it's the right thing to do for these senior patients who don't deserve to be left on their own at this time in their lives. But there's no doubt that hospitals will see a benefit to the bottom line as well," Dreher says. ■

REFERENCE

1. American Hospital Association. Social workers enhance post-discharge care for seniors. Available at: http://bit.ly/312VDJJ.

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. **Which was the most significant finding in a study of a hospital-based pulmonary exercise maintenance program for patients with chronic lung conditions?**

   a. There was a 55% increase in exercise tolerance.
   b. There was a 71% decrease in nights spent in the hospital due to pulmonary problems.
   c. There was a 65% decrease in ED visits due to pulmonary conditions.
   d. Patients reported high rates of satisfaction with the social aspects of the program.

2. **The American Hospital Association reports that almost 20% of Medicare beneficiaries return for readmission within 30 days of discharge. On average, how much does each readmission cost the hospital?**

   a. $2,400
   b. $5,400
   c. $7,400
   d. $10,400

3. **Which in an example of a patient who may need escalation team services at Cleveland Clinic?**

   a. A gravely ill patient whose family could not accept the diagnosis.
   b. An uninsured patient who has trouble paying the ED bill.
   c. An elderly patient who needs home care after hospitalization.
   d. A workers' compensation patient who requires ongoing physical therapy.

4. **Which is a benefit to using an electronic, patient-centered case management tool?**

   a. It can identify patients who need extra case management time at the bedside.
   b. It can quickly populate the medical record with answers to various questions.
   c. It can ensure better care coordination by examining patients' needs and social determinants of health.
   d. It can send text message reminders to patients and their caregivers about medications, exercise, and diet regimens.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

The Case Manager's Toolbox: The Essential Skills of an Effective Case Manager, Part 1

By Toni Cesta, PhD, RN, FAAN

Introduction

RN case managers and social workers are key advocates in the delivery of quality healthcare. Their broad skills and training allow them to assess patients' needs and work well with families and other members of the healthcare team. Negotiating, collaborating, communicating, team-building, precepting, educating, and consulting are the basis of what a successful case manager brings to the care setting each day. This month will begin a discussion of the skill sets every case manager and social worker should possess to be as effective in the role as possible. These skills form the foundation of an effective case manager.

Case management is a collaborative process used to assess, plan, implement, coordinate, monitor, and evaluate options and services to meet individuals' health needs through communication and available resources to promote quality, cost-effective outcomes.

The RN case manager and social worker's expertise is the vital link between the individual, the provider, the payer, and the community. Successful outcomes cannot be achieved without using the specialized skills and knowledge applied through the case management process. Not everyone possesses the skills necessary to become a successful case manager. Case managers and social workers must be clinically astute and competent in their areas of practice. It is important for case managers to be skilled in using the case management process and to acquire the assessment skills to identify the patient's actual and potential health problems. This allows them to implement the required interventions to successfully resolve these problems, and to evaluate the outcomes of care and responses to treatments.

SUCCESSFUL OUTCOMES CANNOT BE ACHIEVED WITHOUT USING THE SPECIALIZED SKILLS AND KNOWLEDGE APPLIED THROUGH THE CASE MANAGEMENT PROCESS.

Assessment is an ongoing and continuous process occurring with all patient-case manager/social worker interactions. During the assessment phase, the case manager seeks a better understanding of the patient, family dynamics, and healthcare beliefs and/or myths. An assessment involves three phases, which at times seem inseparable: gathering data, evaluating data, and determining an appropriate plan. Case managers use a multifaceted subgroup of skills to accurately assess a patient's needs:

Skills for Effective Case Management

- Assessment;
- Planning;
- Implementation;
- Coordination;
- Evaluation.

Leadership Skills

- Patient advocate;
- Facilitator;
- Negotiator;
- Quality improvement coordinator;
- Resource manager;
- Educator;
- Financial analyst;
- Decision-maker;
- Critical thinker;
- Data manager and analyst.

Communication/Interpersonal Skills

- Team-building;
- Customer relations;
- Public speaking;
- Conflict resolution;
- Delegation;
- Information sharing;
- Systems thinking;
- Emotional intelligence.

As an assessor, the case manager must obtain relevant data through skillful investigation. All information related to the plan must be evaluated with a critical eye to objectively identify trends, set and reset realistic goals, and seek viable alternatives when necessary. A vital case management skill is the ability to recognize a patient's health problems and formulate action plans based on data collected during the assessment. The diagnoses express the case manager's judgment of the patient's clinical condition, functional abilities, responses to treatments, healthcare needs, psychosocial supports, financial status, and post-discharge needs.

Planning

Planning is the next step in managing the patient's care. This is accomplished by planning the treatment modalities and interventions necessary for meeting the needs of the patient and family. During the planning phase, the case manager, in collaboration with other members of the healthcare team, determines the goals of treatment and the projected length of stay. Immediately after admission, the case manager initiates the transitional plan of care. The determination of goals is vitally important because it provides a clear time frame for accomplishing the care activities. Case managers must identify immediate, short-, and long-term needs, as well as where and how to meet these needs.

Planning is initiated on admission or before admission, when possible. The case manager's clinical expertise is needed when establishing whether the treatment plan and interventions are appropriate. Data are gathered, plans are established, and an interdisciplinary care plan begins to unfold.

Throughout the acute hospital, subacute, home care, or long-term care stay, the case manager monitors and re-evaluates the plan for accuracy as the patient's condition changes. As a planner, the case manager identifies a treatment plan while remaining cognizant of outcomes and minimization of unnecessary costs. The case manager must include the patient and family in decision-making and consider the patient's goals as an integral part of the care plan. Alternate plans must always be incorporated in anticipation of sudden shifts in the treatment process or in response to treatments yielding complications.

Implementation and Coordination

Implementation and coordination involve building the plan, determining the goals of care, and deciding how to make a viable and realistic plan move to completion. The case manager's goal is to give the patient and family the knowledge, attitudes, and skills necessary to implement the plan. Through communication, collaboration, and teaching, the case manager works with the interdisciplinary team to motivate the patient to succeed in meeting the goals of care.

As the patient nears discharge, the case manager can take three steps to improve the chances of effective implementation: clarifying the transfer of responsibilities of care, reviewing the plan to ensure nothing has been overlooked, and making last-minute alterations and arrangements for the immediate discharge period.

Evaluation

The final step in the case management process is designed to measure the patient's response to a formulated plan, and ensure the appropriateness of the care plan and the quality of the services and products offered.

To achieve successful evaluation and outcomes, the case manager must routinely assess and reassess the patient's status and progress toward reaching the goals of the care plan. If the situation is at a halt or regressing, the case manager must make appropriate adjustments and alter the plan accordingly.

As the evaluation proceeds, ask these important questions:

- Were the patient's needs identified early in the hospital stay?
- Were learning goals identified and teaching documented?
- Were referrals complete and timely?

The Importance of Confirming the Plan

Taking the time to confirm the care plan greatly increases the chances of effective and efficient implementation. Follow-through will help ensure the goals are met.

- Could the patient/family clearly verbalize the care goals?
- Were the patient's/family's problems resolved?

• Did the patient/family seem satisfied with the plan and the decisions surrounding the plan?

• Did the patient/family comply with medical advice and follow the recommendations of the case manager?

• Were the services provided appropriately and authorized by the managed care organization?

These questions will help the case manager determine if the discharge plan was effective, and will assist with quality improvement efforts for future patients.

Leadership Skills and Functions

The case manager must use many leadership skills and functions to effectively master the case management process. Because case managers serve as problem-solvers, resource managers, and members of the interdisciplinary healthcare team, they should be well-trained in various leadership qualities. Nurse case managers and social workers must be adept at negotiating, making sound decisions, and resolving conflicts. To do this successfully, nurses must use critical thinking and problem-solving skills.

Advocacy and Facilitation of Care

One of the most critical elements of the case manager and social worker role is as an advocate for the patient. The patient-case manager relationship is built on trust, to foster mutual respect between nurse and patient, and to establish a rapport that facilitates communication between the family, caregivers, payers, and other healthcare team members. As case managers gain a clearer understanding of the patient's needs and goals, they communicate this understanding to the members of the healthcare team. They also monitor the course of treatment to affect an earlier discharge or arrange for more efficient home care services. As a facilitator, the case manager can be a catalyst for change by empowering the patient or family members to seek solutions throughout the acute care phase and beyond. The case manager always looks for quality improvement that could result in potential cost savings, or possibly prolong healthcare benefits.

Advocacy Skills

Case managers and social workers can best advocate for patients and their families if they:

• Keep the patient's best interest paramount in the process of care delivery;

• Recommend, coordinate, and facilitate the most effective plan of care;

• Protecting the rights of patients;

• Communicate to other providers and document the patient's care preferences;

• Facilitate the patient and family's decision-making activities by keeping them well informed of their rights and options;

• Clarify the goals of therapy and treatment;

• Determine the appropriateness of the post-discharge services and the discharge/transitional plan;

• Ensure the interventions are consistent with the patient's needs and goals of treatment;

• Maintain the patient's privacy and confidentiality;

• Negotiate on behalf of the patient/family with the managed care organization for authorizations of services;

• Facilitate resolution of ethical conflicts;

• Stay abreast of the legal and ethical requirements and standards of patient care delivery;

• Prevent delays and variances in care delivery.

Clinical Reasoning and Critical Thinking

Problems involving the patient, family, and healthcare provider are inevitable. It is important for case managers to solve these problems. The ability of case managers to provide safe, efficient, and competent services depends heavily on their skills in problem-solving, clinical reasoning, and critical thinking. These skills have one thing in common: They all entail the generation of possible solutions to problems, issues, or concerns regarding patient care delivery and options. Case managers use their clinical knowledge, expertise, and leadership skills for this purpose. They capitalize on their role as informal leaders of the healthcare team and facilitators of care delivery to solve these problems.

Case managers are constantly making decisions. They decide what observations should be made, derive meaning from these observations, and decide the course of action. The overall goal is the delivery of optimal, cost-effective, quality care.

Case managers use a framework for decision-making and problem-solving that bridges the present and the future. They assess the patient and family's current state, and anticipate the future goals and expected outcomes of the treatments. They create an action plan to bring the

patient and family to the desired future state. This framework enhances an outcomes-based approach to the delivery of case management services. Usually, the plan is interdisciplinary and implemented only after approval by the healthcare team and consent from the patient and family. Understanding that the action plan may not always result in a resolution of the patient's issues, case managers engage in constant reassessment, monitoring, evaluation, and revising of the plan until the desired outcomes are achieved.

The case manager's decision-making, clinical-reasoning, and judgment skills must always help the patient work through the confusion he or she faces in the complex healthcare environment. Case managers operate by answering questions pertinent to developing the care plan, actual delivery of care, and evaluation of the discharge plan:

- Is the treatment plan appropriate enough to resolve the patient's problems?
- Will the case management action plan prevent readmission?
- Are the treatments provided the best possible treatments for the patient and family?
- Do healthcare team members agree with the plan?
- Do the patient and family have any issues or disagreements with the plan?
- Should any changes be made to the plan of care or discharge plan?
- Will the electricity in the home support a mechanical ventilator?
- Does the patient have safe access to a bathroom on the main floor of the house?
- Is it worth the hospital's financial support to fly a patient out of state rather than incur the cost of an extended stay?
- Can the family learn how to perform tracheal suctioning so that their loved one can go home with them rather than to an extended nursing facility?

Answers to these questions influence the type of care a patient will receive and how it will be accomplished to ensure the best possible outcome in the most cost-effective manner.

CASE MANAGERS OPERATE BY ANSWERING QUESTIONS PERTINENT TO DEVELOPING THE CARE PLAN, ACTUAL DELIVERY OF CARE, AND EVALUATION OF THE DISCHARGE PLAN.

Case managers who can apply critical thinking and clinical reasoning skills in the decision-making process ensure appropriate, effective, and efficient care delivery. This means that the patient and family will receive the necessary support, potential obstacles will be avoided, the potential for readmission will decrease, the educational component of care will be reinforced, and a positive outcome will occur.

Negotiation

Negotiation is a skill that is not primarily taught in nursing or social work education programs. To be a successful negotiator, a case manager must be a good time manager. Along with managing their own time, case managers must learn to determine what work others can and should perform in assessing a patient's needs when preparing a care plan. This understanding allows them to negotiate more effectively.

Negotiation in case management is an everyday occurrence. It is a skill used with payers and providers, with vendors for durable medical equipment, with the patient and family/caregiver, and even with physicians reluctant to opt for a home care discharge plan or placement in a long-term care facility.

Fair negotiation requires trust, rapport, and complete honesty regarding a patient's care needs. Successful negotiation is achieved by presenting the facts clearly and succinctly. To know if you have negotiated your case well, you must be a good listener who tunes in to verbal and nonverbal cues; otherwise, windows of opportunity can be missed. On the financial side, nurses know all too well that healthcare environments are committed to doing more with less, and at a lower cost. Financial prowess is a must in these times of cost containment. Case managers must work with financial support personnel and help them keep abreast of a patient's insurance benefits.

Summary

This month, we began our discussion on the skills needed to be an effective RN case manager or social worker in today's complex healthcare systems. The necessary skills far exceed those acquired through one's professional licensure, and require expanded knowledge and skill sets to be a proficient case management professional. Next time, we will continue the review of the leadership and communication skills needed to be a successful case manager. ■