HOSPITAL CASE MANAGEMENT

COVERING CASE MANAGEMENT ACROSS THE CARE CONTINUUM

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Hospitals and Case Managers Improve Care Transitions for COVID-19 Patients

Efficiency is a goal

By Melinda Young

After 18 months of the COVID-19 pandemic, hospitals are learning how to efficiently and safely transition these patients to community settings.

For example, one study showed an emergency department (ED) and hospital patient throughput management program can save hundreds of hospital patient days after discharge from the ED or observation unit stays.[1]

ONE STUDY SHOWED AN ED AND HOSPITAL PATIENT THROUGHPUT MANAGEMENT PROGRAM CAN SAVE HUNDREDS OF HOSPITAL PATIENT DAYS AFTER DISCHARGE.

Hospitals were in a much better position to handle COVID-19 patients by the spring of 2021, says **Jennifer Puzziferro**, DNP, CCM, RN-BC, corporate vice president for case management at RWJ Barnabas Health in West Orange, NJ.

"In the spring of 2020, we had hospitals exceeding capacity for COVID-19 patients," she says. "We had to provide a care transition program. I had patients here I thought I could send home if we had a way to take care of them."

Puzziferro contacted the director of patient care services and suggested they create a program using case managers to

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monitor patients in a home setting. Eligible patients were required to line up a caregiver, own a smartphone, and use an app called Health Connect that was developed internally.

"Ambulatory case managers were responsible for patient care in the home," she says. "A nurse would contact patients until the physician would say they were medically clear."

The patients also had to meet clinical criteria. They were sent home with a pulse oximeter and an oxygen tank, Puzziferro says. The tanks were delivered by a vendor partner who would go to the home, pick up the tank, clean it, and recycle it after the patient no longer needed it.

The intensive transitional care management intervention helps the hospital optimize bed capacity. It prevents inpatient admissions by discharging patients and providing them with in-home medical support and telehealth care management.[1]

In a retrospective study of five hospitals, researchers found ED providers can screen COVID-19 patients for risk factors that might require a stay of more than 48 hours. Long-stay patients were much more likely to be older than 60 years of age, have diabetes, chronic kidney disease, and ED vital sign abnormalities.[2]

"Our main study findings were that more patients than we expected were hospitalized or needed to be for a short period of time with COVID-19," says **Austin Kilaru**, MD, MSHP, assistant professor of emergency medicine at the University of Pennsylvania. "We thought that people needed hospitalization for COVID-19 or to stay in the ICU setting for days to weeks, but found that a significant portion of people who needed to be hospitalized did get better quickly, and were discharged within 48 hours. We were trying to identify who those people might be based on the information available at admission into the hospital."

Researchers found several risk factors for a short- or long-term

EDITOR'S NOTE

At Relias Media, we are always striving to find new and innovative ways to keep you up-to-date with the latest medical information and continuing education in your field. We are excited to announce that *Hospital Case Management* will now be expanded to include content from *Case Management Advisor*, bringing you even more relevant content and continuing education at no additional cost. Starting with this issue, you can earn 2 CE contact hours per issue and 1.5 CCMC hours — .5 more than before — plus information on a wide variety of topics, including:

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hospital stay. "I thought one thing that was interesting and surprising was that patients with abnormal vital signs generally tended to be less likely to discharge within 48 hours," he says.

Abnormal vital signs included low oxygen levels, tachycardia, fast breathing, and fever. "One criticism would be if a patient had normal vital signs in the emergency department, why did they even need to be admitted at all?" Kilaru asks. "That was actually important; we were identifying that patients could, on paper, look stable for discharge but for one reason or another they were perceived to still need some time in the hospital to make sure they were improving."

Those patients might include people who were throwing up or showed subjective symptoms of troubled breathing, were elderly, or underwent previous transplants but still showed normal vital signs, he adds.

For the COVID-19 patient discharge process at RWJ Barnabas Health, case managers identified patients appropriate for discharge, Puzziferro says.

"We were able to create a truly solid connection between the inpatient case management team, which I have responsibility for, and ambulatory care providers," she says. "Hospital case managers would hand off patients to a nurse in an ambulatory setting, where they were able to connect with patients and make sure they had the care they needed."

During the acute management phase, hospital case managers would monitor patients until they were deemed stable. "If they had primary care providers in the community, we arranged for post-discharge to the primary care provider. If they didn't, we would take care of them with post-discharge services, taking them on as a patient," she explains.

The long-term effects of COVID-19 remain unknown. Case managers have learned to ask patients early about their primary care providers, Puzziferro says. The case management plan is to provide better continuity from the hospital to community, even during times of crisis.

"We need to make sure patients are receiving care consistently. It's really important that we move to being more proactive than reactive in our care delivery system," she explains.

A first step in safely transitioning COVID-19 patients home is to create a chart for the patient receiving telehealth visits and other case management services. This might include using a call center.

"The case manager asks if they have a primary care provider. If so, we document that and let the access center know," Puzziferro says. "We see the patient in the acute stage of COVID-19 and then transition them back home."

If a patient has not scheduled a telehealth visit with a primary care provider, the call center would contact the patient and ask if they would like to continue care through the health system.

"A nurse case manager contacts COVID-19 patients from the ED or inpatient setting and makes sure everything arrives as it should when patients return home," Puzziferro says. "The case manager asks whether they have a pulse oximeter, what are their signs and symptoms, and gives basic instructions for if they need to go back to the ED."

Through telehealth, physicians could see the patients daily as needed. Nurses also call the patients for follow-up, making sure they understand the discharge instructions and asking if they are feeling short of breath.

"If the patient is showing signs and symptoms of exacerbation, the nurse could facilitate a follow-up appointment with the provider so the patient would not have to go to the ED unless absolutely necessary," Puzziferro says.

This type of care transition that provides telehealth, follow-up case management, nursing calls, and additional resources could work for other chronic illnesses besides COVID-19. But it could require bundled payment or shared savings plans to cover the cost.

"Our physician group learned they're very good at doing telehealth and that it is a great option, so they're doing that now as standard work," she says. "Patients can access a telehealth visit at any time in lieu of ED or urgent care visits. It's a great option for patients."

Plan for Future Patient Surges

The COVID-19 crisis will not be the last time hospitals experience surges that overload beds and capacity. When this happens, they need plans in place to better predict which patients can be safely discharged and which need the beds.

Kilaru's study helps clarify this issue. "The goal of the study was to show there are certain risk factors to predict early release," he says.

The underlying concept is that some patients can be discharged early during a public health crisis. But it has to be a collaborative effort with case management, the ED, and physicians, Kilaru says.

"We need to identify those

patients as quickly as possible," he adds. "If there was some other public health emergency, we would want to develop these short-stay pathways quickly and adopt them to make sure the patients are safe, but we can also conserve greater hospital capacity."

The pandemic created many challenges for health systems and case managers, but it also created opportunities for hospital case managers to think about care outside the walls of the hospital, Puzziferro notes.

"It was an unfortunate experience, but it was a great opportunity. We realized we have a very strong infrastructure in case management, and it's something we want to grow and evolve," she adds. "The length of stay and discharge planning have always been the focus, but ensuring patients are connected to the most cost-effective, high-quality care means we want to make sure patients are getting everything they need in the community." ■

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COVID Watch Text Program Enhances Case Management and Monitoring of Patients

New system covered 17,000 patients

By Melinda Young

When the COVID-19 pandemic began, health systems had to come up with new strategies for handling an influx of patients with the disease. One solution is to use technology to extend the reach and monitor discharged COVID-19 patients more efficiently.

The University of Pennsylvania created the COVID Watch text messaging program to follow up with patients on their symptoms, says **Austin Kilaru**, MD, MSHP, assistant professor of emergency medicine at the University of Pennsylvania.

"Patients receive twice-daily automated text messages, asking them if their symptoms today are the same, improved, or worse," he explains. "If it's worse, the technology [sends] separate questions asking for additional details."

EXECUTIVE SUMMARY

The University of Pennsylvania's new texting program, called COVID Watch, could play a key role in the future of monitoring COVID-19 patients after discharge.

- The program sends automated text messages in English and Spanish twice a day for 14 days, asking patients if their symptoms are better, the same, or worse.
- Case managers and nurses determine who is eligible for COVID Watch, enroll patients, and teach them how to use the program.
- The program could enhance case management in the future by expanding to monitor patients with chronic illnesses such as diabetes, hypertension, or heart failure.

One example of a COVID Watch question is, "Is it harder than usual for you to breathe? Reply Y or N."[1]

"COVID Watch [was] developed at the beginning of the pandemic when we realized hospital systems may potentially become overwhelmed with patients, and they needed a triage system," says **Anna U. Morgan**, MD, MSc, MSHP, assistant professor of clinical medicine, medical director of COVID Watch, and director of care management and community health at Penn.

In the early days of the pandemic, COVID-19 testing was lagging. The health system often enrolled patients based on clinical suspicion of COVID-19.

"We usually had about 1,000 patients at a time in peak enrollment, and it was managed by six or seven RNs at a time," Morgan explains. "So far, there have been more than 17,000 patients enrolled in COVID Watch."

COVID Watch also spawned companion programs, including

Pregnancy Watch, which monitors pregnant patients with COVID-19, and COVID Pulse, which enrolls COVID-19 patients from the emergency department (ED) with depressed oxygen saturations and who will need pulse oximeters.

This is how COVID Watch works:

• **Create texting program.** "The program is run through a software platform," Kilaru says. "We had the existing infrastructure to do it."

The health system already used technology called Breathe Better Together, which was developed at Penn for patients with COPD. "That was the foundation on which we built this program," Morgan says.

Breathe Better Together is one of the reasons they built COVID Watch in two weeks.

• **Screen patients.** Case managers or providers offer the program to Penn Medicine patients who have presumed or confirmed COVID-19 infection after they are seen in an outpatient setting or are discharged from the ED or hospital. Patients who can self-monitor from home qualify for COVID Watch.

"They can be enrolled by outpatient providers if they get a positive test after an emergency department discharge," Morgan adds.

• **Send automated messages.** COVID Watch enrollees receive two text messages a day in English or Spanish for 14 days.

"The messages ask them how their breathing is. If they report any difficulty in breathing, they're asked if they want to speak with a nurse," Morgan explains. "If they say yes, then that call is escalated to a nursing team or an advanced practice provider."

The texting service is available 24/7, and the nursing team calls patients back within one hour. The nurse assesses the patient's breathing and tells him or her to go to the ED if needed.

"Sometimes, they'll book them an appointment at the telehealth clinic, or just have them stay home," Morgan adds. "The patients are enrolled for 14 days, and they have the option to end it early if they're feeling better, or extend it to 21 days if they like."

• **Enhance case management.** This type of patient monitoring could be expanded to populations with chronic illnesses, such as diabetes, hypertension, or heart failure, Morgan suggests. The technology could enhance care transitions as patients go from the hospital to home and to primary care providers.

"We want to use these text messaging programs to ease that transition," Morgan explains. "There could be a lot of future applications."

One benefit of the technology is that it is simple to use and efficient, she notes. For instance, seven nurses could watch 1,000 patients simultaneously.

"It is an SMS technology, which is really widely used. It doesn't require an app because it is a text message going back and forth," Morgan says. "A key reason why it is successful is because the program is pretty easy to use, even if they don't have smartphones."

Obtaining patient buy-in is important. "Case managers are instrumental in enrolling patients for this," Kilaru says. "They figure out who is eligible and who is technologically savvy. They get older patients to learn how to use COVID Watch, or else they enroll them in home health."

COVID Watch has helped case managers ensure every patient received what they needed. It was part of the discharge planning for COVID-19 patients, he adds. ■

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Medicare's Bundled Payment Program Could Improve Cost Calculations

By Melinda Young

The way Medicare determines healthcare spending under its Bundled Payment Program could be improved with a different approach, a new study revealed.[1]

"This study suggests a health system should be aware of how statistical issues play into the target prices they are offered under bundled payment plans, and they should study closely how bundled payment prices are calculated," says **Benjamin Cher**, MS, MD candidate class of 2022 at the University of Michigan Medical School. "They should look at how they may be calculated in the future, which could change their decisions on whether to participate in these programs and how to structure their responses to these programs."

Research like this study suggests ways health systems can more effectively and efficiently use their case managers and other resources. For instance, case managers play a tremendous role in reducing inappropriate spending that leads to a financial loss for hospitals under the bundled payment plan.

Bundled Payments for Care Improvement Advanced (BPCI Advanced) uses a traditional methodology formulated by CMS. Researchers compared this methodology to an empirical Bayes approach, which is designed to mitigate the effects of regression to the mean.[1]

Under BPCI Advanced, providers are paid a certain amount per patient that is supposed to encompass all care for a specific procedure. "The amount of money that providers are paid is the target price. One of the challenges in the bundled payment program is figuring out how to calculate an accurate target price," Cher says.

This is especially challenging when the program is voluntary. If the target price offered is high, many providers will join the program. But if the target price is too low, fewer providers will join the program.

"It's kind of like a Goldilocks problem, where too high is a problem and too-low target prices are a problem as well," Cher says. "The goal of this study is to determine a way to solve that Goldilocks problem by calculating target prices as accurately as possible."

Cher has seen firsthand how hospitals could benefit from extra resources up front to provide higher-quality care to patients and cut costs.

"As a medical student, I have had the opportunity to see many cases in the hospital where patients were readmitted or required extra expenses in hospital services because the hospital did not provide the patients with enough upfront resources for care to help them avoid future costly health needs," Cher explains. "As someone interested in health policy, I am excited about bundled payment plans because I can see them having direct implications both for addressing healthcare costs and for improving patient outcomes."

CMS was the study's primary audience, but it also is important for providers to know the current bundled payment system is not as efficient as it should be, Cher notes. CMS may consider adopting a different method that will close current funding loopholes.

"Perhaps health systems need to reconsider in the future how they're going to participate in these bundled payment programs, knowing that CMS may have incentives to change its method of calculating target prices," Cher says. ■

EXECUTIVE SUMMARY

A new study suggests Medicare spending on healthcare in its Bundled Payment Program could be improved by calculating target prices as accurately as possible.

- Case management and other resources could become more effective and efficient.
- Researchers compared Bundled Payments for Care Improvement Advanced program to an empirical Bayes approach in how accurately each determines target prices.
- Using bundled payment plans could provide hospitals with extra resources up front and reduce patient costs for extra healthcare services, thus providing a higher quality of care.

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Caregivers Play Expanded Role in Case Management

By Melinda Young

As the influence of value-based care increases, healthcare providers are learning that training and supporting family caregivers is crucial to patients maintaining optimal health.[1]

Recent evidence suggests the United States is facing a growing deficit of caregivers. As the need for this community support grows, there are not enough people to provide that care. As baby boomers age, the pool of caregivers will shrink.[1-3]

The results of a new study show providers can train family caregivers of patients with cancer by using a simulation-based intervention for care.[4]

"Family caregivers of individuals with cancer are essential to the caregiving team for the patient," says **Susan Mazanec**, PhD, RN, AOCN, FAAN, assistant professor at Frances Payne Bolton School of Nursing at Case Western Reserve University in Cleveland and nurse scientist at University Hospitals Seidman Cancer Center. "As cancer treatment is becoming more complex and is delivered increasingly on an outpatient basis, the family caregivers are being asked to assume more and more responsibilities for care."

As caregivers become increasingly important members of the cancer care team, they are asked to take on more responsibilities, says **Sara Douglas**, PhD, RN, Gertrude Perkins Oliva professor in oncology nursing and assistant dean for research at Case Western Reserve University.

"Caregivers are, at times, asked to provide physical care, but they are also important in providing emotional support throughout the trajectory of the illness," Douglas says. "Research is demonstrating that providing caregivers with information, skills, and emotional support leads to increased confidence by caregivers in the variety of aspects of care and support that they provide."

Increased confidence improves caregivers' psychological outcomes and can increase quality of care for patients. For instance, patients with dementia visit the ED less often when their caregivers demonstrate greater efficacy and confidence and less depression.[5]

"It is vital for healthcare providers to ensure family caregivers have the information, education, and emotional support they need to enhance their confidence and ability to provide support and care to their loved ones with cancer," Douglas says.

EXECUTIVE SUMMARY

Family caregivers need better training and support. This is especially important since the United States is facing a growing deficit of caregivers.

- As cancer treatment becomes more complex, family caregivers are called on to assume more responsibilities of care.
- Research shows patients experience better outcomes if their caregivers are more confident.
- Case managers can link caregivers to further education and training.

Caregivers Might Feel Unprepared

Family caregivers help patients with basic activities of daily living, such as dressing and bathing. They often are responsible for communicating with the healthcare team and other family members about the patient's progress. They also can function as an advocate for the patient.

"They may be asked to monitor for signs and symptoms in terms of toxicities from cancer treatments," Mazanec says.

Family caregivers might be asked to help with tube feeding, monitoring for infection, and assessing patients' skin and helping them manage a dressing or a tube.

"What is astonishing in this report is that about 43% of those caregivers performing those tasks felt they were doing it with very little preparation," Mazanec says.[1] "Cancer caregivers are reporting unmet caring needs. They weren't being trained as fast as they needed."

Case managers and other providers can help train caregivers. Researchers are studying a simulation-based intervention for efficacy.[4]

"This study is in progress and is not complete," Mazanec says. "We are testing the efficacy of this intervention as compared to usual care." The study intervention suggests tactics for enhancing caregiver training.

Case managers can help link caregivers to further education and training, or send them back to the clinical team for more intensive training. Ideally, case managers or nurses will conduct a caregiver assessment at the beginning of the patient's care. This provides a better understanding of the relationship between the recipient and caregiver, as well as the caregiver's ability and confidence.

"Recognizing caregiver distress, anxiety, and acknowledging the caregiver and the role that they play is important," Mazanec adds.

Case managers should understand the relationship between the caregiver and the patient. If the caregiver is feeling distress or anxiety in this personal relationship, it can manifest itself in the patient's mood as well, Mazanec notes.

"What some studies have shown is that if we're helping the caregiver, we can also improve patient outcomes, particularly related to pain and symptom management," she says. "That's really why this is important; it goes beyond the caregiver, and we can impact patient outcomes."

As cancer is increasingly seen as a chronic illness, the caregivers' role is becoming more important than ever for the healthcare community. "Caregivers are expected to provide services and support that were [delivered] by healthcare providers in the past," Douglas explains. "The delivery of healthcare services to cancer patients has become more complex over the years with the advent of new therapies and increased numbers of persons diagnosed with cancer each year."

If the United States healthcare system's goal is to provide the most holistic care for persons with cancer, it will have to rely on caregivers to continue to play a vital role in the delivery of high-quality care, Douglas adds.

Researchers note numerous support people are taking care of patients and family caregivers during cancer treatment. These include case managers, nurses, social workers, dietitians, and spiritual care providers.[1]

"So often they're mostly focused on the patient," Mazanec says. "We are trying to test this intervention as an addition to that usual care to see if it's effective."

Data and research suggest healthcare professionals need to recognize and engage caregivers as members of the team. "Ask them about their experiences and challenges," Mazanec explains. "We also need to screen for caregiver distress."

Case managers and other providers also should assess caregivers' needs and find out what is burdensome to them. "We just have to offer support," Mazanec says. "We need to listen to them and tell them that they are doing as good a job as they can, and we need to offer them training."

Caregiver training should occur throughout a patient's disease trajectory because the caregiver's needs will change as the patient moves through their cancer or other disease experience.

"We also need to remember that there are services in many communities to help caregivers and we need to let them know about those services," Mazanec adds. ■

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Simulation-Based Intervention Trains Home Caregivers

By Melinda Young

The results of a new study suggest the use of a psychoeducational interventional training model can improve education for family caregivers of patients with cancer. The training program uses simulation to enhance skills training.[1]

"Simulation is a form of experiential learning, and it's how we train nurses and doctors in some skills," says **Susan Mazanec**, PhD, RN, AOCN, FAAN, assistant professor with Frances Payne Bolton School of Nursing at Case Western Reserve University in Cleveland and nurse scientist at University Hospitals Seidman Cancer Center. "Most often, we use high-fidelity mannequins to [simulate] cardiac arrest, and then the team of nurses and doctors work together to practice their skills in a very safe environment." Case Western Reserve University uses an entire simulation center, she notes.

Simulation training for caregivers includes these three components:

• The training takes place during the patient's radiation treatment. The key point of the intervention is to support and train the caregiver in real time while the patient is undergoing treatment and experiencing problems.

• Simulation is solely focused on the primary caregiver, not the patient. The patient is not present, and the caregiver could be a family member, neighbor, friend, or someone else. They are whomever the patient identifies as the primary caregiver, Mazanec says.

THE KEY POINT OF THE INTERVENTION IS TO SUPPORT AND TRAIN THE CAREGIVER IN REAL TIME WHILE THE PATIENT IS UNDERGOING TREATMENT.

• The training occurs during the first week of treatment when the caregiver meets with the nurse interventionist. Two other telemeetings are held during treatment.

In the first sessions with caregivers, nurses present an overview of what patients experience. This is to proactively prepare caregivers for what is to come.

"Each session with caregivers follows the same format, beginning by assessing the stress that the caregiver is feeling and what their immediate needs and concerns are," Mazanec says. "Then, we provide education about the theme of the session. There is simulation with mannequins and various devices."

For example, caregivers learn through simulation how to perform a tube feeding for patients with a gastrostomy or tracheostomy tube.

"We will go over with a very structured protocol the basic care of a tube," Mazanec explains. "We also teach them how to do a skin assessment of the area being treated, and how to do an oral exam to monitor for mucositis."

Another type of simulation involves roleplay in which case managers or nurses can teach caregivers communication skills.

"Each session has a theme," Mazanec notes. "The second session's theme is the caregiver's experience, including the common issues and concerns of caregivers."

At the end of the patient's treatment, nurses and case managers prepare the patient and caregiver for the transition to post-treatment survivorship. ■

EXECUTIVE SUMMARY

Simulation-based interventional training can be used to better prepare primary caregivers for supporting patients with cancer and other chronic diseases.

- Simulation has been used at Case Western Reserve University to train nurses and doctors in skills like treating cardiac arrest.
- The simulation intervention occurs in the first week of radiation treatment and focuses on the primary caregiver, not the patient.
- When the sessions and patient's treatments are finished, case managers and nurses help prepare for post-treatment survivorship.

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Case Management Collaboration with Other Service Providers Needed

By Melinda Young

HIV case managers have worked with fewer resources in recent years. This suggests they could best help their patients if they collaborate with other service providers.

The results of a new study suggest case managers and other providers need greater awareness of each other's expertise and understanding of the communities they serve. This allows them to collaborate with other agencies in making referrals and developing programs.[1]

"Organizations need to reassure case managers that while doing interprofessional collaboration they're not losing clients," says **Rahbel Rahman**, PhD, LMSW, assistant professor in the Graduate School of Social Work at Fordham University in New York City. "We need to reconceptualize how we define outcomes and how we define provider success. It could be that sometimes in budget constraints you may feel a little fearful about making referrals."

For example, a client might visit one agency and case manager for HIV clinical services. A second agency offers clinical services and mental health services. "I might feel like I don't have mental health services in my agency, so I make a referral to the second agency," Rahman says. "I would be afraid about making the right referral and wondering if they would take away my client because they have both services."

Is it better not to send the client to two different agencies? "These are questions that are important in how we define success," Rahman says. "How are we accountable to our funders when we talk about collective ownership and interprofessional collaboration?"

The case manager's role is to ensure clients receive comprehensive services. They also have to think about organizational culture and how their collaborations and referrals might affect their own organization's fiscal health. "The work of a case manager cannot be done in a silo," Rahman says.

IPC Best Practices

Researchers studied best practices for interprofessional collaboration (IPC). They surveyed 112 case managers, 80 peer educators, and 75 counselors in New York City. They asked for demographic information, and assessed their knowledge, skills, and self-efficacy, as well as their understanding of the community.[1]

All the professionals interviewed worked in 36 agencies in New York that offered HIV prevention services or clinical services. "These case managers are offering services to those who are at risk for HIV or need any assistance regarding linkages to HIV and social services," Rahman says.

Researchers assessed whether case managers, counselors, and peer educators were confident in their ability to make referrals. "We asked about their opinions and experiences with intercollaboration in HIV care," Rahman says.

They looked at five domains of IPC. These included interdependence, professional activities, flexibility, collective ownership of goals, and reflection on process. The researchers found most case managers were Black and women. Also, a large portion of them had held the position for less than one year.

"Most of the counselors were social workers or mental health counselors and had professional licensure," Rahman says. "Most of our providers, overall, said they had received formal HIV prevention training."

The mean age of the providers was 40 years. About half the case managers had a bachelor's degree. Thirty-five percent of counselors held a master's degree, and 35% of peer educators earned a high school diploma or GED. Researchers found significant predictors of IPC included knowledge, skills, competence, and understanding of the community.

"Our study warns about the need for greater training and supervision to ensure providers are able to go beyond stipulated ability and resolve conflicts," Rahman says. "These jobs warrant interprofessional collaboration to integrate services. Providers need confidence, and that can only be given in terms of assuring them of what they can and cannot do. This happens through training."

Although this study was conducted before the COVID-19 pandemic, its findings were extremely important to the major disruption of preventive clinical and social services during the pandemic, she says.

"Imagine what is happening in the pandemic when providers may not be exclusively having in-person visits right now," Rahman notes. "Think about how referrals were affected when so many providers were laid

off because of budget shortfalls and constraints in different agencies. That's what we are seeing."

Providers were working virtually, under extremely tight budgets. "When we conducted the study, we saw that the Centers for Disease Control and Prevention started to de-emphasize the implementation of behavioral interventions, creating budget constraints," Rahman explains. "Providers would say 'I don't want to give my referral to another agency,' not realizing they're offering a continuum of care."

Providers should make a concerted effort in this environment to reinforce and demonstrate greater leadership. Providers and case managers need to collaborate interprofessionally and make effective referrals.

"It's not to think in terms of losing clients, because the agency's effectiveness is influenced by the clients they serve," Rahman says. "We need to think about how to redefine ownership when talking about collective ownership and how to redefine measurements of our collective success." ■

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Dual-Eligible Medicare Advantage Plans Can Reduce Hospital Admissions

By Melinda Young

As U.S. healthcare providers shift to value-based care, they need to keep up with various governmental funding plans that could increase options for patients.

For example, some states create opportunities for dual-eligible beneficiaries to join Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs) and Medicaid plans operated by the same insurer. Researchers suggest these plans can decrease inpatient admissions and nursing home admissions.[1]

"These are a unique type of Medicare Advantage plans that exclusively enroll dual-eligible beneficiaries," says **Laura M. Keohane**, PhD, assistant professor of health policy at Vanderbilt University School of Medicine. "They are low-income Medicare beneficiaries who have Medicare as their primary source of insurance for services like hospitalizations. Medicaid is their secondary source of insurance for helping with out-of-pocket costs and extra services that aren't covered by Medicare. These include long-term care services and support."

For example, a patient might stay in the hospital for three days. Medicare would pick up coverage for the rehabilitation stay under the Medicare Skilled Nursing Facility Benefits for up to 100 days, Keohane says.

"If the person stays in the nursing home and is a dual-eligible beneficiary, Medicaid becomes the insurer of the long-term stay at the nursing home," she explains. "Dual-eligible beneficiaries can either be in traditional Medicare, where your benefits are administered by the medical federal program directly, or they can be in Medicare Advantage, where they get their benefits through a managed care plan."

Case managers should know of this option for their dual-eligible clients. These types of plans can help enhance case management.

"Some D-SNPs may hire care coordinators directly in the plan to help oversee organization of benefits across different providers," Keohane says. Also, case managers who are familiar with dual-eligible beneficiaries and plans could recommend this program to some of their older patients.

Researchers studying dual-eligible plans found that few enrollees who live in nursing homes were using these plans, even though that population could benefit from such plans.[1]

Some Medicare Advantage plan limitations include extra premiums that could vary across states. Some plans include opt-in coverage that makes it difficult to reach nursing home populations, Keohane explains. Most states require beneficiaries of these plans to have an income level between 75% to 100% of the federal poverty level.

"If you have income above that level but have high nursing home expenses, you can qualify for Medicaid based on your income after you pay out of pocket for nursing home expenses," she explains.

Right now, 11 states are using the D-SNP and Medicaid plans, covering approximately 690,000 people.[1]

"For most beneficiaries, it probably would not involve extra premium costs to be in one of these

dual-eligible plans," Keohane says. "It might have some extra benefits they couldn't get through traditional Medicare or Medicaid, like limited access to dental care." ■

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Making the Most of Multidisciplinary Rounds

By Jeni Miller

Communication is one of the most important aspects of the healthcare experience. This is true for the patient, but it also holds for the staff. The better the communication, the smoother the process — and the more lacking the communication, the more frustrating the process.

Multidisciplinary rounds (also called interdisciplinary rounds at some organizations) should center on positive communications that keep processes running smoothly.

"The purpose of rounds is to be with the different disciplines — including case management, respiratory, physical therapy, nursing, physicians — to discuss the plan of care and ensure that everyone is on the same page," explains **Jill Rogers**, vice president of performance improvement for Kaufman Hall.

During this time of collaboration — which is most effective when it takes place every morning for every patient — providers meet to talk through the patient's plan, anticipated discharge date, and any barriers.

"Without rounds, case management is busy working on discharge planning while nursing is caring for the patient, both likely with different ideas on the patient's plan of care," Rogers explains. "In the meantime, the family may be getting mixed messages, which makes it difficult for them to coordinate their lives to plan for the discharge of their family member."

When rounds are conducted well, everyone has a chance to see the big picture at least once a day. "We've become very task-oriented in nursing with all of the documentation, and sometimes we're not looking at the big picture of a medical plan," she says. "During multidisciplinary rounds, everyone has something different to contribute."

Rogers shares an example of what could happen without that daily communication: "The case manager may talk to the patient and family and find that the patient was independent at home, so the plan is set for them to go back home. But if they don't see that patient every day or there is little to no daily communication with nursing, a change in the patient's condition may arise that the case manager is not aware of. There may be a plan for the patient to go home — but just before discharge, nursing says that they tried to get the patient out of bed but it took two nurses and physical therapy was just consulted. Now, you have to look at finding a skilled nursing facility at the last minute (which may require an insurance authorization). If there were multidisciplinary rounds, collaborative communication would be ongoing, and these surprises would be minimized or averted altogether."

Situations like this might seem minor, but they can easily add on a day to a day and a half to a patient's length of stay. For patients and their families, even hours added on to the stay can cause dissatisfaction.

"We may have the best-laid discharge plans, but if the case manager doesn't know the events that happened overnight, such as a patient fall or change in their medical condition, the discharge plan can be completely disrupted," Rogers explains.

Sometimes, nothing has changed for the patient, but a roadblock arises. For example, a patient might need a central or PICC line inserted to be discharged with IV antibiotics, but they are bumped off the schedule. This is the only piece holding up the patient's discharge. Knowing about this early enough gives the care team some flexibility.

"If barriers are communicated with the multidisciplinary team early in the day, we can ask, 'Can we get into the schedule?'" Rogers says. "Normally, we can work those types of barriers out because everyone understands the urgency of getting patients discharged on time, especially if there are patients in the ED on gurneys. If the patient just needs a line or something gets missed, sometimes we have a chance to get those things worked out, especially when in communication with the physician."

One of the biggest advantages to rounds is the increase in the ever-important communication and collaboration of the care team — but only if managed right.

Rogers reiterates that for multidisciplinary rounds to be worth the time and effort, they need to be performed well. That means rounds should be scripted, focused, and timely.

"Following a script helps keep everyone on track and prevents the team from forgetting to discuss the basics," she explains. "You need a quality control process put into place to monitor the rounds from time to time to make sure the team is on script and the purpose and outcome is what you're working to achieve."

Rogers suggests "sustain[ing] the rounds in the manner in which they were implemented or intended to be" and preparing a script for what the team should cover in as brief a time as possible. The script should normally include questions such as:

- Is the patient eating?
- Is the patient ambulatory?
- Is the patient at baseline function?
- Is the patient's bowel function normal?
- Is the patient still on track for a certain discharge date?

According to Rogers, staying on script is one way to keep on task during the rounds and ensure pertinent information is not falling through the cracks. Similarly, the talk should focus on patients for the full amount of time, ensuring no conversation becomes too lengthy or goes off-topic.

"If we're just getting together to chat and we're not focused, the rounds just get really long and we're getting into a conversation that needs to be taken offline," says Rogers. "The team needs to stay on track so that attendees can get back to work. The round leadership needs to steer the conversation back on track. Ultimately, if the rounds start to take too long or aren't focused, people will stop coming to them."

Another way to help the team stay on task is to designate someone to assign action items and follow-up. This helps avoid wasting time discussing something that has already been managed or completed.

"You must have a way to close the loop to ensure that the action items you talked about today actually get done," Rogers says. "You don't want to be talking about the same thing the next day. If the team leadership can quickly touch base in the afternoon, it can prevent situations like, 'Oh, the order didn't get put in for the COVID test that we need before discharging to skilled nursing, so the patient will have to be discharged tomorrow instead of this afternoon.'"

Staying focused during rounds also helps prevent the unnecessary "extras" that sometimes happen during an inpatient admission. Rogers describes how a patient who might be due or overdue for a test or procedure, like a colonoscopy, might end up getting scheduled for it because they're "in the hospital anyway." She noted rounds often help providers avoid adding these extras that can be performed on an outpatient basis rather than lengthening the stay. Focusing on why a particular patient is in the hospital, and discussing that with the interdisciplinary team, can keep patients on track for discharge.

Timely Discussion

Since the discharge process often begins the day of admission, it makes sense that barriers and psychosocial issues would be included in the discussion on day one, rather than the day of discharge.

As for the rounds themselves, keeping these short and to the point makes it more likely that everyone will be motivated to attend. Beginning rounds earlier in the morning, closer to 8 a.m., is best practice to stay on schedule and be ready for any last-minute challenges.

"Once you start getting toward 11:30 a.m. or later, it can be difficult to get anything done to expedite getting that patient discharged, like checking a lab one more time," Rogers says. "It's quite difficult to complete those tasks if rounds are late in the afternoon. There's just not enough time."

To encourage other disciplines to attend rounds, it is important that meetings are succinct and quick — perhaps one to two minutes per patient, maximum — so everyone can get back to work. With 20 patients on a unit, it should be possible to complete rounds within about 30 minutes since patients who are going to be discharged will not require a full discussion.

The Tangible Benefits

The benefits of multidisciplinary rounds do not end with improved communication and collaboration. The real, tangible results include shorter length of stay, greater patient and family satisfaction, and consistency of care. In some cases, hospital readmissions are reduced. In almost all cases, this results in a smoother discharge process.

"Rounds allow everyone to better plan for the discharge," Rogers shares. "It allows the family time to go out and look at facilities and decide where they really want to have their loved one in skilled nursing. Or, it can help them coordinate work schedules for pickup at the hospital."

Rogers also notes multidisciplinary rounds can bring patients and their families up to date on the care plan. If communication is clear and

consistent, there is less chance of confusion.

Likewise, excellent communication with the attending physician ensures the case management team is familiar with the care plan. Since case management's role is not to create the plan, but to help remove implementation barriers, it is imperative to set aside time for this discussion.

"From an insurance perspective, having a discharge plan and discussing it with the physician helps case managers behind the scenes, especially when insurance may affect the care plan, what's covered, and more," Rogers says. "Better decisions can be made once we have determined the patient's level of functioning and the physician has given the plan. Then, we can start having conversations with the patient that consider what insurance is going to pay for. It might affect where they go for six weeks of antibiotics treatment, for example, or we might decide it is better for them to go home to handle the antibiotics themselves or have a family member do it."

When case managers are trying to plan their day and make the most of their hours, meetings might not top the to-do list. However, case managers cannot afford not to round, precisely because rounds help them prioritize their day and determine the next best step.

"Sometimes we ask, 'Where do I begin when I have a lot of patients?'" she says. "As we're talking through a medical plan and discussing patients, it becomes clear who and how we can discharge in the next 24 to 48 hours. Then, we can prioritize those patients who are getting close to discharge. This can help even when we're completely overwhelmed, or people are out and the department is figuring out how to prioritize the day." ■

The Patient-Centered Medical Home

By Jeni Miller

Many people familiar with the concept of the patient-centered medical home (PCMH) might think it is a bit of a pipe dream. But does it have to be that way, or can it become a reality?

The PCMH model of care enables a patient's primary care physician to be the main point of contact — the avenue through which the patient's treatment and care is coordinated across the continuum. This kind of care also is notable for availability when and where a patient needs it, and is conveyed in a way the patient can easily understand.

It is no surprise the PCMH is growing in popularity due to its ability to increase cost savings by reducing hospital and emergency department visits, all the while improving patient outcomes.

"PCMH is really a team approach to patient care," explains **Cynthia Arnold**, CMPE, PCMH CCE, senior vice president at Kaufman Hall & Associates. "It's designed to understand individual needs. As additional events happen in the patient's life, the team makes adjustments in healthcare."

Arnold notes this model has worked well in many pediatric practices over the years, but its benefits can be realized by other populations and practices as well. **Bob Pryor**, MD, MPH, pediatrician and senior vice president with Kaufman Hall agrees, sharing how a PCMH can be beneficial for almost any patient.

"PCMH gives a structure, and it's all about high-quality care," he says. "The typical physician's practice involves waiting until someone realizes that they want to see the doctor. The patient calls the clinic to make an appointment, comes in for an episode of care, has their complaint diagnosed, treated, and resolved, and are turned over and back into their milieu. Then, they call when need they need to see the doctor again."

Instead of this routine, notes Pryor, "PCMH is concerned with answering how we can utilize all of the assets that we have for the patient's benefit to optimize wellness and well-being, asking what they need in order to live a high-quality life."

This might mean not expecting the patient to wait until they need a colonoscopy screening, for example, but rather the medical home "contacts the patient and lets them know they're due for it," Pryor shares.

Like a Home for Holistic Care

"As physicians start reaching out, people get better and healthier," Pryor says. "It's more than just a doctor seeing a sick person. It's holistic care, taking care of patient needs."

Pryor notes how, in the past, physicians would discover patient needs largely through home visits. PCMH provides a new "home" for the patient's medical care since the practice of home visits is nearly obsolete.

Another benefit is the heavy emphasis PCMH places on prevention, which helps people stay healthy. "Acute care visits slide in and out of the context of keeping the patient healthy, and it's easier to bring the treatment of chronic illness under a PCMH," Pryor notes.

Proponents of PCMH suggest the model increases the chances of using the primary care physician's office as the "front door," rather than the ED.

"When it seems there are no other choices, patients will go to the ED," Pryor notes. "But using the ED as the front door is less desirable because its overcrowded, designed for emergencies, and one study shows that the same level of care in the ED is 40% more expensive than in the physician's clinic. Truly, the last place a patient should want to be is in the hospital, since home is safer and more efficient."

Arnold notes the PCMH model allowed providers to better explain COVID-19 to patients. "For those who had a PCMH, we were able to introduce the concept of the virus into patients' lives in a way that they understand," she explains. "COVID showed us how we can easily overwhelm the system when patients continue to arrive at the ED for chronic issues, like asthma."

Pryor notes two main reasons why patients use the ED for chronic illnesses rather than their physician's office:

- Available hours of care, especially after hours;
- Lack of insurance, leading to a habit of not considering a physician's office as part of the routine for stable care.

The trouble with this habit is the resulting lack of a relationship between patients and physicians and no continuity of care.

"With PCMH, the provider develops a relationship," Arnold shares. "But a patient will typically never see the same doctor twice in the ED. If you have a PCMH, the care team sees you when you're sick, and you don't have to start your story at the beginning. They know you, so you just pick up where you're at."

The Role of Case Management

PCMH can save case managers time and enable a better process for the patient. But how?

"One way is through chart audits," Arnold explains. "In the 80s and 90s in family medicine practice, you'd frequently see family charts — and maybe there were even 10 people in that chart. When the doctor looked at it that way, it gave them insight into the care and the daily life of that family. Think about how that impacts the continuity of care for that patient. Today, with electronic records, we have a team of people in the practice to collaborate, and that's helpful."

Pryor agrees, adding that not only is it easier for a case manager to access a PCMH patient's chart, but the discharge process is much smoother.

"When the doctor decides it's time for the patient to go home, often giving the case manager but 10 minutes' notice, the case manager has to quickly find out if there is a caregiver in the home and arrange for that, determine if there are social issues, whether there is insulin in the fridge and arrange that, and the list goes on," he notes. "They are absolute saints."

"When a doctor discharges a PCMH patient, all of the resources are there," Pryor adds. "Mental health, nutrition, everything is already bundled, and that can save the case manager time and effort. Plus, no more middle-of-the-night wondering if it all got done, or if there was a gap, or something fell through. The case manager can have peace of mind because the loop gets closed in a way they can measure and feel good about."

Arnold and Pryor note how PCMH can help decrease overall costs of medical care due to the higher likelihood of preventing illness in the first place, shorten recovery time, and the lower costs associated with diagnosing an illness earlier rather than later.

"Healthcare insurers often strike arrangements with those offering PCMH, and those saved dollars can sometimes help defray the cost of other supports," Arnold says.

While case managers cannot create a PCMH, they can help promote the concept, Pryor notes. Resources like the National Committee for Quality Assurance publish statistics showing the vast benefits of PCMH. These resources can be shared with the primary care physicians within a hospital system to "talk about how this facilitates case management and how the assets needed to care for the patient are there and more cost effective than you think," he explains. *(More information is available at: https://bit.ly/3vVAw9P.)*

Arnold notes that through technology, messaging, and quicker response times, case managers might be able to connect more with PCMHs over the coming years. Pryor predicts case management might be embedded in PCMH practices in the future as well. They acknowledge that while it often takes more staff — nutritionists, mental health professionals, more clinical staff — PCMH is an "aspirational goal that every practice should seek." ■

HOSPITAL
CASE MANAGEMENT

CE QUESTIONS

1. **Which COVID-19 patients would require a hospital stay longer than 48 hours?**

   a. A man age 45 years
   b. A patient presenting with abnormal vital signs in the ED
   c. A patient with a family history of migraines
   d. A pregnant patient

2. **Which is a key reason COVID Watch is easy to use for COVID-19 patients?**

   a. It does not require a smartphone.
   b. It is a free app.
   c. It does not allow any hospital calls.
   d. It keeps track of every aspect of patient health.

3. **What is essential for the caregiving team of patients with cancer, according to Susan Mazanec?**

   a. Social services
   b. Family caregivers
   c. Dietary care
   d. Mental health services

4. **Which is a component of simulation-based interventional training for family caregivers of patients with cancer?**

   a. It includes sit-down sessions with both caregiver and patient.
   b. It involves hands-on experience with the patient as the model.
   c. It occurs during the last week of the patient's treatment.
   d. It is focused solely on the caregiver, not the patient.

5. **Which is a frequently cited obstacle to HIV case managers making referrals to other service providers?**

   a. Patient declines offer
   b. Lack of knowledge
   c. Budget constraints
   d. Time consumption

6. **Which group of patients has few enrollees in Medicare Advantage Dual-Eligible Special Needs Plans, suggesting case managers should recommend this to that population?**

   a. Older patients in nursing homes
   b. Medicare patients younger than age 65 years
   c. Patients with chronic diabetes
   d. Older patients who do not qualify for Medicaid

7. **The patient-centered medical home model encourages patients to engage with medical care primarily through:**

   a. the emergency department.
   b. the specialist's office.
   c. the primary care physician's office.
   d. home health.

8. **Multidisciplinary rounds are most effective when they are:**

   a. early, lengthy, and focused.
   b. scripted, focused, and timely.
   c. flexible, daily, and lengthy.
   d. unplanned, weekly, and scripted.