HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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PATH-s Tool Helps Caregivers Understand What Is Needed

Tool assesses caregiver capacity

By Melinda Young

Researchers developed a transition care tool that helps caregivers better understand their role and what is expected of them in supporting and caring for patients.

The results of a recent study showed that after completing the Preparedness Assessment for the Transition Home After Stroke (PATH-s), caregivers could accurately identify long-term implications of stroke and their role.[1]

PATH-s was developed from a model born of transitional care research, says **Michelle Camicia**, PhD, RN, FAAN, director of operations with the Kaiser Foundation Rehabilitation Center at Kaiser Permanente Vallejo (CA) Medical Center.

Developing the tool generated items that represented the Model of Caregiver Readiness, including the domains of caregiver/care recipient relationship, willingness to provide care, caregiver's pre-existing health conditions, other responsibilities, experience, access to home and transportation, resources, emotional response, and ability to sustain the caregiver role.[2]

> "THERE IS SUBSTANTIAL FOUNDATIONAL RESEARCH THAT TELLS US THAT CAREGIVERS FEEL OVERWHELMED WITH THE TRANSITION HOME FROM THE HOSPITAL."

"There is substantial foundational research that tells us that caregivers feel overwhelmed with the transition home

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HOSPITAL CASE MANAGEMENT

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from the hospital," Camicia says. "They feel unprepared for the role; they feel like an iceberg sent out to the ocean on their own."

Fifty-three million people — more than one in five American adults — serve in a caregiving role, serving adults or children with special needs, according to a 2020 report from AARP.[3]

Unpaid caregiving is increasing while there are fewer potential family members available to provide help. This trend will continue as baby boomers age, the report notes.[2]

Caregivers often have unmet support needs. They worry about their ability to handle medications, urinary tract infections, and other problems that arise with caring for someone with chronic illnesses. "Assessing the caregiver helps the clinical outcomes of the care recipient," Camicia says. "You have a competency for the significant role caregivers have when they're transitioning."

Assess Commitment, Capacity

Camicia and co-investigators worked on this model, the tool, and validation of the tool. "From the model of caregiver readiness, developed as theoretical framework from qualitative research, Barbara Lutz and I developed all the items on the PATH instrument in draft form," Camicia explains. "From draft form, we went through a very robust process to refine and validate all of the questions in the PATH assessment tool."

The tool includes 25 items to assess caregivers' commitment and capacity for providing care. It is self-administered and can be used as a clinical assessment of caregivers to assess their readiness for the role.[4]

Helping caregivers is an important part of care transition and quality care throughout the continuum. "If we provide comprehensive care to patients with chronic illnesses and expect them to manage the illnesses when they are discharged, it goes beyond the doors of the hospital," says **Barbara Lutz**, PhD, RN, CRRN, FAAN, McNeill distinguished professor at the University of North Carolina Wilmington School of Nursing. "It goes beyond doors of the hospital. We have to figure out how to better help these patients who transition. It can't just be 'Do you have the right meds? Are you taking the right blood pressure medication?'"

EXECUTIVE SUMMARY

A new study on the Preparedness Assessment for the Transition Home After Stroke (PATH-s) revealed what caregivers understand about patients' disease and their own role.

- More than one in five American adults serve in a caregiving role. This proportion is increasing.
- An important part of case management might be to help caregivers with their part of the transition home and maintaining patients' health.
- Issues that could create barriers to optimal caregiving include the caregiver's commitment and relationship strength to the patient, and the caregiver's own health issues and other responsibilities.

Commitment items include the strength of their relationship and the willingness of the caregiver to perform in a giving role, Camicia says. Capacity issues include the caregiver's own health problems and other roles and responsibilities. Experience in caregiving, accessibility to transportation, and support (including financial resources) also are capacity issues.

"Support includes informal support, like people at their church, social group, or other affiliations," Camicia says. "One question asks if they have any family or friends who are willing to provide direct care."

Another question asks if people are available to help them with shopping, cooking, yardwork, and running errands. "It separates personal care from all the other ways somebody can help because some people are willing to do other things, but not personal care," Camicia explains.

Look for Deeper Issues

The tool looks beyond just surface capacity issues. For instance, on transportation, the issue is more than just accessing a car or a bus. "If the care recipient uses a wheelchair, do they have wheelchair access or public transportation that accommodates a wheelchair," Camicia says.

Home accessibility needs also depend on the patient and his or her environmental barriers. "Case managers can look into whether the person owns or rents their home, and if they rent, are they able to make modifications," she explains. "If there are environmental barriers, there's a question about financial resources to address those barriers. Does a person have the money to do what needs to be done, or do they have people who can volunteer to make the changes?"

In another paper, Camicia and co-investigators noted it is essential for providers to adequately assess caregivers' needs and incorporate education, preparation, and support for the caregiver role during transitions to the community.[5]

"We found by their completing the assessment, it helps caregivers understand what they need to start thinking about," Camicia says. "It triggers their anticipation of what they need to do, and it cues them to action to prepare for their role as a caregiver."

As part of the instrument development process, researchers presented information to a small cohort of caregivers, asking them which format of response they preferred.[3]

"What caregivers unanimously chose was the first-person response," Camicia says. "The first-person response includes the answers of 'I have no understanding,' 'I have some understanding,' 'I have a lot of understanding,' and 'I understand a little.'"

Using first person in their answers helped them connect with their own experience as a caregiver. "This [told] them, 'You're an important person, and these questions are about you,'" Camicia says.

Create Targeted Interventions

Case managers can use the PATH-s tool to create interventions for caregivers. "When case managers receive the responses and if there is a response that indicates a caregiver needs an intervention, then they can develop a plan of care in response to that," she explains. "They can give specific information of where we need to focus a case management intervention so there is an individualized plan of care to address the caregiver's needs."

The program is designed to suggest targeted interventions to address areas identified in the assessment. "We have a catalog of interventions that the case manager can choose from," Camicia says. "Each item has a catalog of interventions to put in the plan of care."

For example, the first question is, "Do you understand what to expect about recovery over the next six months?" If someone says, "I don't know," or "I have little or no understanding," then the case manager can re-send information about stroke recovery, as well as written materials, to the caregiver. "They also can send a message to the primary care physician, asking them to spend more time talking about the prognosis of stroke with that patient," she adds.

Another example involves a question about conflict in the caregiver-patient relationship. "If someone has a lot of conflict in their relationship, then we refer them to some counseling or provide some mutual building skills and activities to help improve the relationship," Camicia says. "It's really important [to know] that if you already have strains in a new caregiving relationship, it could be problematic."

A third example involves one of the most commonly reported issues raised by caregivers: "I have many other roles and responsibilities other than the caregiving role."

"One thing we've been doing very successfully is helping people with Caring Bridge and Sign-up Genius to get people to use a platform so they can send out to a support system," Camicia says. "They can say, 'Here's the things I need help with.'"

Asking for help through a technology platform alleviates some of the social pressure involved in asking people for assistance. People can be encouraged to ask for simple things, like asking someone to stay with his or her family member for an hour a day so the caregiver can take a walk, or to pick up items from the grocery store.

"For people who have a lot of roles and responsibilities and are trying to manage so much in their lives and also have the caregiving role, using that platform can help," she adds.

The study authors obtained comments from caregivers who had used PATH-s and found it often gave caregivers a feeling of mastery. "More than anything, it helps them process [information] by reading questions," Camicia says. "They may think, 'Yes, I'm doing better than I thought. I do know enough, and I do have the resources I need, and this is going to be OK.'"

It is important for case managers to reinforce the work of caregivers and to help them understand how to maintain their health and the relationship with the patient.

Ideally, the tool would be used to address caregivers' needs and improve post-acute care management. Case managers help this process by addressing the caregiver's needs, identified through the assessment, Camicia says. ■

REFERENCES

1. Camicia M, Lutz BJ, Harvath TA, Joseph JG. Using the Preparedness Assessment for the Transition Home After Stroke instrument to identify stroke caregiver concerns predischarge: Uncertainty, anticipation, and cues to action. *Rehabil Nurs* 2021;46:33-42.
2. Camicia M, Lutz BJ, Harvath T, et al. Development of an instrument to assess stroke caregivers' readiness for the transition home. *Rehabil Nurs* 2020;45:287-298.
3. Whiting CG, Reinhard S, Heinz PA, et al. *2020 Report: Caregiving in the U.S.* Published by AARP Family Caregiving and the National Alliance for Caregiving. May 2020. https://bit.ly/2OEfPQl
4. Camicia M, Lutz B. PATH-s is a freely accessible, evidence-based tool designed to assess caregiver's preparedness to transition stroke patients home. Association of Rehabilitation Nurses. 2021. http://bit.ly/3sarXY1

The Balancing Act: Patient Satisfaction and the Hospital Bottom Line

By Jeni Miller

Case managers often are pulled in different directions — not just in terms of the many duties with which they are charged, but also with competing goals. Take patient satisfaction vs. hospital spending. Are these two diametrically opposed? Not necessarily, and not always, it seems.

The main hospital spending metric is length of stay — especially during the COVID-19 crisis, says **Beverly Cunningham**, RN, MS, partner and consultant at Case Management Concepts.

"For some reason, there seems to be an increase in the focus on length of stay," she says. "Some of it may be due to the financial impact that hospitals are seeing with having to stop elective surgeries and depend, for the most part, on their medical patients for their payment [due to COVID-19]."

Of course, longer length of stay does not only affect spending, but also patients who are waiting in the emergency department (ED) for admission.

"Patients waiting for a bed in the ED have been a challenge for many hospitals," Cunningham shares. "This was true, to a certain extent, before COVID, but it is definitely higher with COVID. Also, larger hospitals that would accept more complex patients through their transfer center are not able to take these higher-level patients because there are no beds."

This matters, she adds, because it affects the hospital's ability "to accept more complex patients with higher reimbursement, and hospitals that traditionally transfer to them could get in the habit of transferring to a hospital that has had more ability to accept their transfers."

All this pulls on hospital spending, while at the same time potentially causing patient satisfaction to take a nosedive. Patient satisfaction may be harder to come by in crisis situations due to several factors — the most common of which is communication.

"Patient satisfaction has been challenging during the COVID experience, as families are dependent on calls from physicians, case managers, and nursing to help them plan for the next steps for their family member," Cunningham says.

Communication delays from any of those sources could increase a patient's length of stay as families take longer to plan for an appropriate post-acute care setting for their loved one. Not only that, but since the case manager's own communication may look different from the typical bedside visit — taking place instead by phone, FaceTime, or Zoom — it may be more challenging for the patient to be sufficiently involved in his or her own discharge plan. Cunningham explains that even patients who are not hospitalized due to COVID, but rather another reason, may not be seen in person by an RN case manager or social work case manager. This is a great concern, too, because communication is one of the most critical questions on the patient satisfaction survey.

An Impossible Goal?

In some ways, it seems that it is nearly impossible to please both the hospital administration and the patients and their families, especially in times of crisis. However, the case manager is in a unique position to bring both along — assuming they have the right tools to do so. Without the help of a wise and invested hospital case manager, the chances of a positive experience for the patient are lower, and hospital spending is more likely to be higher.

"Depending on the orientation process for the case manager, whether it is an RN case manager or a social work case manager, the leadership mentoring and support of case management staff and the sense of urgency by the entire discharge planning team, the odds are out there," Cunningham says. "If a case manager does not understand the need for a sense of urgency in discharge planning and care coordination during the hospital stay, length of stay may be impacted negatively."

Since communication is so key, especially when face-to-face interaction is limited, it is even more important for case managers to find ways to prioritize it. That also can help the hospital achieve its spending goals.

> "PATIENT SATISFACTION HAS BEEN CHALLENGING DURING THE COVID EXPERIENCE, AS FAMILIES ARE DEPENDENT ON CALLS FROM PHYSICIANS, CASE MANAGERS, AND NURSING TO HELP THEM PLAN FOR THE NEXT STEPS."

"Case management staff who delay returning phone calls to families and/or patients can also [extend] length of stay and/or [harm] patient satisfaction," Cunningham explains. "Working with a goal of prompt and complete communication with patients and/or families, as well as a sense of urgency in the care coordination and discharge planning processes, will result in a huge step to achieve both patient satisfaction and hospital spending."

Cunningham suggests several tips for the case manager who wishes to keep an eye on both priorities:

- **Look closer at avoidable days**. Tracking, reporting, and intervening in any avoidable days can help identify gaps in shortening length of stay.
- **Set complex cases apart.** A complex discharge planner, most often a social work case manager, can focus on the more complex discharge plans, leaving the unit social work case manager to focus on his or her caseload. Patients with complex discharge plans can, at times, take several hours in a case manager's day, leaving little time to focus on the other patients in his or her work.
- **Assess early and fully.** Complete the initial case management assessment on the day of admission with an appropriate and timely referral to a social worker, as needed.
- **Leading and mentoring.** Leadership in the case management department means regular rounding, with a focus on mentoring their case management team members. They also should look at their orientation program to ensure it produces best-practice staff.
- **Know patient satisfaction is not just a bonus.** With satisfaction a part of value-based reimbursement, the patient experience is important. For example, when a patient is in a hospital that allows one visitor per patient and then transfers to a skilled nursing facility that does not allow visitors, that is a huge dissatisfier for patients. Some patients have even asked to stay in the hospital longer just so they can see their visitor.

It is not a pipe dream to achieve both patient satisfaction and appropriate hospital spending, but it definitely takes intense focus and prioritization to make a healthy bottom line and a healthy, happy patient a reality. ■

Health System Nursing Students Follow Up with High-Risk Patients During Pandemic

By Melinda Young

When the COVID-19 pandemic hit California in early 2020, many regular opportunities for nursing students to gain clinical experience were put on hold. A health system devised a program that benefited both students and an elderly population followed under a population health program.[1]

"When COVID hit, we knew that students were being pulled from acute care sites," says **Eileen Haley**, MSN, RN, CNS, CCM, director of population health at UC San Diego Health. "Since they could no longer be at the hospital, I reached out to nursing education, and someone asked if we could offer a curriculum that would allow nursing students to get clinical hours to graduate on time. We worry about the long-term supply of nurses. An assembly bill passed, saying that as long as the curriculum met certain standards, they would allow us to take students and offer them this work."

In April 2020, the Board of Registered Nursing approved the health system's plan for a computer-assisted, phone-based wellness outreach program. The clinical work brought students on site five days a week, taking COVID-19 precautions.

A study revealed 93% of nursing students believed the rotation was applicable to their clinical practice. Eight-two percent reported this was their first time performing phone outreach. Also, 91% of students said they believed the experience made them more comfortable and better prepared to speak with patients on a nursing level.[1]

"We were excited," Haley says. "Students helped us reach out to patients — elder seniors who were high-risk based on their risk stratification score and the electronic health record."

Patients are admitted to this wellness program with a general risk score of 11 or higher. The scoring is the UC San Diego Health metric built into the electronic health record. It accounts for risk factors including frequent emergency department visits, age, comorbidities, and hospital utilization.

Nursing students followed a script aimed at assessing patients' social determinants of health, such as their medication supply. "Did they have food? Were they doing OK at home?" Haley says. "There were four to five questions."

The nursing students received training on population health, social determinants of health, evidence-based patient outcomes, and the importance of medication management. They also received daily education and rounding with an onsite instructor, a dedicated population health registered nurse, and social work support.

Initially, nursing students found this work challenging. "What this did was allow them to look at things through the population health lens, using telehealth and connecting with patients and listening to them," Haley says. "If they found any patients who had insecurities or barriers, those patients were escalated to our complex case management team."

The health system's complex case management program for ambulatory team-based care started in 2016 after a shift to value-based care. "When patients are discharged, they go into a black hole, and it's up to family care doctors to understand this patient population," Haley explains. "This program created the area of case management from a medical and social lens and getting primary care physicians to shift their thinking into a more holistic approach with the care plan."

The nursing students started to contact patients in April 2020. They received clinical hours for their work, which entailed one day a week, for about 10 days over a semester. A dozen students were on site each day. "We set up space that had been vacated, and it had 70 cubicles in this space," Haley says.

EXECUTIVE SUMMARY

Health systems and their case management or population health departments could benefit from providing student nurses with clinical experience opportunities, such as calling complex care patients for follow-up.

- Nursing students, following a script aimed at assessing social determinants of health, contacted the high-risk patients of UC San Diego Health.
- The students learned about population health and developed listening skills.

The students were separated due to COVID-19 distancing guidelines. Instructors also worked and trained in the space. "We make sure didactic training dovetails with the syllabus the instructors put out," Haley says.

Students documented the information they collected in patients' medical records, allowing case managers and providers to identify patterns. If a problem requires help from a social worker or someone else, the student can keep the patient on the phone and ask the social worker to join the call. For example, if a student calls a patient who expresses thoughts of potentially harming him- or herself, the student flags the instructor, who calls the social worker.

"It's a very controlled environment," she says. "The students' questions are evidence-based, and they're documented in the electronic record and statistical software so we have some data showing the value of the program."

The health system pays for the program — mostly equipment costs and instruction — through its population health department. ■

REFERENCE

1. Haley E, Harris V, Agnihotri P, et al. COVID-19: A unique opportunity for population health to align with nursing schools to help vulnerable populations at risk of adverse outcomes. *Clin J Nurs Care Pract* 2021;5:001-002.

Technology Can Help Patients with Self-Care of Pain

Similar apps could be case management tool

By Melinda Young

Patients experiencing chronic pain could improve their self-care by using a novel, digital pain management tool, according to the results of a recent study.[1]

The Manage My Pain app was part of a study that included chronic pain participants in both urban and rural pain clinics. Researchers wanted to find out if the app would help with patient care during the COVID-19 pandemic shutdown in which in-person patient visits dropped to a small percentage overnight, explains **Hance Clarke**, MD, PhD, FRCPC, staff anesthesiologist, director of pain services, and director of GoodHope Ehlers-Danlos Clinic, and medical director of the Pain Research Unit at Toronto General Hospital.

The app gave clinicians data about patients' pain levels. It proved especially useful during the pandemic when patients were unable to make regular return visits, Clarke says.

App use was voluntary. The researchers found 73.6% of participants agreed to use the app, and 63.4% used the app for at least one month. "Most apps don't make it past 20% engagement with patients, so this is very attractive to patients," Clarke notes.

The researchers also found using the app was associated with participants experiencing less pain-related anxiety and lower pain catastrophizing scores. Both pain-related anxiety and catastrophizing can lead to health problems for patients, including misuse of prescription opioids.

"I think the app, in itself, enables a sense of a release of anxiety," Clarke says. "Over time, they can see trends in terms of what is happening to them, and this leads to reduction in anxiety and rumination. One of the strongest predictors of poor outcomes are people who are high catastrophizers. Someone may ruminate significantly about almost anything, but when they perseverate about pain and can't get over pending doom and fear, it's bad."

Any tactic or technological tool that helps calm psychological symptoms, allowing patients to focus less on negative aspects of pain, likely will lead to more success.

App Helps Self-Management

Self-management is key to success, and using the app appeared to help with that goal. "You have doctors who can help you and give you [treatment], but you need to cope with the pain and live with it to have a more fulfilling life," Clarke explains. "If a tool can give someone a sense of control, then their overall psychological distress about their condition will be reduced."

Patients with chronic conditions have been struggling with mental health problems — especially during

the pandemic. "Folks were locked in their homes and told not to get out," he adds.

One of Clarke's initial goals for using the app was to collect data that could be monitored by case managers or other providers who could contact patients when they saw problematic trends in the data.

"It could be a case management tool," Clarke says. "We could [use the tool to] say, 'Let's reach out to this person and get them in for a visit.' I don't know if that's achievable, but it's something we could try."

Patients download the app and follow a brief tutorial on how to set up their profile, including entering their relevant medications and pain conditions. They learn how to enter a pain rating score from zero to 10. After entering their pain level, they are asked to provide additional information, such as details regarding pain location and characteristics.

The tool gives clinicians and providers a pain report showing the patient's pain trends over a period of weeks or months. Since patients enter their pain levels at a daily prompt by the app, the information collected likely is more accurate than self-reports every six weeks or several months.

The app shows a direct trajectory of patients' pain trends. "Getting people to engage with these types of tools [helps] with the goal of getting them back to a place that's closer to their pre-injury place," Clarke says.

The app's trend lines also can spot malingerers. If the pain trend does not fluctuate and remains at a steady, high level, then it is possible the person giving this data is not honest about their pain levels. "Most importantly, this app gives people the ability to better understand signs and symptoms and to communicate with their healthcare provider," Clarke says.

Conversations between patients and providers are richer, with more information than a few simple answers about their chronic issues, he adds. ■

REFERENCE

1. Bhatia A, Kara J, Janmohamed T, et al. User engagement and clinical impact of the Manage My Pain app in patients with chronic pain: A real-world, multi-site trial. *JMIR Mhealth Uhealth* 2021;9:e26528.

Keeping an Eye on Mental Health

By Jeni Miller

It has been reported that mental health has collectively plummeted in the wake of COVID-19.

The Centers for Disease Control and Prevention reported that nearly 20% of U.S. adults were living with a mental illness in 2019 — and that percentage shockingly doubled to 40% in 2020. For young adults in particular, the rate of suicidal thoughts rose to an alarming 25%.[1]

Since hospital case managers typically have a front-row view of what is happening in the healthcare world, they no doubt have seen these statistics firsthand.

"COVID has had a direct impact on mental health, and it has compounded things that may have already existed for some people," says **Laurie Signorelli**, DBH, LMSW, ACM, national healthcare consultant with the Center for Case Management (CFCM). "Even among people who were never troubled before, COVID-19 has left a lot of people feeling very uncertain, unsettled, and isolated, and none of those things are good for mental health. Especially for the aging and infirm populations, who may have barriers to communicating properly through masks and FaceTime, it has had a profound impact on emotional health and well-being."

According to Signorelli, the case manager's job is made increasingly more difficult as mental health concerns in patients make hospital discharges more challenging, especially at a time when discharges are needed to make space for more patients.

"Many case managers are struggling," Signorelli shares. "They want to do what's best for their patients and residents, and yet there are so many barriers to doing that, so it's inherently stressful. Not to mention, they are the people who get lashed out at by patients or families, and sometimes the hospital system itself is asking, 'We need discharges, what are you doing?' It's very challenging, many are feeling the pressure, and some can't get what they need for their patients."

Another factor is that while case managers work to serve the needs of patients, they also are experiencing the personal effects of COVID-19. "They may have been ill, or have family members or friends who have, or have suffered losses," Signorelli says. "Yet, they are still showing up and dedicated to meeting the needs of others."

Still, it is important for case managers to meet the challenge head-on and pay particular attention to rooting out the truth of patient wellness, especially concerning mental health.

Conduct Assessments and Prepare Plan

Key to helping identify and assist patients who may be suffering from mental health issues is what Signorelli calls a "comprehensive, fast, and deep assessment" of a patient. She suggests case managers look at the patient "holistically, with a practiced eye, to determine what the person truly needs for optimal success."

Case management departments are tasked with conducting these assessments under CMS rules. But, depending on the organization, these assessments can run the spectrum from light to more robust. Still, asking the right questions is important to uncovering mental health issues that might otherwise go unnoticed, and therefore untreated. It is important to include evidence-based assessments for anxiety, depression, mental health and addiction, and social determinants of health (e.g., safety, food, housing, health literacy), in addition to the more typical core functional and medical standard assessments used in healthcare settings.

"The more robust assessments do take more time up front, but they also help frontload and identify what this patient, in the context of their family and friends system, will need," Signorelli explains. "This helps care managers to be more proactive and efficient. I know many case managers can often get caught between 'get them out the door' and the optimal outcome, but there is a sweet spot. When you do that deep but quick assessment, it becomes a valuable tool that reflects what you need to do next."

Another benefit to performing early, quick assessments is the ability to then look at the patient as a whole person, and not as "just cardiac or diabetes or what have you," Signorelli says. "By understanding the mental health piece, the case manager will really be able to help reach positive outcomes."

> "THIS IS THE KIND OF THING THAT IS GOOD TO REMEMBER WHEN YOU FEEL LIKE SOMETIMES YOU DON'T HAVE TIME TO DO AN ASSESSMENT. BUT REALLY, YOU DON'T HAVE TIME NOT TO."

This is especially true for patients with mental health or substance abuse issues, as these can compound medical recovery and achievement of optimal outcomes. It is critical to understand how the patient was functioning before entering the hospital or facility to understand and attend to any barriers or challenges that need to be considered when formulating a plan.

"It could be that a patient's history of drug addiction has burned bridges for any hope of home health and help in dealing with their issues," Signorelli says. "Their options may be very different than someone not in that situation, and it's good to know that when heading into planning for discharge. This is the kind of thing that is good to remember when you feel like sometimes you don't have time to do an assessment. But really, you don't have time not to."

A clear and comprehensive discharge plan should be the robust goal of this assessment. It is important to see and involve the patient and the family or caregiver, when possible, to engage them in the plan.

Without this direct engagement, Signorelli explains, case managers "could be shocked by what you actually see [when visiting with the patient]. The patient may look very different on paper than in person."

When Beds Are Scarce

At the start of the COVID-19 crisis, when mental health issues were rampant and hospitals were quite full, the problem was made worse when no beds were available for people in need. Signorelli saw how this played out with residents in a long-term care facility who needed attention due to their mental health, but could not get help due to overwhelmed hospitals.

"We had residents who were really escalating with mental health behaviors way beyond what a nursing home would typically deal with," she explains. "They waited weeks in an ER with no bed available, only for the nursing home to be told they have to take them back because there are no beds."

These kinds of situations have been mitigated by creative approaches like telehealth, she says. The hope is that telehealth is here to stay, which is a positive as it has improved access for some people. Case managers should consider options for patients

who might not otherwise have access to care due to bed shortages or other barriers.

Resources and Data

Similarly, case managers who are attuned to mental health issues "need to have a real [understanding] about what community resources are available, and the key point people to contact," Signorelli says. Keeping those contacts and resources up to date can save time and effort later, when it matters the most.

Signorelli also encourages case managers to avoid "doing the same three and four referrals," but rather to broaden their connections with community partners. Sticking with the same referrals can lead to "missing out on something that could open up a whole world," she added.

Another benefit to connecting with community partners is the opportunity to work together to fill gaps in care options in the community. "If there are no facilities, for example, that take people with dementia with behavioral disturbances, your ER and hospital will back up with people because there is just nowhere else for them to go," Signorelli notes. "But if you can identify needs — and this is critically important — and also keep statistics on barriers and outcomes, down to granular level, you can work with community partners to develop something that doesn't yet exist. Data can tell us, 'If I send patients routinely to two home cares, and two-thirds of patients come back to the hospital from one home care and with the other only one-third are readmitted, I can more easily ask what that is.'"

Collaborating Brings Clarity

The final piece to ensuring mental health needs do not go unnoticed and unaddressed in the hospital setting is making time for nurses, physicians, social workers, and case managers, as well as other allied health professionals, to come together and address patient needs, risks, complexities, and potential options. This does not need to take long, but it is a critical component to ensuring nothing about a particular patient that will prevent a positive outcome is overlooked.

"It's a team sport, and everyone's input is important," Signorelli says. "The team should briefly go over every patient on a daily basis, if possible. It's best if they are face-to-face, or even virtual face-to-face, with a standard script to ensure they cover everything, including mental health needs."

Since mental health is such an important aspect of human life, and case managers are there during a person's most vulnerable moments, it is crucial to consider the patient as a whole person, body, and mind. Since mental health has been shown to affect physical health, it is a worthwhile practice to keep an eye on each patient's mental health status — especially during a time of crisis or pandemic, when depression and anxiety are on the rise.

"We don't only want to deal with problems or crisis, but rather support the overall health and well-being of a patient," Signorelli notes. "Sometimes, that gets lost in the shuffle, but by being attentive, encouraging people, and reinforcing their attempts at healthy habit adoption, case managers can do a lot to help."

Social work case managers in particular, due to their mental health background and ability to conduct behavioral assessments and interventions, can help patients meet their goals through addressing mental health needs and planning to support a patient's overall medical and behavioral well-being. ■

REFERENCE

1. Czeisler M, Lane RI, Petrosky E, et al. Mental health, substance use, and suicidal ideation during the COVID-19 pandemic — United States, June 24-30, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69: 1049-1057.

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Hospital at Home Model Benefits from Traditional QI Approach

By Greg Freeman

The Hospital at Home care model is gaining favor with hospitals and health systems as a way to provide hospital-level care in a patient's home while lowering costs by almost one-third and reducing complications. The approach is receiving more attention now as a way to avoid asking patients to come to the hospital during the COVID-19 pandemic.

The program was developed at the Johns Hopkins Schools of Medicine and Public Health and tested at multiple hospitals. *(More information on the model is available online at: hospitalathome.org.)*

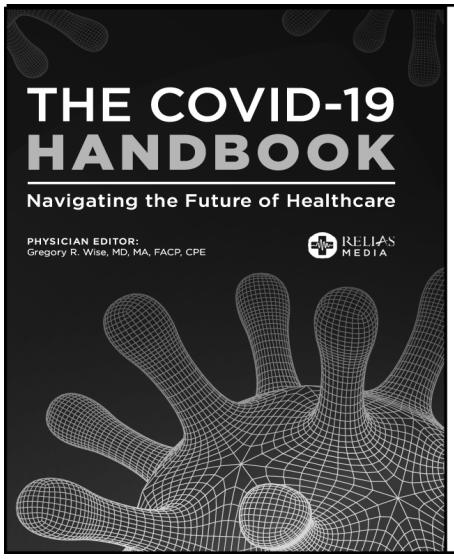
The results are promising, but where do quality improvement activities fit into this new model? The good news is the traditional tenets and goals of quality improvement remain the same with Hospital at Home, says **Summer Knight**, managing director in the life sciences and healthcare practice at Deloitte in Philadelphia. "Although in many ways novel, Hospital at Home is not so different from a virtual hospital wing, but the infrastructure is digital rather than physical steel and concrete," she says. "If quality management is done well, then QI and patient safety fits into Hospital at Home in the same way it fits into other aspects of care."

The starting point involves similar metrics that affect standards of care, such as blood clots from lack of movement and anticoagulation (e.g., DVT, hospital-acquired infections, length of stay, and mortality). Since care from Hospital at Home is connected to the hospital digitally, quality professionals can collect data throughout the care process, even to specific date/time stamps to examine timeliness of care, such as medication administration and response to events.

"Expected outcomes from a patient perspective will still be measured to assess if a problem has resolved clinically or returned to the level of functional status that was expected," Knight says. "Did you receive the attention you needed and expected when you most wanted it? Was the cost of care from your perspective, out of pocket expense and copays, what you expected? Instruments for comparing satisfaction should evolve as patients pivot from the familiar inpatient environment to the new Hospital at Home programs."

These program administrators will continue to assess clinical quality, both outcomes and process, along with service and cost. As more tech-care partnerships form to enable similar programs, and as acute care moves from inpatient settings into patients' homes, service-level agreements increasingly will carry provisions that affect QI and patient safety metrics.

"While QI professionals focus on data, the sources of the data, the speed and frequency at which it is delivered, will move to continuous feeds and then to proactive advanced analytics that can forewarn of future events. In some respects, this represents both an expansion into a new arena as well as a shift of professional capability," Knight says. "The use of these raw data to improve the delivery of care is an opportunity that has not been fully captured to date in 'standard' care." ■



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CE QUESTIONS

1. **According to the Preparedness Assessment for the Transition Home-Stroke (PATH-s) model, which is a capacity issue that could affect a caregiver's ability to handle the role with recovering and chronically ill patients transitioned home?**

   a. The caregiver's general medical knowledge
   b. The caregiver's relationship to the patient
   c. The caregiver's access to financial and other support
   d. The caregiver's literacy level

2. **Which is one of the most critical items on the patient satisfaction survey?**

   a. Meal quality
   b. Communication
   c. Discharge plan
   d. Visitor policy

3. **Nursing students provided phone follow-up with at-risk patients, following a script that included asking patients:**

   a. "When were you discharged, and which medications are new?"
   b. "Do you have enough food?"
   c. "Do you understand your disease?"
   d. "Have you exercised today?"

4. **In 2020, reports showed which percentage of adults were living with mental illness?**

   a. 9%
   b. 20%
   c. 25%
   d. 40%

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.