HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

Relias Media

From **Relias**

OCTOBER 2020 Vol. 28, No. 10; p. 109-120

Hospital's Transitional Care Programs Help Heart Failure Patients Stay Healthier

Programs focus on education, screenings

By Melinda Young

Hospitals that focus on collaboration between case management and transitional care clinics for people with congestive heart failure (CHF) are finding positive outcomes in their patients' health and 30-day readmissions.

Heart failure patients can improve their quality of life if they access the resources necessary to maintain their health, says **Connie White-Williams**, PhD, RN, FAAN, senior director of the Center for Nursing Excellence at the University of Alabama at Birmingham (UAB) Hospital. She also is the senior director of the heart failure transitional care clinic for adults.

"For the underserved population, navigating their self-care and being good stewards of their own health are not always easy," she says. "You can help them understand what it takes to feel better and to live a good life. It is all about taking their medicines, eating right, not smoking, giving up [illicit] substances, and trying to exercise."

> "FOR THE UNDERSERVED POPULATION, NAVIGATING THEIR SELF-CARE AND BEING GOOD STEWARDS OF THEIR OWN HEALTH ARE NOT ALWAYS EASY."

The Valley Hospital of Ridgewood, NJ, has developed a transitional care program for patients

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.

HOSPITAL CASE MANAGEMENT

***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.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@relias.com
ReliasMedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at groups@reliasmedia.com or 866-213-0844.

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.

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

ACCREDITATION: In support of improving patient care, Relias LLC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

1.5 ANCC contact hours 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 target audience for *Hospital Case Management*™ is hospital-based case managers.

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

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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

with heart failure that successfully prevents 30-day readmissions. *(See story in this issue about how the heart failure transitional care program works.)* The six-year-old program, which involves a dedicated outpatient transitional care unit, started as a pilot project, explains **Elvira Usinowicz**, APN, supervisor of the outpatient transitional care unit at The Valley Hospital.

The CHF care coordination program was established based on national and international guidelines from heart associations, critical care nursing, nurse practitioner groups, and others. The goal is to create a care plan focused on patients' needs during hospitalization and post-discharge, Usinowicz says. It also includes best practices in communication and supervision in the seven to 14 days after discharge, she adds.

"That's a vulnerable period for heart patients to come back to the hospital for any cause for hospitalization," Usinowicz says. "We teach them self-care management strategies at home to take care of their heart failure condition."

Results of a recent outcomes study shows positive change. In 2014, the rate of all-cause readmission within 30 days for patients with heart failure was 6.25%. In 2018, the rate was 2.71%.[1]

"What is valuable to patients and families is recognizing heart failure symptoms, which they report to their cardiologist, or call our program," Usinowicz says. "Patients and families find this supportive, global look at how they're functioning in the community with their heart failure as very helpful." It empowers patients and gives them some autonomy over controlling their symptoms, she adds.

Consider Stress, Environment

When the transitional care team educates patients about their condition, they take anxiety levels and environment into account, says **Christina Haddad**, BSN, RN, CHFN, unit nurse at The Valley Hospital.

"For inpatients, since they are in an acute care setting, we understand their anxiety is already high," Haddad adds. "We provide a booklet and stress the importance of three main topics: daily weights, recognition and understanding of a heart failure zone tool, and a low-sodium diet."

EXECUTIVE SUMMARY

Heart failure patients often need transitions to outpatient clinics, where they can learn how to better maintain their health and stay on their medications.

- The Valley Hospital of Ridgewood, NJ, offers an outpatient transitional care unit for heart failure patients that reduced 30-day all-cause readmissions from 6.25% to 2.71%.
- Heart failure patients can improve their own health and quality of life by following a program focused on medication adherence, diet, exercise, and giving up cigarettes and illicit substances.
- Coordination programs for heart failure patients should follow national and international heart guidelines.

The education is basic and relies on reinforcement. The team also reaches out to family members and caregivers, recognizing their importance in achieving optimal outcomes.

The UAB Hospital's heart failure transitional care clinic is interprofessional. The clinic can refer patients to other professionals. Hospital case managers are instrumental in referring patients to the clinic's services, White-Williams says.

"Hospital case managers are very important. They are our referral source, and all of the hospital case managers and social workers work together in partnership with the clinic," she says. "If they know a patient is underserved, they refer them to our clinic, and we work closely with them."

A nurse practitioner and, sometimes, a social worker are the first people to see new patients, White-Williams says. Each patient completes a routine intake with the nurse practitioner checking their vital signs, taking a medical history, and conducting a physical. Patients receive guideline-directed therapy.

"There is a full social assessment where we assess social determinants of health," White-Williams says. "We've developed our own assessment."

The social determinants of health assessment includes these questions:

- "'We worried whether our food would run out before we got money to buy more.' Was this often true, sometimes true, or never true for your household in the last 12 months?"
- "'The food that we bought just didn't last, and we didn't have money to get more.' Was that often true, sometimes true, or never true for your household in the last 12 months?"
- Does the patient use tobacco, alcohol, or engage in substance use?
- Has the patient experienced abuse?
- Does the patient struggle with safety, housing, insurance, social support, food, violence, income, job training, mental health, or non-citizenship status?

Patients are assessed for depression, anxiety, and substance abuse based on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) scale, which screens for severity of substance use and identifies the appropriate level of treatment. *(More information is available at: https://bit.ly/2Q3AvhF.)* The clinic also uses the Kansas City Cardiomyopathy Questionnaire, a 23-item, self-administered instrument that assesses at patients' physical function, symptoms, social function, self-efficacy, knowledge, and quality of life. *(Find out more at: https://bit.ly/3kTDW8O.)*

"All patients complete a depression and anxiety [screening] every time they come to the clinic," White-Williams says.

Help Patients Take Control

CHF is a complex syndrome that causes serious illness if patients do not have access to medications or if they stop taking their medicine because of social determinants of health. "An underserved population of patients might have to make decisions about whether they should pay their electric bill, put food on the table, or take their medications," White-Williams says. "Food for the family will win over taking care of their health."

Heart failure also is difficult to control because it requires patients to self-manage their diet, exercise, medicines, and routine maintenance. "If they don't take care of themselves, they could very easily end up right back in the hospital," White-Williams says.

The goal is to help patients meet their personal goals for health and quality of life. "Part of our assessment is asking the patient, 'What do you want? What are your goals?'" White-Williams says. "Many of them will say, 'I want to see my daughter get married,' 'I have a grandchild on the way,' or 'I'd like to be able to breathe so I can walk around the block.'"

Transitional care nurses are passionate about education and helping patients change their behaviors for the better, says **Barbara Picewicz**, RN, BSN-PCCN, unit nurse at The Valley Hospital. "It is challenging to implement behavioral change. Our patients need constant positive reinforcement."

Education is tailored to the patient's specific needs. For example, nurses give patients a five-question test about their sodium allowance and diet choices. The team created a nutritional cart with empty boxes and cans to show the dietary information of various food items.

"This is extremely helpful for our visual learners," Haddad says. "Patients seem to understand when the education is interactive."

Working with heart failure patients is rewarding, says **Erika Bartsch**, BSN, RN, CHFN, unit nurse with The Valley Hospital. "One of the biggest joys is to see patients really feel well after joining our program. There is a real sense of making a difference in our patients' lives." ■

REFERENCE

1. Usinowicz E, Ronquillo K, Matossian B, et al. Reducing readmissions for heart failure. *Crit Care Nurse* 2020;40:82-86.

The Elements of a Transitional Heart Failure Care Program

Staff develops rapport with patients

By Melinda Young

Hospitals and subacute facilities monitor congestive heart failure (CHF) patients closely, but there may be a gap in care once patients are discharged.

A transitional heart failure care clinic can fill that gap. A skilled team of professionals oversee patients' progress in maintaining their medication regimen and adopting healthy habits. The clinic can serve patients after they have transitioned home or to a long-term care facility.

"We have some patients who are in assisted living. Their families will pick up the patient and bring them to the program," says **Elvira Usinowicz**, APN, supervisor of the outpatient transitional care unit at The Valley Hospital in Ridgewood, NJ.

This is how The Valley Hospital's CHF program works:

• Establish the care transition unit. The hospital created the program in the former dialysis unit. It keeps daytime hours for seeing patients in person.

"Basically, we're inside the hospital, but act as a physician office. We can refer to wherever we want the patient to go," Usinowicz explains.

The unit's staff includes Usinowicz as the supervisor, along with registered nurses (RNs), nurse practitioners, office coordinators, and a collaborating physician who specializes in heart failure. The unit also works with an infectious disease physician and can access services advanced cardiac therapies and heart transplant.

"If the patient has a complex wound, we pick up the phone, write a prescription, and the patient goes to the wound department," she says.

If patients cannot visit the unit, as has happened with some people during the COVID-19 pandemic, the mobile intensive care unit (MICU) can visit the patient at home. The MICU is staffed by a nurse paramedic.

"RN paramedics go into the patient's home, perform a physical assessment, and then call our nurse practitioners to report the patient's symptoms," she explains. "We do phone triage and decide on medications for the patient."

• Identify CHF patients. The program receives a printout identifying hospitalized patients with a heart failure diagnosis. The algorithm is highly accurate, Usinowicz says.

"If someone gets intravenous Lasix, they're keyed in," she adds. "It's a way of identifying patients before they leave the hospital so we can proactively teach and tell patients that their doctor wants them to come into the program."

• Visit the patient's hospital room. The unit's nursing team visits patients before discharge. "They say, 'I'm a registered nurse with the outpatient transitional care program. Your doctor would like to ensure you do not come back to the hospital with heart failure symptoms,'" Usinowicz says. "'I'm going to take the opportunity to teach you some things about your heart failure diagnosis and talk about how we can keep you from returning to the hospital with heart failure.'"

During this first visit, nurses give patients teaching materials. "After introducing myself, I usually begin with providing our heart failure pamphlet and explaining, 'When your heart is not efficiently pumping for varying reasons, the following might happen…'" explains **Erika Bartsch**, RN BSN-CHFN, unit nurse with The Valley Hospital.

"I try to approach the patients in a positive manner and engage them in taking charge of their chronic condition," Bartsch says. "By joining our team, along with their primary cardiologist, other physicians, and family, we can help manage their condition and keep them feeling well and out of the hospital."

One teaching tool is a guide to CHF zones, which helps patients identify their symptoms and whether they should call a nurse practitioner or go to the hospital. The zones are:

- Green: The patient's breathing is normal and not experiencing symptoms;
- Yellow: The patient has gained a little weight, is starting to cough, and needs to find out what to do next;
- Red: If the patient is experiencing chest pain, it is time to call 911, Usinowicz explains.

The transitional care unit team created a laminated placemat for patients that includes a heart-healthy food shopping list and a reminder of the best low-sodium foods to select.

Nurses also help patients make

appointments to visit the transitional care unit within seven to 14 days after discharge.

• **Use tools to improve patient education.** "Education is paramount in our program," Bartsch says. "We are very passionate about educating our patients and their families."

For instance, on each patient's first visit, nurses provide CHF binders created by the heart failure RNs. These include sections for patients to keep their personal information, such as doctor's information, their medication list, their lab tests drawn on that visit, and a daily log for them to chart weight and heart failure symptoms. The binders include information on a low-sodium diet, physical activity, and the heart failure zones diagram, Bartsch adds.

• **Connect with patients.** "On the initial meeting, the patient needs to put their trust in you as a provider to accept the treatment you're recommending," Usinowicz says.

The key is to approach patients in a way that avoids that raised-eyebrow skepticism. "Every patient is approached holistically," she explains. "We deal with the mind, body, and spirit. We try to make a connection with the patient on some personal level."

The transitional care unit team gets to know patients' families and caregivers. Nurses will celebrate patients' anniversaries and birthdays with balloons and cake.

"Patients become very endeared to us," she says. "Our approach is to evaluate their learning style and their cognitive ability to retain information, their health literacy, and what kind of family support they have at home."

The transitional care staff become close to patients. "We are very lucky to work in a program where we have the opportunity to really get to know our patients," Bartsch says. "This gives us the relationship with them to be their cheerleaders when they are doing well, and their support and guidance when they fall off track."

Patients can call the transitional care team whenever they run into issues with their weight or new symptoms. "I think they feel very secure that we are there for them if they have setbacks, and this encourages them to stay on top of their disease," Bartsch says.

• **Assess patient at first post-discharge appointment.** The patient meets the outpatient transitional care unit team at the first appointment after discharge.

"They are introduced into the purpose of the program, which is to help them manage their heart failure symptoms and to stay well and healthy in the community," Usinowicz explains. "We take their health history and conduct a physical exam."

The team also screens patients for depression, using the patient health questionnaire (PHQ-9), and screens for sleep apnea.

"More than 40% of patients with heart failure have some type of sleep disorder with breathing," she explains.

After drawing blood and conducting the physical exam, the team reviews the patient's medicines. If needed, nurse practitioners can provide intravenous diuretic therapy and optimize patients' medications to improve their symptoms. "The goal is to improve the patients' morbidity and mortality," Usinowicz says.

Heart failure is a deadly disease with an expected survival of five years or less after diagnosis, she notes. "It's a progressive, chronic disease," she says.

While the transitional care program has not collected evidence to show patients receiving this care improve their mortality rate, the data do show improvements in their health outcomes as evidenced by fewer hospital readmissions.

• **Repeat visits, as needed.** Patients return to the transitional care unit, as needed. It depends on their symptoms.

"We'll see patients once, twice, three times over a month or a few months," Usinowicz says. "If they feel very well, then we see them as needed with a referral back to the cardiologist."

Occasionally, patients are so debilitated and sick the unit team will see them weekly for treatment. "Some patients get tuned up and feel terrific, and we don't see them again for a few years," she says. "Some need advanced therapy centers and are on the transplant list."

Each visit includes the general health assessment, but patients are screened for depression and sleep apnea once a year. "We ask how they're feeling, weigh them, and perform a physical exam, vital signs, and repeat the blood panel as ordered," Usinowicz says.

The team reviews the patient's medications and assesses where patients are in relation to their treatment from a prior visit.

During the COVID-19 pandemic, the unit has offered phone visits for patients when feasible. They follow safe patient guidelines with hand sanitizers, social distancing, and scheduling patients to not be clumped together at the front desk. Patients are permitted to bring one visitor if they need help because of mobility or cognitive issues.

"Some patients are socially isolated, and they come here because we give them so much time, whereas at the physician office it might be a 10-minute visit," Usinowicz says. "Coming here is a social outing for some patients, and they enjoy it." ■

How to Harvest Big Data to Reduce Readmissions

By Jeanie Davis

"Big data" is a buzzword in healthcare these days. The term refers to the vast amount of electronic data healthcare providers have accumulated over the years, explains **Dina Walker**, RN, MSN, national director of case management for Encompass Health.

While the concept can seem pretty abstract, big data is more relevant than ever and potentially at every case manager's fingertips. You just need the right tools to "harvest" it, Walker says.

Walker has been harvesting Encompass Health's big data since she joined the company in 2016, and has seen firsthand how the organization reaps results by using data to build tools to help clinicians. In 2017, Encompass Health reduced readmissions to acute care during a rehab stay within the first six months of using their predictive analytic tool, ReACT.

To reach these results, Encompass Health partnered with its electronic medical record (EMR) vendor to create a customized dashboard, data analysis tools, and electronic clinical workflows. The data revealed where changes were needed (in-hospital processes) to reduce readmissions, Walker says.

Her message to case managers: "Look for opportunities to use your big data and you can perform this same type of analysis in your own hospital."

Phase One: Assessing the Current State

Encompass Health is the largest owner and operator of inpatient rehabilitation hospitals, with 136 facilities in 35 states and Puerto Rico. Last year, they discharged nearly 187,000 patients. They also are the fourth-largest provider of Medicare-certified home health services, with 245 home health and 83 hospice locations.

"That translates into a lot of data that can be analyzed to make performance improvements," Walker explains. "When you combine internal data from EMRs, for example, with external data like Medicare claims, you can really learn some valuable information about your current state and the possibilities for improvement. It is very exciting."

Every Encompass Health rehab hospital and home health agency uses the same documentation platform. Combining data from each system afforded the ability to track patient data across the continuum of care through the inpatient rehab stay and the home health encounter. Then, they reviewed claims data from the Centers for Medicare & Medicaid Services (CMS).

"By using all those data, we could slice and dice and analyze the causes of the two types of readmissions that CMS measures us on: those that occur during a rehab stay (we call those ACTs — acute care transfers) and those that occur after discharge," Walker explains.

"Readmissions that occur during the stay" is a CMS metric unique to rehab hospitals, she adds. For example, a Medicare patient in rehabilitation after a hip replacement might develop a complication like infection. If the infection is severe enough, the patient may have to return to the acute care hospital for treatment. If the surgeon keeps the patient to treat the infection, or performs another surgery, that counts as an "inpatient readmission" and incurs additional healthcare costs that are billed to Medicare.

"In those types of scenarios, inpatient rehabilitation may appear as if it is costly to Medicare, so we have to try to control those costs," Walker says. "One main way to control costs is to focus on controlling preventable readmissions during an IRF [inpatient rehabilitation facility] stay," she adds.

"In the hip replacement scenario, a predictive tool may have picked up a change in the patient's condition and potentially avoided that readmission."

Medicare Spending per Beneficiary (MSPB) refers to the total cost of an episode of care. The episode begins on the day of admission to the IRF and ends 30 days after discharge. It is the cost of the IRF stay, plus all Medicare Part A and Part B healthcare services used within the 30-day post-discharge window.

For example, the average length of stay (ALOS) for an IRF stay is about 13 days. Combining that stay with roughly 17 days of home healthcare equals the 30-day MSPB measure window. Because of this, "we have to effectively manage care delivery during and after the IRF stay," says Walker. "If we can prevent ACTs and avoid post-discharge readmissions, we will improve the MSPB. We also need to help avoid unnecessary emergency visits that can lead to unnecessary acute care hospitalizations. It's not just about Medicare spending, though; avoiding these unnecessary types of healthcare transitions is also the right thing to do for the patient."

The beauty of analytic tools is their ability to learn from historical data, says Walker. That is the function of ReACT.

"The ReACT tool is a model that risk-stratifies patients for risk of an ACT (the readmissions during the IRF stay)," she explains. "We leveraged a robust database of over 90,000 encounters from about 65 sites over a two-year period."

The model showed statistical significance of about 30 clinical variables associated with higher ACT risk, says Walker. "We tested and validated the predictive algorithm and deployed the ReACT risk assessment and ReACT dashboard across all Encompass Health hospitals at end of 2017."

In the dashboard view, clinicians can see patient trends over time (past 12 hours, past 24 hours, and past 48 hours) and can clearly see whether the patient's risk level is improving or becoming more elevated.

The ReACT tool and clinician dashboard indicate when a patient's risk level is increasing, says Walker. This risk level assessment is based on factors including functional measurements, Braden skin score, patient's participation in therapy, certain medications, laboratory test results, demographics, pain level, and appetite.

ReACT indicated patients in the Very High Risk level are six times more likely to be transferred back to the acute care hospital than Low-Risk patients, she says.

ReACT was implemented in all Encompass Health hospitals by November 2017. "By March 2018, we began really seeing a nice decrease in the ACT rates," says Walker.

How ReACT works: The algorithm starts monitoring documented factors upon admission, and as more data are entered in the patient's EMR throughout the stay. Each patient's ReACT risk score is displayed on a dashboard in their EMR, along with the list of factors contributing to that risk. Clinicians receive electronic notifications about risk score changes.

As the scores update over time, the trend becomes available. Nursing is electronically tasked to assess the patient if he or she escalates to Very High Risk level. They document the assessment on a custom-built screen in the EMR. Nurses inform the physicians of their assessment findings.

"Historical data can help identify issues in the patient care process," Walker explains. "When those processes improve, readmissions decrease."

Phase Two: Clinical Decision Support Tools

When analyzing readmission data, the team discovered opportunities to improve clinical care of chronic conditions like heart failure or chronic obstructive pulmonary disease (COPD).

"We also realized that in order to improve both ACTs and readmissions after discharge, we had to get the management of these conditions during the IRF stay right," Walker says. "For that reason, we implemented clinical decision support tools for CHF and COPD."

A business intelligence tool called Beacon Dashboards are the heart of the program. Beacon houses clinical care metrics, program adherence measures, and outcomes that can be monitored on the dashboards. Clinicians use these dashboards to trend results and detect areas of opportunity, as well as success stories.

Some key results:

- The number of opioid prescriptions written at discharge are decreasing.
- Medication reconciliation is performed more timely before discharge.
- The percentage of patients discharged home is increasing.

They also saw "marked improvement" in ACTs by March 2018, within six months of initiating the ReACT tool. "The 2018 average ACT rate across all hospitals was 10.41%. In 2019, it was 10.31%," says Walker.

"These metrics are critical to Medicare IRF Compare reports, as they may impact consumer/patient

perception of the quality of care," she adds. "Data are transparent now more than ever, so organizations have to be aware of how they appear on websites like IRF Compare."

Walker advises: "Assess the data, identify the issues, then work to fix them. The true driver for these tools is to improve patient care. Better care results in improved outcomes, and improved outcomes may lead to becoming a trusted, recommended provider."

Phase Three: Tackling 30-Day Readmissions

Piggybacking on the success with the ReACT program, Encompass Health and its EMR vendor developed a readmission prevention algorithm that monitors both IRF and home health patient data as patients move through the continuum of care.

"The Readmission Prevention predictive model was developed using data collected from over 400,000 patients over a two-year period," Walker explains.

The model was piloted in eight inpatient rehab hospitals and 10 home health branches. The model continuously monitors more than 40 clinical features or variables. From this, the model calculates a patient's probability of a post-discharge readmission and reports a "risk score percentage," she explains.

The Readmission Prevention tool identifies patients with a high probability of readmission to an acute hospital after discharge from the rehab hospital. Although the algorithm monitors clinical factors, patients also may have nonmedical risk factors.

"Assessing for and documenting those factors is critical. They can include social determinants of health, like food insecurity, limited literacy, or lack of caregiver support," Walker explains. Because of this, a case management risk assessment was built in the EMR.

"Over time, as the case managers become proficient at assessing and documenting these nonclinical factors, that documentation will feed the predictive algorithm," she says. "The algorithm will then help determine if those nonclinical factors are indeed contributing to readmission risk."

One issue they discovered during the Readmission Prevention pilot phase was some readmitted patients were missing home health visits. "We discovered those patients were not allowing home health nurses to visit because they 'didn't feel like having company' or they 'didn't feel well,'" says Walker. "That is the very time a patient probably needs to see the home health staff."

They also found patients who did not attend their physician follow-up appointment timely after discharge were more likely to be readmitted.

Changes Based on Data

Now, a case manager explains the significance of the home health visits and reminds the patient to avoid canceling home health visits — even if he or she does not feel well.

"We also have taken a more active approach to scheduling post-discharge follow-up appointments within three to five days of discharge," says Walker. "We provide information about the types of phone calls a high-risk patient may get after discharge. We ask them to be cognizant of keeping their phone charged, keep it with them, and to answer it — even if the call is from an unknown number."

The time gap from discharge to the follow-up appointment with the primary provider is a risky period when readmissions are likely to occur, she adds. Encompass Health implemented another unique intervention to tackle that problem: The discharging IRF physician helps bridge the transfer gap from IRF physician to the patient's own physician.

"The IRF physician will follow the patient with home health and our case manager for a few days post-discharge, until the patient sees their own physician — to bridge that gap," says Walker.

The readmission predictive algorithm helps determine the level of risk, but staff also were trained on actions and interventions to mitigate that risk. "Those interventions are outlined in a playbook," says Walker. "Since avoiding post-discharge readmissions is an interdisciplinary process, the playbook includes key actions for all members of the interdisciplinary team, including our home health team."

She expects to report more information on the Readmission Prevention program and the results they achieve at national case management conferences in 2021.

"After a recent conference presentation, someone asked if they can buy the ReACT or Readmission Risk algorithms. Those algorithms are proprietary and customized for our rehab hospitals," says Walker. "Hospitals can work with their EMR provider to develop their own tools, assess their current state, and pilot an improvement program. Start with analyzing as much data as you can."

Bring Clinicians Aboard

"Integrating the ReACT and the Readmission Prevention predictive

tools into the clinical workflow required clinician buy-in," says Walker. "We educated all clinical staff and all physicians on the program and their role." The team discussed patients' ReACT and readmission risks in interdisciplinary huddles, focused on the highest-risk patients and those showing worsening trends.

At every step, clinicians were encouraged to embrace notifications and triggered electronic tasks. They could intervene at the earliest point possible when risk is escalating.

Walker advocates using "business intelligence" tools (like their Beacon dashboards) to analyze clinical data to develop targeted clinical decision support tools and interventions. They have been extremely valuable in readmission reviews, retrospective analyses, and process improvement.

"Predictive tools are a form of artificial intelligence and can be a tremendous addition to patient care workflows," she says. "But they are just that: artificial. Absolutely nothing replaces good clinical knowledge, critical thinking, sound clinical judgment, and the ability to act on what you think is best for the patient."

Her advice for case managers: "Talk to your IT department leaders and ask what data are currently available for analysis," says Walker. "Tell them the type of analysis you would like to do and see if they can help pull some reports for you, or ask if there is a plan to work with the EMR vendor or create monitoring dashboards."

She adds: "It is easy to get overwhelmed with all the predictive tools, the dashboards, and the numbers and feel some sense of 'analysis paralysis.' Just remember, behind each number is a patient, and behind each trend is a certain volume of patients who have been impacted by your current processes and the care you provide."

Be open to what the numbers are telling you about your processes, Walker says. "Use them to justify and support those initiatives or improvements you have long known are needed." ■

VA Care Coordination Satisfaction Rates Higher Than Community Care

Program uses patient-aligned care team

By Melinda Young

Focusing on better communication and care coordination, a Department of Veterans Affairs (VA) facility exhibited strength in its communication and care coordination, according to the authors of a new study.[1]

"There is a lot of focus on the VA self-coordinating care," says **Megan E. Vanneman**, PhD, MPH, core investigator and career development award recipient with the Veterans Affairs Salt Lake City Informatics, Decision-Enhancement and Analytic Sciences Center. Vanneman also is an assistant professor in the division of health systems, innovation, and research in the department of population health sciences, and in the division of epidemiology in the department of internal medicine at the University of Utah School of Medicine.

In the VA, primary care is the hub for coordinated care, Vanneman explains. "Patients are assigned to a patient-aligned care team [PACT] to coordinate their services."

PACT is part of the VA's New Models of Care initiative, designed to transform care for veterans through providing a patient-driven, proactive, team-based, and personalized approach to wellness. *(For more information, visit: https://bit.ly/30PdRzJ.)*

The VA's Office of Community Care's coordination model uses triage to determine clinically indicated levels of care coordination. These range from basic to moderate to complex and to urgent care. "The VA uses the Care Assessment Needs [CAN] score that predicts hospitalization within the next year," Vanneman explains. "It's used as a model of care coordination."

The CAN score, created in 2013 by the VA, looks at these factors:

- demographics;
- coexisting conditions;
- vital signs;
- use of services;
- pharmacy visits;
- lab results.

The CAN score helps providers in primary care, case management, and other services work together and accurately predict high-risk patients. *(More information is available at: https://bit.ly/3aiwOxS.)*

The study authors assessed veterans' satisfaction when

communicating with providers, asking them to rate communication questions from one to four, Vanneman says.

Communication questions included:

- Did the provider explain things in a way that you could understand?
- Did they listen to you?
- Did they show respect to what you had to say?
- Did they spend enough time with you?

In looking at the scores and controlling for factors like age, gender, physical health status, and perceived mental health status, the study found the differences in scores between how patients perceived the quality of services received in the VA vs. community providers to range from 2% to 15%, Vanneman says.

"The 2% was a provider rating on specialty care, and 15% was for primary care coordination," she explains. "Basically, if there's a 2% difference, you could ask if that's clinically meaningful or a policy-relevant difference. That's up to the eye of the beholder, but 15% is a substantial difference."

The provider rating measure was from zero to 10 points. All baseline scores were better in the VA than in community care.[1]

The primary care group works hard to coordinate care. "It's a complicated process, but everybody is doing their best to make sure veterans have coordinated care," Vanneman adds.

The study authors found VA respondents were significantly different in sociodemographic characteristics from community care respondents. For instance, VA respondents were older, reported better perceived physical health and mental health status, were more likely to be men, had lower educational levels, and lived in more urban areas. VA respondents also were more likely to be married.[1]

The one factor that did not cause significantly different ratings between VA care and community care was access to care. "In this study, we found access to care was similar with the VA and community for primary care and mental health care," Vanneman says. "The community scored better on specialty care, and specialty care improved in both over time."

These are a few examples of the questions about access to care:

- Did you get the appointment when you needed it?
- Did you see the provider within 15 minutes of the appointment time?
- Did you receive an answer to your questions on the same day?
- Did you receive an answer to your medical questions as soon as you needed it?

"It was interesting to see the scores for access were similar for primary care providers and mental health, but the community did better on specialty care access," Vanneman says. ■

REFERENCE

1. Vanneman ME, Wagner TH, Shwartz M, et al. Veterans' experiences with outpatient care: Comparing the Veterans Affairs system with community-based care. *Health Aff (Millwood)* 2020;39:1368-1376.

Healthcare Planning for the Lone Senior

By Jeanie Davis

Social isolation is a life-and-death matter, believed to influence mortality as much as obesity and smoking. Yet amid the growing population of seniors, many are unmarried, widowed, or have no children living nearby.

"They might have a few acquaintances, but not a strong support system, nobody checking on them frequently, no one calling them every day or monitoring their status with a discharge plan," says **Jennifer Axelson**, LCSW, CCM, CLCP, a certified life care planner and expert life care manager for Lifecare Innovations.

In her work, Axelson evaluates the patient's home environment before hospital discharge, and helps smooth the transition to home care. When discharge planning for the lone senior, case managers should know several points about this demographic, she says.

Axelson describes common traits she sees in her patients: "Many come from an era where pride is an underlying theme in their personality. This can make for a dangerous situation when they're discharged from the hospital because discharge planners may not be fully aware of this isolation."

The lone senior may not bring anyone to the hospital who can add details to help discharge planning, says Axelson. "The case manager has to take the patient's word on details about the home environment. The information you get can be pretty limited."

"This person is predisposed to not doing well post-discharge, which can lead to hospital readmission," she

continues. "Isolated seniors, even with the best of intentions, can be discharged with an insufficient discharge plan because the information given to the discharge planner was incomplete or incorrect. It may be incorrect on purpose or because the patient has a cognitive issue."

Axelson advocates making an in-person, at-home evaluation of the patient's living space. Hospitals can contract with community-based care management organizations to provide this on-site evaluation. "It's often a key component to determining the patient's capacity and ability to care for oneself."

How an In-Home Evaluation Works

Evaluating a patient's living environment starts with a few questions: Is the patient experiencing functional issues? What medical conditions are the patient managing?

Axelson looks for signs of hoarding, fall risks, and bathroom locations. Is the patient still safely driving? Do doors and windows close and lock? Do the air conditioning and heat function? Are there any major repair issues? Are there signs of excess spoiled food? Is the patient taking medications correctly? "Any of these issues can be a red flag," Axelson says.

The patient may need support that was not obvious, like Meals on Wheels or a medication delivery program, she adds. "Seeing how people live, and talking one-on-one, can give you that information, whether they are making meals or confused about their medications."

The home assessment can identify other "ticking time bomb" issues that could become a bigger concern, Axelson says. "We curb those issues before they become catastrophic, like malnutrition, dehydration, or hoarding — which leads to falls and bacterial issues that can cause infection."

One patient was hospitalized for dehydration; a home visit identified 16 medication bottles. The patient had carefully noted the dosage on each bottle cap. But the bottle caps had gotten mixed up, so she was taking cholesterol pills four or five times per day, and pain pills once per day. "We see medication confusion quite often, and it can lead to serious side effects," says Axelson.

Addressing Deeper Issues

If the patient wishes, Axelson can follow up with a post-discharge visit and provide reminders about follow-up appointments. The level of support she provides depends on how many red flags she finds in her home visit.

The consultation also can go deeper, including legal issues like power of attorney. "The patient may want her daughter in California to be power of attorney. But when we speak with the daughter, we learn she doesn't want to be involved. We can help make alternative suggestions," Axelson says.

Another concern: Helping isolated seniors obtain resources on decision-makers, naming a person or organization to make their financial decisions when the time comes. Also, there might be a discussion of putting wishes in writing, like allocation of assets and healthcare decisions at end of life. Those discussions can start at the home evaluation visit.

Often, the patient will lead the conversation, Axelson says. "If they know you will help them, the isolated senior will have their own concerns and will bring them to the forefront. More often than not, people are receptive to our help. Other times, when they are not, we can only provide resources hoping they will eventually take steps."

Isolated males can be prideful but willing to accept assistance when they get to know you, she explains. "Females are very used to managing things on their own, so not super eager to hand over personal information or to let us start managing things. I get that."

"Every client we see has their own unique characteristics, life experiences, and their own trail of events that has led them to this point where we meet them," Axelson adds. "We meet them where they are and understand their situation. Our end goal is to keep them safe. No one likes being in the hospital, so we want to get them out and keep them from going back."

Agencies providing care management and nonmedical personal care are readily available in most towns and cities, says Axelson. The Case Management Society of America and the Aging Life Care Association can provide names and agencies that can help.

During the COVID-19 crisis, most patient visits have been via phone call, she adds. "We're assessing status and following up as best we can."

While insurance does not yet cover the home assessment visit, some hospitals have partnered with community-based organizations. Most care management organizations are willing to work within budgetary guidelines.

"We all have the same goal: to ensure the patient is well cared for, that conditions are managed, and that the discharge plan allows them to live the best possible life with quality," says Axelson. ■

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log onto ReliasMedia.com and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

CE QUESTIONS

1. **The Valley Hospital's heart failure transitional care program showed what kind of change in 30-day hospital readmissions for this population?**

   a. Readmissions increased by 14%.
   b. Readmissions decreased by 53%.
   c. Readmissions declined from 6.25% in 2014 to 2.71% in 2018.
   d. Readmissions declined from 16.9% in 2014 to 4.22% in 2018.

2. **What does Encompass Health's ReACT tool measure?**

   a. A patient's risk of heart failure
   b. A patient's risk of transfer to an acute care hospital
   c. A patient's risk of transfer to assisted living
   d. A patient's risk of falls at home

3. **The Veterans Administration's Care Assessment Needs score is used by investigators at the University of Utah School of Medicine to predict:**

   a. mortality within the next year.
   b. hospitalization within the next year.
   c. higher cost of hospital services.
   d. exacerbation of chronic illness symptoms.

4. **Jennifer Axelson, LCSW, CCM, CLCP, evaluates a lone senior's home for risks such as:**

   a. adequate furnishings.
   b. access to internet and technology.
   c. depression.
   d. functioning air conditioning and heat.

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.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Understanding Social Determinants of Health

By Toni Cesta, PhD, RN, FAAN

Introduction

Case management professionals have always known the dynamic relationship between psychosocial issues and clinical outcomes. If our patients' social and financial issues are not addressed first, then it is likely their clinical conditions and expected outcomes will suffer. Recently, this understanding has expanded beyond the typical social and financial issues case managers and social workers have traditionally used to assess patients. These criteria, called social determinants of health, provide a much broader understanding of the issues patients face in managing their health outcomes.

There is widespread acknowledgement that community-level social determinants — affordable housing, stable employment, reliable transportation, and access to healthy food — are a crucial component of holistic strategies to promote health, well-being, and longevity while also reducing healthcare costs. This month, we explore this concept and what it means for case management professionals, and most specifically social work case managers.

PUBLIC HEALTH LEADER LESTER BRESLOW SAID "IN THE LONG RUN, HOUSING MAY BE MORE IMPORTANT TO HEALTH THAN HOSPITALS."

Economic and Social Disparities in Health

The United States spends more on healthcare than any other country at $11,172 per year per person. *(https://go.cms.gov/2Em3KtH)* The average country spends about $3,453 per year. Despite these expenditures, the U.S. ranks 33rd out of 36 Organization for Economic Cooperation and Development nations in infant mortality and life expectancy. *(https://bit.ly/3aFb7Ze)* This means that in 32 other countries, babies are more likely to survive, and people are likely to live longer than in the U.S. How can this be when we spend so much more than other countries?

Additionally, people who are uninsured or underinsured are less likely to receive preventive care and manage their care adequately. Patients often seek care after they are much sicker, adding to a higher cost of care when treating them.

Finally, and perhaps most importantly, healthcare is only one contributor to health and may actually be one of the smaller factors. The quality of the healthcare we receive, the amount spent on it, and continuous medical advances are not the main contributor to individual or population health. Public health leader Lester Breslow said "in the long run, housing may be more important to health than hospitals." *(https://bit.ly/325uFC5)* The Centers for Disease Control and Prevention reports about 20% of the nation's health is the result of medical care, 5% the result of biology and genetics, 20% is the result of individual actions, and 50% relates to social determinants of health. *(https://bit.ly/2CG6EZC)*

What Are Social Determinants?

It has long been understood that poverty and other social disparities can negatively affect a patient's health. Nevertheless, most healthcare settings do not conduct a comprehensive assessment of patients' social risk determinants. It is increasingly understood that social risks are linked to poor adherence to medical treatments, resulting in worsened health outcomes and higher costs of care.

Unfortunately, the notion of social determinants does not always mean something to healthcare providers. Think of social determinants as:

• Conditions of life, such as how we live, work, move around, and what we eat and drink.

• The causes of those conditions, such as government policies, social structure, and the actions of powerful organizations.

The medical model of care is based on helping people after they are in trouble. Conversely, managing social determinants is aimed at discovering why people are in danger. It looks at our society's infrastructure, why it is built as it is, and the resulting consequences of these conditions on our health. One example is corporate decisions related to advertising. Ads for tobacco, alcohol, and health foods have shown disparities in wealthier white neighborhoods vs. poor minority neighborhoods. Racism in our society, combined with discriminatory housing practices, means minorities are at a greater disadvantage as it relates to air pollution, dampness, dust, and pests.

Drivers of Conditions of Life

The drivers of the conditions of life as a well as the drivers themselves are considered social determinants of health.

Drivers:

• Actions of industries and corporations;

• Race/ethnic and class-based organization of society;

• Government policies.

Drivers affect how we:

• Live: Use economic resources, housing, and neighborhood quality;

• Eat: Amount of and quality of food available;

• Work: Job conditions, including physical and psychological;

• Move: Ease of biking, walking, public and private transport.

Each driver affects our health outcomes. These outcomes include injury, disease, and premature death.

Measuring Social Determinants

There are relatively few tools for actually measuring social determinants of health. Although the categories measured could be summarized across tools, there is wide variation in the categories included in each tool. Little consensus exists for the indicators used to measure social determinant categories.

Nevertheless, the Healthy People 2020 national framework provides a starting point for defining categories of social determinants, including these five categories:

• Economic stability (employment, food insecurity, housing stability, poverty);

• Education (early childhood education, higher education, high school graduation, language, and literacy);

• Health and healthcare (access to healthcare, access to primary care, health literacy);

• Neighborhood environment (access to healthy foods, crime and violence, environmental conditions, housing quality);

• Social and community context (civic participation, discrimination, incarceration, social cohesion). *(Find out more at: https://bit.ly/32lhYn1.)*

Twelve categories have been identified as the essential categories of any social determinants of health assessment tool. Some electronic tools are available, including NowPow, which is used at Rush University Medical Center in Chicago. The software directs patients to resources for addressing the identified social determinants at risk. It determines how a patient might benefit from one or more community organizations and provides a care plan with recommendations.

If you do not have access to such software programs, you can consider how to measure selected determinants. Many of these can be open-ended questions as you review them with your patient.

• Demographics
• Economic Stability
- Resource availability
• Employment
- Rate and stability
• Education
- Level of completion
• Food Environment
- Food insecurity
- Quality
- Access
• Health and healthcare
- Insurance status
- Access
- Medication adherence
- Use of primary care
• Housing
- Homelessness
- Physical characteristics of housing
• Neighborhood environment
- Exposure to pollutants
• Physical activity and lifestyle
- Tobacco use
- Drug and/or alcohol use
- Violence
- Physical activity level
• Safety
- Environmental
- Activity
• Social and community context
- Exposure to physical and chemical pollutants at work or home
• Transportation and Infrastructure
- Availability

- Type
- Cost

Social workers should consider how to add these questions to a psychosocial assessment. Every case management department should use a standardized social work assessment tool to assess patients presenting with negative social risk factors. These social determinants can be added to an existing tool or form the foundation of a new tool, and will assist in identifying those complex patients in need of a social work intervention. Such tools should be used in the inpatient and outpatient settings.

Using the Data Collected

Traditional means of identifying complex patients is grounded in the downstream medical model, including chronic conditions, health outcomes, and hospitalization and emergency department use. Providers should consider these downstream factors when identifying complex patients, as they are influenced by social determinants. Care teams must understand their patients' clinical and nonclinical complexities to make informed, patient-centered care decisions.

Addressing social determinants of health can help organizations participating in value-based care reimbursement. It also can help achieve the Quadruple Aim of better health, lower costs, and improved patient and staff experience. However, current payment systems do not adequately incentivize treating social determinants, ensure sustainability of services, or cultivate community partnerships necessary for approaching health holistically and in an integrated fashion.

Once you have collected these data, you can identify where the patient may need an intervention, change, or other assistance. The level of support the social worker can provide will largely depend on the time he or she spends with the patient. If the social worker is assessing an inpatient, then the best intervention for a high-risk patient would be to refer that patient to a community social worker. If the social worker is community-based, he or she can create a robust, comprehensive plan.

The United States spends less on social services than other developed countries. The largest percentage of the gross national product is spent on healthcare at 17%. Unfortunately, we rank 23rd out of 34 nations in terms of social service spending. Finding the resources to assist patients with social determinants can be difficult and time-consuming. A focus on the most important factors is one way to deal with this. Since homelessness is considered the riskiest variable, it is a good place to start.

Another effective intervention is to send community health workers into the patient's home to address other risk factors. You may consider starting with the diagnoses representing the greatest opportunity as they relate to social factors, such as asthma, chronic obstructive pulmonary disease, or cardiac disease. Many such programs are associated with community case management programs where lay people are trained and educated to make effective nonclinical home care visits.

PRAPARE

One such program is the Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE), which helps health centers and other providers collect the data to understand their patient's social determinants of health. Such programs are helpful as healthcare providers work to improve outcomes in reimbursement models such as bundled payments, accountable care organizations, and value-based purchasing. Programs like PRAPARE assist providers in identifying and measuring the socioeconomic drivers of poor outcomes and higher cost. Providers can use social determinants of health to define and document the increased complexity of their patients. Other outcomes include transforming care using integrated services and community partnerships to meet the needs of their patients and advocate for changes in their communities.

PRAPARE uses an evidence-based set of core measures informed by research on social determinants of risk domains that predict poor outcomes and high cost. PRAPARE also worked with key stakeholders, such as patients, providers, clinical leadership, nonclinical staff, and payers. It aligns with national initiatives such as Healthy People 2020.

Core Measures in PRAPARE

- **Personal Characteristics**
  - Race;
  - Ethnicity;
  - Farmworker status;
  - Language preference;
  - Veteran status.
- **Family and Home**
  - Housing status and stability;
  - Neighborhood.
- **Money and Resources**
  - Education;
  - Employment;
  - Insurance status;

- Income;
- Material security;
- Transportation needs.

• Social and Emotional Health

- Social integration and support;
- Stress.

• Other Measures

- Incarceration history;
- Refugee status;
- Safety;
- Domestic violence.

PRAPARE data analyses have revealed:

• High-risk populations experience greater social determinants of health risks.

• The general population faces about five simultaneous social determinant risks.

• Complex patients can face 10 social determinant risks.

• Patients with uncontrolled diabetes experience more social determinant risks than patients with controlled diabetes.

• Types and extent of social determinant risks are related to clinical outcomes.

• There is a positive correlation between hypertension and the number of social determinant risks a patient faces.

• Ability to afford medications affects the likelihood of controlling diabetes.

• Stress affects the likelihood of controlling hypertension.

• The most prevalent social determinant of health risks between 2015 and 2017 across health center cohorts in seven states were limited english proficiency, education less than high school, lack of insurance, high levels of stress, and unemployment. *(https://bit.ly/3aGDFS2.)*

PRAPARE provides users with an implementation and action toolkit. The toolkit includes best practices, lessons learned, and user stories that will the user collect data and respond appropriately to social determinant needs.

Actionable Responses to Social Determinants

Physicians are increasingly aware of the need to identify and address social determinants. In fact, 76% of doctors queried indicated they believe that the healthcare system should cover the costs of connecting patients to services that can address their social needs. Specifically, these physicians indicated they would like to be able to write prescriptions for fitness programs, nutritional food, transportation, and housing assistance. *(https://rwjf.ws/2YkCH99)*

The lack of reimbursement for interventions that would improve the health of at-risk individuals is the biggest barrier to implementing effective change. Without addressing the drivers of the conditions that are placing our patients at risk, the unhealthy conditions will persist. Some individuals and organizations are working to draw attention to these drivers. Social change, such as work against the tobacco industry, has resulted in a decline in cigarette smoking.

Summary

The question remains as to what social workers can do to help patients. The emphasis in the field of human rights has been placed on political and civil rights, but that is changing. Increasingly, we see a focus on social and economic rights, including the right to health. These rights may require more social work staff that is educated and can access needed services for patients. Additional resources must be provided for ongoing patient support such as community case management.

Finally, care providers must be afforded the resources and time to spend with patients regarding their clinical care management and social needs. Some of these needs can and should be addressed. As with many issues affecting health, social determinants will improve only with comprehensive and sustainable interventions that improve quality of life for our patients. If you can apply at least one significant improvement to each of your patients, you will make a great deal of difference in that person's life. ■