



# HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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RELIAS  
MEDIA

## Case Managers Help Patients Bridge the Digital Divide Before Discharge

*Digital health use skyrocketed in 2020*

*By Melinda Young*

**D**uring the great and spontaneous social experiment of remote and digital patient care during the COVID-19 crisis, healthcare systems have learned patients and staff find virtual visits and digital health services acceptable — sometimes, even preferable.

“Digital solutions provide an opportunity for the patient to stay connected to their healthcare team, following discharge,” says **Patrick Dunn**, PhD, MS, MBA, FAHA, program director for the

American Heart Association’s Center for Health Technology and Innovation in Dallas.

“The pandemic has demonstrated: ‘Wow! Look at what technology can do,’ specifically as it relates to telehealth,” says **Devlon N. Jackson**, PhD, MPH, assistant research professor and healthy Me/ Mi Salud project director, department of behavioral and community health, Herschel S. Horowitz Center for Health Literacy at the

Maryland Center for Health Equity.

“DIGITAL SOLUTIONS PROVIDE AN OPPORTUNITY FOR THE PATIENT TO STAY CONNECTED TO THEIR HEALTHCARE TEAM, FOLLOWING DISCHARGE.”

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**AUTHOR:** Melinda Young

**AUTHOR:** Jeanie Davis

**EDITOR:** Jill Drachenberg

**EDITOR:** Jonathan Springston

**EDITORIAL GROUP MANAGER:** Leslie Coplin

**ACCREDITATIONS DIRECTOR:** Amy M. Johnson, MSN, RN, CPN

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#### EDITORIAL QUESTIONS

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“We saw before the pandemic that patients can fill their prescriptions digitally and have prescriptions delivered to them,” Jackson adds. “Now, you can connect with providers over digital platforms, whether on your computer or smartphone.”

When the global shutdown started in March, health systems moved to telehealth visits. Some digital technology service providers report business expanded by tenfold or more.

“We went in the month of March from 350 virtual visits per month to 4,000 virtual visits per month,” says **Allison Crawford**, MD, PhD, associate professor in the department of psychiatry at the University of Toronto. “Prior to COVID-19, we were using virtual health for people in rural and underserved areas. With COVID-19, we quickly scaled it to all our patients, and it was easier to scale in some areas than others.”

## Solutions Improved Quickly

The pandemic led to some fast improvements in digital and telehealth solutions. “At the beginning of COVID, we moved

everyone to digital platforms,” says **Scott Conard**, MD, president of Converging Health in Dallas, and consultant to the American Heart Association. “One of the most exciting things coming out of this is those platforms are getting better and simpler. Many elderly patients struggled initially, but now more and more people are adopting it. We’ve made significant progress in the last four months, and will continue to do so.”

Results of a recent study revealed 70% of patients with low health literacy need help with any online task, and 61% need help with printing online. Also, 43% require assistance using a search engine, and 47% need assistance with videos.<sup>1</sup>

For example, a person with low health literacy might need help from a family member to understand how to use the online dashboard, says **Valerie Press**, MD, MPH, assistant professor of medicine and pediatrics in the section of general internal medicine at the University of Chicago Medicine.

“The study authors were trying to understand the patient’s access to devices and whether their risk of not having or using devices differs, depending on their health literacy,” Press explains.

## EXECUTIVE SUMMARY

Since the COVID-19 pandemic shut down in-person social life across the world, digital solutions in healthcare exploded in use. Healthcare providers found that some patients struggled with digital health literacy.

- Results of one study revealed 70% of people with low health literacy needed help performing simple online tasks.
- Before the pandemic, billing for digital health encounters was problematic. This was temporarily resolved during the pandemic.
- Technological challenges can prevent some patients, including older people, homeless people, and others, from becoming comfortable with digital health solutions.

There always has been interest in telehealth and digital solutions, but funding it was challenging until the pandemic hit.

“One of the barriers was the lack of ability to bill for that time,” Press says.

During the COVID-19 crisis, the federal government and other payers have temporarily relaxed rules on compensation for telehealth visits. “If we want patients to talk with physicians over a video visit, then we need to compensate them for that time,” Press says. “The pandemic galvanized the ability to provide these telehealth visits, which is absolutely great.”

Previously, video visits were billed at a higher rate than phone visits. But this increases health disparities since some patients do not have access to the technology or broadband required for video visits, Press notes.

Billing phone and video visits at the same rate has rapidly advanced the use of telehealth technologies, she adds.

## Technology, Health Literacy Are Barriers

Individuals’ technological challenges also can prevent elderly patients, homeless patients, and others from becoming comfortable with the telehealth. Also, some communities have poor engagement with digital health, which can contribute to negative health outcomes.<sup>2</sup>

“There were many different kinds

of barriers, so we wanted to create a framework that would help us — from a patient’s perspective — determine what those barriers would be,” Crawford says.

The barriers start upstream. “They don’t just start with, ‘Do you have a computer to turn on and off?’” she says.

Providers gained a better understanding of their patients’ digital health literacy after technology took front stage during the COVID-19 public health emergency. (See *story in this issue on how to help patients improve digital health literacy.*) This is important as health systems move into an era in which digital health is increasingly important. But, there is one problem: How can case managers and others help patients improve their digital health literacy?

“Digital strategies can be a solution or a barrier, based on the patient’s technical literacy,” Dunn says. “It is best if the digital strategy begins in the inpatient setting, ideally before discharge, so the patient and their family can become oriented and ask key questions.”

Digital literacy involves a person’s lifestyle. Structural barriers to digital health literacy include age, geography, gender, socioeconomic status, and disability. “We tried to be as expansive as we could and think about upstream barriers,” Crawford says. “We wanted to create a model so we could think about it systematically.”

Another way to improve digital health literacy is through empowering

patients to participate in their own care and health decision-making. This can start with addressing the patient’s emotional state, followed by engagement.<sup>3</sup>

“The thing that happens so frequently is a person is sick, in the hospital, and they’re not with it — cognitively distracted, at best — and then send them home, and they’re completely confused about what to do,” Conard explains.

The key is to involve them quickly in the transition and self-care process. “Digital solutions offer a whole spectrum of ways to integrate them into the outpatient care process and make sure they’re safe,” Conard says.

Case managers can emphasize self-care knowledge and skills during these critical transitions from hospital to home, Dunn says.

“Self-care behaviors can be reinforced, and prevention strategies can be encouraged,” he says. ■

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# Case Managers Can Help Patients Improve Digital Health Literacy

Check patients' access and skills with technology

By Melinda Young

Digital solutions make it easier for patients to access health information and improve their self-care, but some barriers and disparities remain. These challenges are particularly acute for older patients, some ethnic and racial minority groups, and others.

“Not all individuals have easy access to smartphones, the internet, or to a laptop, let alone have access to understanding the health information they’re processing,” says **Devlon N. Jackson**, PhD, MPH, assistant research professor and healthy Me/Mi Salud project director in the department of behavioral and community health, Herschel S. Horowitz Center for Health Literacy at the Maryland Center for Health Equity. “Maybe they have access to technology, but their health literacy level is not adequate. You’re sending them home, and maybe they’re not equipped for that.”

The COVID-19 crisis revealed a solution to in-person care — telehealth. But it also exposed existing disparities that allow some patients to fall behind, Jackson explains.

Jackson and digital health literacy researchers offer these suggestions for how case managers and hospitals can help patients improve their health literacy:

- **Always ask patients to describe how they will follow instructions.**

One of the objectives of the Office of Disease Prevention and Health Promotion’s Healthy People 2020 national health goals is to “increase

the proportion of persons who report their healthcare provider always asked them to describe how they will follow instructions.” This same objective now is recommended to be

“NOT ALL INDIVIDUALS HAVE EASY ACCESS TO SMARTPHONES, THE INTERNET, OR TO A LAPTOP, LET ALONE HAVE ACCESS TO UNDERSTANDING THE HEALTH INFORMATION THEY’RE PROCESSING.”

a highlighted goal for the proposed 2030 Healthy People initiative.<sup>1</sup>

“The target was not met for Healthy People 2020,” Jackson says.

Another objective in the Healthy People 2020 goal involved increasing the proportion of people who use electronic personal health management tools. The 2030 version includes a proposal to “increase the proportion of persons who use health information technology (HIT) to track healthcare data or communicate with providers.”<sup>1</sup>

There are many ways case managers and others can meet this

objective. One of the common methods is through teach-back, Jackson says.

- **Use digital solutions to teach the basics.** “Learning how to manage a chronic condition, such as diabetes or heart failure, is a process that begins with foundational knowledge, building to mastery,” says **Patrick Dunn**, PhD, MS, MBA, FAHA, program director of the American Heart Association’s Center for Health Technology and Innovation in Dallas. “It is similar to learning a new language, learning how to play a musical instrument, or learning a new game. It is rare for someone to demonstrate mastery initially.”

Digital solutions help by allowing people to learn the basics and grow in their knowledge. “Think about how computer games go from one level to the next,” Dunn says. “It is the same idea.”

Case managers, and the healthcare system in general, do not have the time and capacity to work with patients while they grow in their knowledge, he explains.

“Digital solutions allow us to leverage the healthcare system workforce capacity,” Dunn says.

- **Steer people to easier technology.** For patients who struggle with phone apps, there is other technology that could make their access to health information easier.

“You meet the person where they are,” says **Scott Conard**, MD, president of Converging Health in Dallas, and consultant to the

American Heart Association. “If they’re techno-savvy, then you say, ‘Log into this, and this is how it synchronizes,’” he explains. “But maybe the person has dementia and significant difficulty moving around.”

For patients with low digital health literacy, the easiest solution is to give them technology that works automatically or more simply. For example, Amazon’s Alexa and Apple’s Siri voice-operated technology can answer questions and send health information to providers.

“I see Siri and Alexa as being more what people would gravitate toward,” Conard says. “You can say, ‘Siri, what is the weather today?’” Conard says. “That’s more realistic than expecting the elderly to download apps and learn a digital platform.”

There also are digital solutions that send patients’ information, such as weight, blood pressure, temperature, and blood glucose levels to their providers automatically. “This technology is being employed in age-in-place scenarios,” Conard says.

• **Identify people who need support.** “Low health literacy puts people at risk,” says **Valerie Press**, MD, MPH, assistant professor of medicine and pediatrics in the section of general internal medicine at University of Chicago Medicine. “We need to identify people who need support in using digital interventions,” she says. “Screen people for low health literacy, or you can take the precautions approach, where you assume everyone has low health literacy.”

Interventions should be developed with digital health literacy needs in mind. “Case management can provide initial training,” Press says. “Take the hospital-to-home scenario: Perhaps X intervention comes with a practice scenario, and a case manager or any clinician could help walk the patient through it.”

Once patients are discharged home, they can receive support through technology. If they need help setting up the technology, case managers or other professionals could give instructions by phone.

• **Provide hands-on experience for patients and simulation programs for staff.** Case managers can help patients with digital self-care solutions by teaching them how to access the apps on their phones or laptops. They could learn how to help patients through simulation programs.

“We have a simulation program where people run through cases with an actor who can model things like a patient saying, ‘I can’t hear you,’” says **Allison Crawford**, MD, PhD, associate professor in the department of psychiatry at the University of Toronto. “We play around with different problems and digital barriers that can happen. We let them practice, and teach them how to [perform self-care] in a virtual environment,” Crawford says.

• **Use new digital technologies to improve well-being and health literacy.** Bluetooth technology and sensor devices enable patients’ scales, blood pressure cuffs, clothing, jewelry, and other wearable or household devices to send health data to case managers and other providers or monitoring companies.

“New biometric sensors can detect a number of factors, such as heart rate, respiratory rate, sleep, ECG, gait, temperature, speech, and others,” Dunn says.

These sensors detect problems before patients and clinicians know what is happening. Researchers are studying whether wearable sensors can discover heart attacks and other health problems early, he notes.

For example, researchers are studying whether some devices

can discover COVID-19 infection through detection of subtle vital sign changes. The devices may find an infection several days before symptoms appear. Several devices, including a smart ring that take a person’s pulse, temperature, and assesses sleep and exercise patterns, are under investigation as early-warning systems for COVID-19. (*More information is available at: <https://wapo.st/3hPZxO1>.*)

• **Teach staff how to improve virtual visits.** Researchers found that effective patient-clinician encounters require better quality of care in equity, safety, person-centeredness, effectiveness, efficiency, and timeliness.<sup>2</sup>

Providing optimal quality of care through digital solutions can be challenging. For example, a case manager might transition an elderly patient home, but the patient needs a virtual mental health visit. If the patient does not know how to use his or her tablet or phone for a video visit, then the case manager might have to walk the patient through the process.

“We have clients with developmental disabilities who found it hard to use the equipment. We used peer support workers to help them access the video visits,” Crawford says. “We also tried to make it very easy so it’s just a link they have to follow and don’t have to download an application.”

Education also should include tips on how to make patients feel safe and comfortable. For instance, the camera angle can make a big difference during a video call, Crawford notes. “You don’t really make eye contact in a virtual call, but when the camera angle is slightly downward-pointing and a certain distance away, that simulates the experience of eye contact,” she explains.

Clinicians who use two screens, one with the virtual session and the other with the patient's health record, might show the patient their profile, making it look as though they are not connecting with the patient, Crawford adds.

Technical glitches that freeze frames or put the video and audio out of synch can increase

the patient's feelings of not being connected.

"If you don't feel connected, then you don't feel the clinician is there to help you," Crawford says. "We have ways to train people on how to repair this problem." ■

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# How COVID-19 Changed Hospital Telemedicine

By Jeanie Davis

The COVID-19 pandemic pushed healthcare systems to quickly adopt digital technology to keep providers, patients, and family interactions safe. Cellphones and tablets were literal life-savers, supporting videoconference meetings to avoid one-on-one interactions.

At the outset, telemedicine was in the spotlight as the Centers for Medicare & Medicaid Services relaxed regulations that had limited application of teleservices throughout the country. Many hospitals quickly engaged telemedicine services to connect providers with patients and families.

Now, with the initial surge a few months past, healthcare analysts are assessing the lessons learned.

"The crisis showed us what's possible," says **Dan Clarin**, CFA, senior vice president at Kaufman Hall Consulting, who has counseled hospitals on digital planning. "The telemedicine industry has been in some ways held back by reimbursement considerations and regulatory red tape. The CMS response to COVID removed a lot of that. What we're seeing now is an exponential increase in use of telehealth."

The technology "is so widely

available we can use it in any setting, not just acute care or a physician's office," says **Hussein Michael Tahan**, PhD, RN, FAAN, a case management expert and corporate vice president of nursing professional development and workforce planning at MedStar Health in Columbia, MD.

"Telehealth provides personnel resources in a crisis, including consults from specialty providers — especially palliative care or infectious disease," explains Tahan. "With a virtual consult, we are able to provide a high level of care, yet the provider didn't need to be present on site. This is specialist care provided in a timely manner, very efficiently."

## Rural Hospitals Benefit

These readily available specialists often are not on site at rural and suburban hospitals, Tahan explains. "Telehealth technology can bring the service to them remotely, which expedites patient care planning and prevents unnecessary transfers to a tertiary hospital. It can expedite transfer when indicated so the patient receives a higher level of care in a more timely manner — which would contribute to improved outcomes."

Clarin agrees: "It can be very difficult to recruit physicians to a rural environment, whether primary care or specialists. Virtual hospitalists are relatively new, whereas the telespecialist is a model that's been prevalent for a longer time, whether supplementing ICU [intensive care unit] coverage or providing patient consultations on an as-needed basis."

Also, small hospitals are burdened with the cost of locum tenens (temporary doctors) to cover vacations. Telemedicine provides a more cost-effective way to manage coverage — another attractive feature in recruiting efforts.

## Telerounding

Telerounding is when team members can remotely discuss patient care and/or discharge planning. Some clinicians may find it easier, even more effective, participating remotely, says Tahan.

"During the COVID crisis, telerounding minimized use of PPE [personal protective equipment] and the number of people needing to visit patients in their rooms," Tahan explains. "It showed team members don't need to be in the patient care

area to be effective. With audio or an audio/visual bidirectional telehealth system, they can access the patient's electronic medical record and discuss the plan of care, with the patient present or without the patient, and gather the healthcare team only as necessary."

During the crisis, use of telehealth technology has reduced risk to patients discharged to home care as the patient could be monitored remotely, Tahan says. On the first day after discharge, the clinician can visit the patient virtually, perform any necessary assessments, speak with the patient and family, and initiate interventions to enhance the patient's engagement in his or her own health and well-being.

"Video technology, even a simple cellphone or tablet, can be used pre-discharge to assess the patient's home for any risks, like furniture setup that may increase risk for falls," he adds. "Video can be used to scan medications the patient has at home, instead of asking and waiting for the family to bring them into the hospital for medication reconciliation purposes. Such requests may not be feasible during a pandemic."

Home monitoring apps and digital tools can be helpful in monitoring a patient's status remotely, Tahan adds. However, it is critical the patient can use them correctly. "It's important to do a remote assessment of whether the patient can perform a blood glucose reading or blood pressure check effectively."

Some available tools work via automated sensors that can run in the background as a form of remote monitoring. These do not require direct patient intervention. The tools communicate key information about the patient to the providers, he adds. With such opportunities of ongoing remote monitoring, timely

and necessary interventions can be proactively initiated.

## Follow Up with At-Risk Patients

Tahan prefers the term "telehealth" or "tele-case management" over "telemedicine" because the technology can be applied beyond medical care to address social determinants of health and other social/human services that are conducive to healthcare outcomes.

"Finances often are an issue for some patients. They cannot afford copays for medications, so they may ration them instead," he explains. "Or they can't afford — or don't have access to — food appropriate for their required special diet based on their chronic health conditions, like diabetes or end-stage renal failure. They may not have transportation to a doctor's office, or their family member may not be able to take a day off from work to accompany them to the clinic. Telehealth can be helpful in maintaining follow-up care of these patients to prevent their condition from deteriorating, resulting in an otherwise avoidable trip to the emergency department or a readmission to acute care hospital."

## Financial Benefits to Hospitals

Hospitals can realize significant cost savings from telemedicine, adds Clarin. "There's definitely the opportunity to get a more efficient care model here, but there haven't been a lot of hospitals that have optimized that."

In the past, telehealth was an appendage to the current system, Clarin says. "It was not integrated in such a way that the benefits were fully

realized, so there's work ahead for us. Now that we've seen significant adoption of different telehealth adaptations, hospitals will be more open to redesigning their overall care delivery to take it into consideration."

Now that hospitals have seen significant adoption of different telehealth adaptations, they will be more open to redesigning their overall care delivery systems and take such tools into consideration, Tahan adds.

Telehealth digital technology also can help healthcare leaders set up contingency plans for future disaster planning, says Tahan. "We had never before considered increasing the number of critical care beds to the extent we needed to during the pandemic, for a crisis like this. Now we know we must have a number of contingencies in our disaster plans for expanding such beds to 200%, 300%, or even 400%."

Additionally, the plans must include a deliberate focus on the use of digital technology that can assist with telehealth services, such as specialty consults for all patients to expedite care progression, and yet still control the need for special supplies like PPE.

## Long-Term Benefits

Tahan believes the pandemic experience has changed professional case management practice. "It will never be the same. It must always be updated to include impactful care delivery strategies and interventions for all people."

Innovative care sites such as "virtual clinics" have contributed to timely access to health and human services despite the COVID-19 pandemic, Tahan explains. "In essence, a natural experiment has occurred that shows virtual care

delivery is as important as the services provided in traditional care settings such as primary care clinics. In fact, virtual care delivery may result in patients' enhanced adherence to care regimens and engagement in their own health and well-being."

The pandemic "has forced

nonconventional collaborations," Tahan says. For example, acute care settings are providing training, education, and personnel to long-term care providers. This facilitates "healthcare services in place," rather than transferring skilled nursing facility residents to the acute care setting when such may

not be preferred during a crisis like COVID-19.

Ultimately, "these person-centered care approaches have served to advance case management very well," Tahan says. "The future is bright for all involved — patients, providers, payers, patient advocates, leaders, and all other stakeholders." ■

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## CMS Relaxes Telemedicine Regulations

By Jeanie Davis

In the early days of the COVID-19 pandemic, hospitals received the go-ahead to expand telemedicine/telehealth services via a waiver from the Centers for Medicare & Medicaid Services (CMS).

There was urgency to help people who needed routine care and to treat patients with mild symptoms in their homes so they would not have to travel to a hospital or clinic. This was focused on limiting community spread of the virus, as well as reducing the exposure to other patients and staff members to slow viral spread.

Across the country, case managers embraced the opportunity to add telemedicine to the tools used to diagnose and treat patients, says **Vivian Campagna**, MSN, RN-BC, CCM, the chief industry relations officer for The Commission for Case Manager Certification. "We've been working toward this point for many years. Now, CMS realizes telemedicine can be done well, and that it provides tremendous advantages and opportunities to improve outcomes."

In the pre-COVID-19 days, CMS covered costs of telemedicine in specific circumstances. Patients were required to have an "established relationship" with the physician

within the past three years. That stipulation disallowed a telemedicine professional from assisting during emergency and many more medical cases.

Before the waiver, Medicare could only pay for telehealth in limited circumstances, such as for patients in a designated rural area who leave their homes and go to a clinic, hospital, or certain other types of medical facilities for the service. Hospital patients could be seen only in certain "originating hospitals" approved by the Department of Health and Human Services (HHS), including county hospitals designated as Metropolitan Statistical Area sites or rural hospitals with health professional shortage. The attending physician was required to be on-site at the time of visit to bill Medicare, which complicated billing when telemedicine was involved. (*More information is available at: <https://go.cms.gov/31hedjx>.)*

With the waiver:

- Medicare can pay for office, hospital, and other visits furnished via telehealth across the country, including the patient's home.
- The "originating hospital" and "attending physician" requirements have been lifted.
- Medicare will pay for telehealth

services furnished in any healthcare facility, including any hospital across the country.

- A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, can offer telehealth to their patients.
- There is flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

### HIPAA Restrictions Waived

The 2020 action also relaxed penalties with the Health Insurance Portability and Accountability Act (HIPAA). The HHS Office for Civil Rights (OCR) is waiving penalties against healthcare providers who treat patients using everyday communications technologies, such as FaceTime or Skype, during the public health emergency.

Even before the pandemic, CMS took steps to improve telemedicine for rural patients. In 2019, Medicare began paying for brief communications or virtual check-ins with healthcare providers. Medicare Part B also pays clinicians for e-visits, which are patient-initiated

communications through an online portal. Medicare beneficiaries could receive telehealth services such as routine office visits, mental health counseling, and preventive health screenings.

## The Case Manager's Perspective

“For the case manager, telemedicine is an excellent tool to move patients effectively through episodes of care,” says Campagna. “Telemedicine opens up a whole new way to apply best practices and a high standard of care that result in better outcomes.”

This is especially important in rural areas. “Specialist services will be more readily available, which means patients won't require transfer to

another hospital that might be two hours away,” she explains.

She believes a teleconsultation also can help with patient education to clarify a diagnosis or treatment plan. For example, when both a specialist and a primary care doctor participate in a virtual consult with the patient, they can help the patient understand his or her condition, says Campagna. “The case manager also could participate in the consult to help reinforce and explain.”

Similarly, telehealth can improve post-discharge home care and reduce readmissions, Campagna says. “A televisit 48 hours post-discharge, with the patient and physician, is a chance to answer questions about the discharge instructions.” If a caregiver can join the discussion, that will help fully ensure best practices.

Telehealth also can be useful in

the emergency department, bringing in specialists (like behavioral health) on an as-needed basis. “There's no waiting for the doctor to arrive, which facilitates the patient's treatment,” Campagna notes.

Overall, “the case manager's workload becomes a bit easier because they're able to work more efficiently with telemedicine visits,” says Campagna. “Whether you're in a large metropolitan hospital or a rural hospital, there are multiple applications for telemedicine.”

While older patients may be uncomfortable with the technology, “I think they can get used to it,” says Campagna. “Especially for people who are elderly, not feeling well, or simply busy, there are so many benefits. I think the more experience seniors have with telemedicine, the more they will see the advantages.” ■

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# Case Study: Small-Town Hospital Adopted Telemedicine

By Jeanie Davis

Two years ago, Doshier Memorial Hospital was losing one of its three hospitalists. This small-town hospital in Southport, NC, needed to fill the slot quickly, which had never been easy. Yet without that hospitalist, there would be no overnight coverage.

That is when the chief executive officer investigated telemedicine, and found the services to be a “much more economical way to go, more fiscally responsible to quickly fill the gap,” says **JD Hammond**, RN, clinical informatics nurse.

The 25-bed critical access hospital does not offer an intensive care unit, but the emergency department (ED) always is covered by a physician, he explains. Critically ill patients

are stabilized and transferred (often via a 10-minute helicopter ride) to Wilmington, NC. This includes code stroke, code stenting, and code ventilator patients. Those who are not critically ill are admitted to the patient care unit under the supervision of the hospitalist or telehospitalist.

A team of 10 nocturnists — physicians caring for hospital patients from 7 p.m. to 7 a.m. — are available via telemedicine. They can access the electronic medical record and admit/assess patients with the assistance of an on-site staff nurse. A high-tech cart carries all components needed for the teleconsult, including a camera, TV monitor, sound bar, and a wired stethoscope.

During the teleconsult, the remote physician and patient can see and communicate with each other. The physician can ask questions, zoom in and zoom out, and pan the scene, using a high-definition camera. The physician also can read all bedside monitors, including ECG.

Staff nurses have received special training in interacting with a telenoctrurnist. For example, the nurse will palpate the patient, and the telenoctrurnist will use the wired stethoscope (held by the nurse) to hear lung sounds.

If a code blue occurs during the night, the telenoctrurnist is contacted immediately. It has only happened once in the past year, but the system

went smoothly, says Hammond. The ED physician first responded to the room, then the respiratory therapist came in to intubate the patient. While that was happening, a staff member texted the telenoctrnlist that a code blue was occurring. At that point, the team ran the code blue according to the telenoctrnlist's orders — pushing medications, monitoring compressions, just as if the physician was in the room. "It was like the physician was standing right there, with the nurses performing the interventions," says Hammond.

Nurses receive training to operate the telemedicine cart, including troubleshooting connectivity issues. "The technology is pretty simple to operate," he explains. "Training took less than an hour."

"It really helps to develop a relationship between nursing and

physicians," Hammond adds. "The physician has to have confidence in nurses, and nurses must have confidence that the physician will be there when they reach out."

Hammond has observed that staff nurses have gained more confidence in their everyday duties as well. They demonstrate more autonomy by not turning immediately to a doctor for things that already are within their nursing scope.

The financial savings — \$200,000 — was evident in the first year due to the telemedicine program, he adds. Patient satisfaction scores also have improved.

"We found that patients were impressed their small community hospital had cutting-edge technology," says Hammond. "The telenoctrnlists all have a bedside manner that builds rapport within the first few minutes.

It feels just like the physician was right there, listening and focused only on the patient. No one interrupts a teleconference. Not one patient has voiced a negative experience with the telemedicine physician."

Based on the success of the telenoctrnlist program, Doshier Memorial now has a contract for telecardiology services. Similarly, the cardiologist can hear a heart murmur or valve regurgitation via a cart stethoscope. "It's very impressive," Hammond says. Doshier Memorial also has expanded telephysician coverage to a nearby Doshier clinic, on an island off the North Carolina coast.

In every instance, telenoctrnlists have been "very quick to respond; typically within seconds we get a reply," says Hammond. "We were pleasantly surprised." ■

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## Decline in Medicare Readmissions Likely Not Caused by Reduction Program

By Melinda Young

Results of a comprehensive study, analyzing more than 6 million Medicare admissions, revealed declining 30-day hospital readmissions from 2009 to 2014. The readmissions rate fell from 19.65 per 100 beneficiaries in 2009 to 17.27 in 2014, a 12.1% decrease. Some policymakers have attributed the decline to the Hospital Readmissions Reduction Program (HRRP), introduced in 2010. But researchers found the declining readmissions also could be explained by declining hospital admission rates over the same period.<sup>1</sup>

"We noted a trend that has largely gone unnoticed — that the period of readmission reductions also has been one in which admission rates

declined substantially," says **Michael McWilliams**, MD, PhD, Warren Alpert Foundation professor of healthcare policy and professor of medicine at Harvard Medical School and Brigham and Women's Hospital.

Declining admissions likely was due to several causes, including the Recovery Audit Contractor (RAC) program that cracked down on very short hospital stays and prompted a surge in observation stays, McWilliams says.

"Other factors might include our growing ability to handle more complex conditions on an outpatient basis or in the emergency department without admission, and a decline in the number of hospital

beds in the United States," he explains.

### Bed Decline Already Underway

The hospital bed decline has been happening for some time, he adds. "This [readmissions] decline cannot be due to the Hospital Readmission Reduction Program because it is evident across all payers," McWilliams says. "Hospitals would not sacrifice 12% of their revenue in response to much smaller penalties applicable only to Medicare patients."

Also, the admission trend was underway before the HRRP was

announced and levied its first penalties to hospitals with too many 30-day readmissions.

“We know that most readmissions are not related to the care provided in prior admissions, but are independent events — that is, other admissions that happen to occur within 30 days of another,” McWilliams says.

## Other Factors Affect Readmissions

Studies show that about 20-30% of readmissions are due to potentially preventable deficits in care during the prior admission. “An even smaller percentage are actually due to such deficits,” McWilliams explains. “Because the probability of two independent admissions falling within 30 days of each other is lower when there are fewer admissions per patient, we would expect that the declining admission rate would reduce readmission rates, too.”

Two other studies revealed the Medicare readmissions reduction was overstated because of a difference in diagnosis coding used to risk-adjust readmission rates.<sup>1,2,3</sup>

“As an analogy, you could think of a crowded dart board. As more darts are thrown, the probability of your next throw hitting a dart and falling to the floor goes up,” McWilliams says. “But that doesn’t mean that you are any worse at throwing darts.”

When investigators conducted a computer simulation to determine the readmission reduction expected from the declining admission rate, they found the expected decline in readmissions was as large as the observed reduction.

“This suggests the reduction attributed to the HRRP was likely the byproduct of a broader decline in admissions,” McWilliams says.

“The takeaway message from the study is either hospital responses to HRRP incentives were weak or ineffective, or they may have improved quality of care, but both resulted in prevented readmissions and induced readmissions,” he says. “This is because when we reach out to patients and follow patients, we often recognize unmet needs. If it’s the latter, it suggests readmissions are not a valid measure of quality and presents the question, ‘What is the point of a pay-for-performance program that does not reward

improvements in the quality it elicits?” he adds. “Such a program would provide no incentive for providers to improve.”

The findings more likely suggest the HRRP’s efforts were ineffective, McWilliams says.

“In general, I think the national conversation would be better served by a focus on what improves quality rather than a continued focus on how to fix pay-for-performance programs that have intractable problems and cause unintended consequences,” he says. ■

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# HOSPITAL CASE MANAGEMENT

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## CE QUESTIONS

- 1. A recent study showed which percentage of people with low health literacy need help while performing a task online?**
  - a. 15%
  - b. 28%
  - c. 46%
  - d. 70%
- 2. Which is one of the objectives of Healthy People 2020 that also will be an objective of the Healthy People 2030 national health goals?**
  - a. To increase providers' in-person educational efforts
  - b. To maintain the health literacy of the population
  - c. To increase the proportion of persons who report their healthcare provider always asked them to describe how they will follow instructions
  - d. To decrease the number of people who obtain health information via cellphones instead of laptops
- 3. Before the Centers for Medicare & Medicaid Services waived telemedicine requirements, Medicare would only pay for telemedicine services if:**
  - a. patients used the services exclusively at home.
  - b. patients lived in rural areas and presented to a clinic or hospital for services.
  - c. patients in any area presented to a clinic or hospital for services.
  - d. the service was used in an emergency.
- 4. An analysis of 6 million Medicare admissions from 2009-2014 revealed 30-day readmissions declined by:**
  - a. 10%
  - b. 11.5%
  - c. 12.7%
  - d. 13.9%

## 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.