HOSPITAL CASE MANAGEMENT

COVERING CASE MANAGEMENT ACROSS THE CARE CONTINUUM

DECEMBER 2021 Vol. 29, No. 12; p. 149-164

INSIDE



Relias Media
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# Geriatric Patients Need Advance Directives and Transdisciplinary Care Across Continuum

*Deaths from falls are on the rise*

*By Melinda Young*

By the end of this decade, one in five Americans will be older than age 65 years, according to the U.S. Census Bureau.[1,2]

Data show adults age 65 years and older comprise more than 22 million emergency department (ED) visits annually and represent 16% of all ED visits in the United States. Two-thirds of older adult ED patients are discharged home.[3]

"As our geriatric population grows, we are seeing people live longer and more functional lives into their 80s and 90s, which is great," says **Maureen Dale**, MD, assistant professor and director for education and clinical care of the Geriatric Fellowship Program at the University of North Carolina at Chapel Hill. "But what it means is when our geriatric patients get hospitalized, they're at higher risk of complications happening in the hospital. This can lead to longer hospital stays and the need for short-term stays in rehab facilities. It also can lead to loss of some degree of independence at discharge from the hospital."

> "WHEN OUR GERIATRIC PATIENTS GET HOSPITALIZED, THEY'RE AT HIGHER RISK OF COMPLICATIONS HAPPENING IN THE HOSPITAL."

Timely communication between hospitals and post-acute care providers



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HOSPITAL CASE MANAGEMENT

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

**GST Registration Number: R128870672.**

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can improve the discharge process and reduce readmissions, she adds. *(See story in this issue on improving care for geriatric patients.)*

Case management continues to evolve toward optimal transitions for geriatric patients, particularly those with life-threatening illnesses or injuries that land them in the ED.

One best practice is transdisciplinary care that attends to patients' well-being, health, and lowers costs, says **Cameron Gettel**, MD, MHS, assistant professor in the department of emergency medicine and clinical investigator with the Yale Center for Outcomes Research and Evaluation.

"It is such a complicated issue that there isn't a one-size-fits-all," Gettel says.

One area to measure is patients' functional status — their ability to walk up stairs or go on a long walk.

Researchers need to perform more qualitative research, including in-depth interviews with patients, Gettel notes. For instance, investigators could ask patients these questions:

- How was the discharge process?
- Why did you go to the ED?
- What were you told at discharge?
- How was the follow-up experience?
- What barriers did you experience during the care transition?
- How could this process improve?

"Getting the direct patient experience in words is going to be really foundational to identify interventions that will be directly helpful," Gettel says. "Certain interventions will have to be tailored to older adults, but it has to be designed by the emergency medicine society, the case management society, local communities, and more. It has to be a pairing with local community services."

Case management and transdisciplinary care of older patients should address their social needs and include a component that recognizes the importance of adequate food and housing. "There has to be a continued focus because so much of our health depends on the social aspect and the resources we have available," Gettel adds. "So much needs to be transdisciplinary to address the social needs of older adults."

While there is not yet a blueprint for this approach, a concerted effort is underway to learn more about successful care transition interventions,

## EXECUTIVE SUMMARY

Millions of older Americans visit emergency departments each year, often for traumatic injuries, including falls that can lead to death. Case managers and health systems should consider how to improve end-of-life care discussions and advance directive documentation in this population.

- Transdisciplinary care can help patients' well-being as well as lower costs.
- Care should address older patients' social needs, including housing and food security.
- Older patients experience more severe injuries, more comorbidities, and worse outcomes and they take more medications. They are especially in need of advance directives.

particularly for geriatric patients in the ED. For example, the Geriatric Emergency care Applied Research (GEAR) Network has engaged interdisciplinary stakeholders and searched electronic databases to identify ED discharge care transition interventions among older adult populations.

A paper on the GEAR Network noted ED care transition intervention studies often address at least one social need of patients. These most commonly are related to access to food, medicine, or healthcare.[3]

"Some of the research thus far has focused on the social determinants of health, and more needs to happen and be addressed about the individual social needs of adults," Gettel says. "Other countries address the social needs more than we do as a country. I think there is an opportunity for improved patient outcomes and less cost to the system in general."

The first step is more research into the needs of geriatric patients. "Many of these interventions that we looked at were bundled with a comprehensive geriatric assessment, a telephone follow-up, and discharge planning," Gettel explains. "Many of these trials and interventions threw the kitchen sink at these adults to help them. But it's important to identify which of these components is really helpful and beneficial, and then [use data] in boosting support for that care transition, whether it can be case management, discharge planning, or a telephone call to make sure there is adequate follow-up."

The authors of a new study suggested a benefit to geriatric care when advance care planning is integrated.[2]

There is a need for advance directives and care transition tactics to help a population that experiences more severe injuries, more comorbidities, and worse outcomes and they take more medications. says **Janet S. Lee**, MD, resident physician in the department of trauma and acute care surgery at the University of Colorado Health Memorial Hospital. Lee also is resident physician at Anschutz Medical Campus, Aurora.

"Thirty percent of trauma patients are over age 55; they take a huge proportion of the trauma population. This number is expected to rise as the population gets older," Lee says. "The most common cause in the geriatric population is falls."

Fall deaths among older adults in the United States increased by 30% from 2007 to 2016, according to the CDC.[4]

When geriatric patients visit the ED after a fall, the emergency doctors and trauma team evaluate the patient for an injury that requires admission, Lee says. Someone also could determine whether the patient has an advance directive.

"Our service, led by geriatricians, does a good job of talking with patients about their care goals and what their wishes are," Dale says.

This is particularly important for patients who visit the hospital frequently because their chronic conditions are exacerbated. "One of the things we have always known is we need to do a better job of talking about advance care planning with patients, both in the clinic setting and in the hospital," Dale says. "We have found, over the course of the last 18 months of the pandemic, that this is more critical work than ever, but it's work that still is often overlooked and unrecognized."

The ideal place to start advance care planning discussions and documentation is in the outpatient setting, where there is more time for patients to discuss their own values and goals for end-of-life care.

People need time to identify a decision-maker and decide what they want to happen when they cannot decide on their own, Lee notes. But this does not always happen. If the patient is in the ED or admitted to the hospital for a serious trauma, there is no documentation of the patient's wishes.

"When they come after a severe injury, sometimes they're not able to participate in that discussion. That's when advance directives really matter," Lee says. "It's a lot of emotional burden for them."

Case managers and social workers can help fill in the gap when hospitalized patients suffer trauma or severe illness and lack an advance directive. *(See story on talking with patients about advance directives in this issue.)*

Many geriatric patients are readmitted soon after a fall or traumatic injury, and there is a risk of death. This suggests someone could intervene at the time of the first ED visit or hospitalization to begin an advance directive conversation.

"One quality improvement [metric] is identifying whether a patient has an advance directive," Lee says. "Even if the patient doesn't have an advance directive when arriving at the trauma center, there's an opportunity for us to intervene and have that discussion. This could be a nurse, social worker, and case manager."

For instance, one hospital paired a social worker with the palliative service to obtain advance directive documentation on all admitted patients. "The social worker went first and discussed it with patients," Lee adds.

If the patient already prepared an advance directive, the social worker would track it down.

Another tactic is to ensure

everyone who is admitted to the ICU — regardless of age — has documentation of power of attorney and a decision-maker.

Also, case managers should know advance care planning may not be one and done. It is something that should be discussed at every hospital admission with every geriatric patient, and it should continue each time a patient is admitted or seen, Dale says.

"There are ongoing discussions with patients, loved ones, and caregivers about what they want in care, looking to the future and understanding where care is at that moment," Dale explains. "It can change from office visit to office visit, from hospitalization to hospitalization." ■

## REFERENCES


1. United States Census Bureau. Older people projected to outnumber children for first time in U.S. history. Updated Oct. 8, 2019. https://bit.ly/3FKsgQ7
2. Lee JS, Khan AD, Dorlac WC, et al. The patient's voice matters: The impact of advance directives on elderly trauma patients. *J Trauma Acute Care Surg* 2021; Sep 14. doi: 10.1097/TA.0000000000003400. [Online ahead of print].
3. Gettel CJ, Voils CI, Bristol AA, et al. Care transitions and social needs: A Geriatric Emergency care Applied Research (GEAR) Network scoping review and consensus statement. *Acad Emerg Med* 2021; Jul 30. doi: 10.1111/acem.14360. [Online ahead of print].
4. Centers for Disease Control and Prevention. Facts about falls. Reviewed Aug. 6, 2021. https://bit.ly/3oZ8R8h


# Geriatric Program Develops Tactics to Improve Care for Older Patients

*By Melinda Young*

With the goal of continuous quality improvement, a health system created programs and tools to provide care for older patients that focuses on advance care planning, cognitive decline, and how to ensure safe transitions.

The goal is interprofessional geriatric care and providing good care to complex, hospitalized older adult patients, says **Maureen Dale**, MD, assistant professor and director for education and clinical care of the Geriatric Fellowship Program at the University of North Carolina at Chapel Hill.

One example is staff training on dementia. UNC's Hillsborough campus, which includes a geriatric inpatient unit and geriatric ED, trained every employee — even cafeteria staff — on geriatric patients and how to provide dementia-friendly care. Employees complete online modules and attend one in-person, hour-long class on dementia-friendly communication techniques led by a geriatric nurse practitioner. For instance, staff learned how to introduce themselves when they enter patients' rooms and how to calmly reorient patients.[1]

"We trained dementia champions and other hospital staff members to continue to give the session to new hires as time went on," Dale says. "They could continue the training and put together a dementia-friendly training manual for [educators] to use to teach those sessions."

Another tactic is to use a discharge summary template with every geriatric patient. The template can include questions about advance care planning. It also can be embedded in a health system's medical record.

"Our template allows providers to fill in information about a patient's functional status, what activities of daily living and instrumental activities of daily living they are able to complete on their own or with assistance," Dale says. "There's a section on their cognitive status. If they're delirious during the hospital stay, we include that. If we did any cognitive testing to look for signs of cognitive impairment or dementia, we include that in the template."

The tool includes questions about whether a patient has designated a healthcare decision-maker and any goals of care or advance care planning.

"We use the template as our standard discharge summary template for all patients on geriatric service," Dale says. "It's not always that the template is fully or thoroughly filled out, but our goal for our service is for each patient to have a comprehensive geriatric assessment when they're in the hospital."

The template also can be filled out over time, rather than in one 20-minute documentation session. "It's a document we can add to throughout the patient's hospital

stay, so we don't fill it out all at once," Dale says. "As we get more information from the patient and caregiver about the patient's functional status, we fill out the functional piece and the cognitive piece; it can be built throughout their hospital stay."

Another way to provide optimal care to geriatric patients is for case managers and providers to remember that older adults often have a caregiver or partner who is helping manage the patient's care.

"Often, it's someone who is older, and we should keep in mind any sort of transportation or functional limitations that could limit their ability to do some of the follow-up we're asking them to do," Dale explains. "The people in their lives and what they need help with is increasingly important as time goes on." ■

## REFERENCE


1. Castellucci M. UNC Health Care trains staff to treat dementia patients. *Modern Healthcare*. Oct. 19, 2019. https://bit.ly/3FQfiQS


# Simple Techniques for Talking with Patients About Advance Directives

*By Melinda Young*

New research shows most older patients do not have documentation of an advance directive when they present to a hospital for a traumatic injury, such as a fall.[1]

A multicenter analysis of patients older than age 65 years who experienced a traumatic injury between Jan. 1, 2017, and Dec. 31, 2019, revealed the vast majority did not have an advance directive. Of 6,135 patients, only 751 had an advance directive. The patients with an advance directive presented with more pre-existing conditions, including cerebrovascular accident, congestive heart failure, and functional dependence.[1]

It is challenging for case managers and healthcare providers to discuss end-of-life issues with patients, particularly when they are facing a life-threatening injury or illness. But it is useful to make advance directives a part of a palliative care service as well as a general part of case management with geriatric patients after a traumatic injury.

Case managers, social workers, providers, and palliative care can take on an important role in the ED by discussing advance directives with patients.

"Anyone who is comfortable [with end-of-life care] can have this discussion and assist in documentation," says **Janet S. Lee**, MD, resident physician in the department of trauma and acute care surgery at the University of Colorado Health Memorial Hospital. Lee also is a resident physician at Anschutz Medical Campus.

The simplest first step is to check the medical record or ask patients if they have an advance directive on record at the hospital or at home. For example, asking about advance directives could be a routine part of taking a patient's history when he or she is admitted to the ICU. This could involve offering patients an advance directive form and asking them who they would like to be their decision-makers. When patients sign it, hospital staff can scan it and upload it to the medical record.

"Our hospital has a patient portal that you can go through steps and identify power of attorney and advance directives," Lee explains. "You can upload it to our electronic medical record [EMR], and everyone with access to the EMR can take a look to see if the patient has an advance directive."

Case managers in hospitals that do not offer a portal for advance directive documentation can advocate with hospital management to add one in the electronic record, she adds.

For patients without an advance directive, the biggest hurdle is talking with them about what it means and how it would be used. "There's some stigma about involving palliative care service, but having it does not mean the patient is dying," she explains. "They just help in the ICU when the team would have that [end-of-life] discussion."

Palliative care teams can teach case managers and others how to hold these conversations in a way that patients and their families can accept and learn. For example, patients sometimes fear that an advance directive might lead to their receiving less care.

"The study showed that advance directives did not lead to increased withdrawal of care, which is one of the fears of advance directives — that they'll get their line unplugged," Lee says.

Advance care education also could emphasize the importance of a person putting their own decisions and needs in writing. "It's important to recognize that having documentation about what you want for end-of-life care is super important," Lee says. "Families do not always know what patients want."

The study also showed that socially and economically disadvantaged groups especially lacked advance care planning. "We should target everyone, but especially these populations," Lee says.

With documented advance directives, patients have autonomy over their own care. "Our study highlights that we have a huge deficit in advance directive planning, especially in the geriatric population, and we need to do a better job," Lee says.

Even if the first attempt to discuss advance directives does lead to a patient signing a document, it is a step in the right direction. Many patients have heard of advance directives, even if they have not yet signed one, Lee says.

Holding repeated discussions helps. Eventually, the patient might decide to create an advance directive, she adds. ■

## REFERENCE


1. Lee JS, Khan AD, Dorlac WC, et al. The patient's voice matters: The impact of advance directives on elderly trauma patients. *J Trauma Acute Care Surg* 2021; Sep 14. doi: 10.1097/TA.0000000000003400. [Online ahead of print].


# Hospitals in States Without Medicaid Expansion Face Discharge Challenges

*By Melinda Young*

New research involving acute ischemic stroke shows that Medicaid expansion is associated with fewer hospitalizations among the uninsured and more rehabilitation at skilled nursing facilities (SNFs).[1]

"About a dozen states have declined to expand Medicaid under the Affordable Care Act (ACA), and the vast majority of these states are in the stroke belt — a region of increased mortality from stroke, primarily in the Southeastern United States," says **Blake McGee,** PhD, RN, assistant professor at Georgia State University's Lewis College of Nursing and Health Professions. "You have an overlap of a region where low-income patients remain uninsured and are also at risk of adverse outcomes from a stroke. We were interested in what these Medicaid expansion decisions at the state level had for ischemic stroke patients."

From a case management perspective, discharges and transitions are simpler in Medicaid expansion states because insured patients will have more post-acute care options. But regardless of the state or expansion status, some of the same principles apply, says **Karen Seagraves**, PhD, MPH, APRN, enterprise vice president of the Neurosciences Institute for Atrium Health in Charlotte, NC.

Stroke patients might not have access to a SNF if they lack Medicaid or other insurance funding. But it is possible for hospitals and case managers to help them with functional recovery while they are in the acute care setting. "People who have more intensive therapy for stroke have better long-term outcomes," Seagraves notes.

People can regain functional recovery when they are provided the resources and therapy. Seagraves suggests several ways to help stroke patients with no insurance or too few financial resources to obtain the therapy they need:


## EXECUTIVE SUMMARY

States that have expanded Medicaid under the Affordable Care Act reported fewer hospitalizations for uninsured acute ischemic stroke patients than states that did not expand Medicaid.

- In non-expansion states, many low-income patients are uninsured and are at risk of adverse outcomes from a stroke.
- Hospitals in both Medicaid-expansion and non-expansion states can help uninsured and underinsured stroke patients by creating a therapy gym in the acute care setting.
- Another tactic is to create an equipment gym from which patients can take home equipment for stroke therapy.

• **Create a therapy gym in acute care.** Seagraves worked for more than eight years at a public safety net hospital in the Southeast with a large homeless population. The hospital opened a science center to treat people with ischemic strokes.

"Once you have these patients, they don't have funding and it's impossible to place them," Seagraves says. "They can languish in bed, waiting, because they are not safe for us to discharge."

One potential solution is to bring acute inpatient rehabilitation to them. "We took a patient room offline and fully equipped it as a physical therapy gym," Seagraves says.

The traditional hospital physical therapy (PT) is limited to people walking up and down a hall and spending 10 minutes or so with a physical therapist, she notes. With the hospital's new PT gym, patients could use a variety of equipment, including parallel bars and a bathroom to practice transfers to the commode and in and out of the shower.

"It was a real-life experience, and this was rehab in the acute setting," Seagraves says. "We did this to help people improve enough to go home and to educate them and their family members on how to continue to rehabilitate them at home. The longer you work with them after the acute inpatient setting, the better they do."

• **Create an equipment library.** Another tactic employed by Atrium Health is to create an environment in which stroke patients can obtain equipment to use at home.

"You can have a library of equipment where people donate all kinds of equipment," Seagraves says. "This can be normal equipment like walkers, wheelchairs, and hospital beds. This is equipment that [uninsured] patients could not afford."

Patients can take the equipment home, use it as long as needed, and either keep it or return it if they like.

"Several organizations have a program where families can turn in equipment when it's no longer needed," Seagraves says.

This service can be offered in conjunction with programs that provide medication to underfunded patients. "We work closely with social services, case managers, nurses on the unit, and families," Seagraves says. "These might be patients who are not homeless, but who don't have any resources financially to manage even the equipment they need to be successful at home."

Case managers and others teach families how to use the provided resources to help patients through the recovery trajectory. "We work with them to collect all the resources they'll need in a post-acute setting," Seagraves explains. "It's a commitment on the hospital's part to work closely with these patients."

• **Negotiate with rehab settings.** A large health system that refers many insured patients to an acute inpatient rehabilitation facility might negotiate for the facility to accept some uninsured patients as well.

"When you are negotiating contracts, you can make arrangements for a certain number of patients who are unfunded or underfunded to have access to that rehab," Seagraves says.

Hospitals need to transition stroke patients to safe settings for necessary rehabilitation and care. When patients lack insurance coverage, they might have to stay in the hospital long-term because there is not a safe environment for discharge. This is disadvantageous to both the hospital and the patients.

"It uses a lot of hospital resources. Being in a hospital is not a good thing for long periods of time because patients are more vulnerable [to infections, etc.]," Seagraves says.

The study's findings present a mixed picture of how Medicaid expansion affected acute stroke care nationwide.

"We were not surprised to find that the number of stroke hospitalizations covered by Medicaid increased 5.3%," McGee says. "There was a net decline of 3.5% in uninsured stroke hospitalizations in states that expanded Medicaid vs. states that did not."

Under the ACA, declines in uninsured hospitalizations occurred

across the board, but the decline was wider in Medicaid expansion states. Medicaid expansion reduced the risk of financial hardship for many low income patients.

"In terms of outcomes for [stroke] patients, we found that after even adjusting for differences in hospital characteristics, Medicaid expansion was associated with 33% increased odds of discharge to a skilled nursing facility," McGee says. "It also was associated with decreased probability of being sent straight home from the hospital."

Investigators did not find an association with the odds of discharge to an inpatient rehabilitation facility. "That might have implications for what resources are available for patients after stroke in the community," McGee says. "Medicaid coverage for inpatient rehab vs. SNF care is variable."

Also, the concentration and quantity of inpatient rehab beds in a community varies by region. Inpatient rehab facilities often require upfront discharge plans before a patient can be transferred. This barrier could affect both Medicaid and uninsured stroke patients.

"Many Medicaid members might lack the resources or caregiving support to have that in place when they're discharged from the hospital. [This] is one reason why we might have seen an uptick in transfers to skilled nursing facilities, but not to inpatient rehab facilities," McGee explains.

In the stroke study, investigators looked at a national database in which more than 2,000 hospitals participate. They compared states with expanded Medicaid before 2018 with those that had not expanded Medicaid at all by that time.

"What we had to do is exclude a handful of states that had expanded health insurance coverage to low-income adults on a large scale prior to the ACA's Medicaid expansion," he adds. "The states not included were New York, Vermont, Massachusetts, Delaware, Wisconsin, and the District of Columbia."

Few states in the Southeast expanded Medicaid. Only Louisiana and Kentucky had accepted Medicaid expansion. Arkansas used a hybrid model that covered the same population.

"The vast majority of patients in our non-expansion sample were in the Southeast, and the majority in the expansion sample were outside the Southeast," he says. "We adjusted for demographic and clinical differences between those populations as well as differences in hospital characteristics."

The study's findings make a strong business case for Medicaid expansion, McGee says. "I think the politics of it make it complicated because of the connection or association people have between Medicaid expansion and Obamacare," he says.

Some states are considering adopting a hybrid model similar to that in Arkansas to expand coverage to low-income, working-age adults. They sometimes are more interested in exploring private-public hybrid models that can achieve some of the same goals, McGee says.

"It may be more politically palatable in holdout states," he adds. ■

## REFERENCE


1. McGee BT, Seagraves KB, Smith EE, et al. Association of Medicaid expansion with access to care, severity, and outcomes for acute ischemic stroke. *Circ Cardiovasc Qual Outcomes* 2021 Sep 30;CIRCOUTCOMES121007940. doi: 10.1161/CIRCOUTCOMES.121.007940. [Online ahead of print].


# Case Management Depending More on Advanced Practice Nurses

*By Melinda Young*

In some hospitals in the United States, advanced practice nurses (APNs) have become case managers, a trend that is boosted by managed care and broader healthcare trends.[1]

"Accountable care organizations are about saving money for hospitals and improving quality of care," says **Neeraj Puro**, PhD, study co-author and assistant professor at Florida Atlantic University (FAU) College of Business.

While nine in 10 U.S. acute care hospitals provide case management services, only 12% of the hospitals use APNs to provide those services. The use of APNs still remains despite its growth due to managed care trends. Another factor is that hospitals with more severely ill patients are more likely to employ APN case managers, researchers found.[1]

The study's results imply hospitals create opportunities for nurses to

develop treatment plans that prevent high-need patients from overusing hospital resources — meaning APNs can benefit the hospital's financial picture.

Adding APNs to a care coordination/case management program helps hospitals achieve improved quality of care, better communication at discharge, and fewer readmissions. "It's important in improving the quality discharge of the patient," Puro says.

In some states, APNs can prescribe medication, which also can lead to successful discharge outcomes, says **Scott Feyereisen**, PhD, the study's lead author and assistant professor at FAU College of Business.

The use of APNs expanded during the COVID-19 pandemic as governors passed emergency declarations allowing APNs to practice independently to ease staffing shortages. "Some states say they can be independent; some states say not," Feyereisen says.

But the pandemic's effect on the overall healthcare workforce added weight to the argument that APNs should be independent in all states moving forward, Feyereisen says. The downside of more independent APNs is that fewer will be drawn to the case management role.

"We actually saw increased [APN] case managers in states where there were restrictions and where APN independence was less likely," Feyereisen says.

For hospitals with high-cost patients due to illness severity, hiring APN case managers is a practical decision. "It's all about the cost," Puro says. "Case managers can make a good example of how hospitals reduce their costs. If you can cut costs by using APNs as case managers, then that's one of the goals of the Affordable Care Act — to improve quality and cut costs."

> "IF APN CASE MANAGERS HAVE A GOOD WORKING RELATIONSHIP WITH PHYSICIANS, THEN THINGS CAN GO WELL; OTHERWISE, THINGS COULD BE ADVERSARIAL AND RESULT IN TURF WARS."

Physician acceptance is a roadblock to hiring APN case managers. As the study authors noted, some hospitals find physicians are not open to involving APNs in discharge planning and care transitions because it takes away some of the physicians' discharge responsibilities. For instance, treatment plans designed by APN case managers might be met with physician resistance because they limit physicians' decision-making power about patient treatment.

"Culture really matters in terms of how well they're received," Feyereisen says. "If APN case managers have a good working relationship with physicians, then things can go well; otherwise, things could be adversarial and result in turf wars."

Any case management department that wants to incorporate APN case managers into its program should obtain physician buy-in. They should assess whether current staff is willing to accept this change, and they should plan how it would work.

"For example, maybe the physician could recommend a battery of tests for patients, and the APN says that only one can be done at a time from a cost standpoint," Feyereisen says.

It is up to case management leadership and other departments to collaboratively decide the responsibilities of each person involved in discharge planning and care transition and to avoid potential areas of conflict and overlap. "Case managers can help improve efficiency and reduce duplication of services," Puro says.

One way this helps is that APN case managers can carry out discharges without long waits for a physician's signoff. This allows physicians to make their rounds and not worry about as many care transition details, Feyereisen says. This could save hours in bed turnovers, making discharges faster

## EXECUTIVE SUMMARY

Advanced practice nurses (APNs) are becoming case managers as part of a trend fueled by the growth of managed care.

- APNs helping with care coordination can contribute to improved quality of care and communication at discharge and reduce readmissions.
- Because of the COVID-19 pandemic, governors in some states signed emergency declarations to allow APNs to practice independently.
- APNs working with high-cost patients can help hospitals reduce costs and make the discharge process more efficient.

and more efficient — particularly when the hospital's beds are full.

"APNs have more independence now than ever because of the pandemic," Puro notes. "Let's see what happens after COVID-19."

The restrictions that were loosened could return when the pandemic ends. "It will be an interesting time in a year or two to see what happens," Puro says.

"There's a fair amount of research to show the benefits of increased usage and independence of APNs," Feyereisen says. "Most APNs have doctorates with the education and experience, so why do some states allow them to do less than they're trained for?"

From a researcher's point of view, it is an interesting dynamic. "When APNs are case managers, the results are good," Feyereisen says. "When APNs do their things, they tend to do well." ■

## REFERENCE


1. Feyereisen S, Puro N, Thomas C, et al. A new kind of gatekeeper: The increasing prevalence of advanced practice nurses as case managers in US hospitals. *Health (London)* 2021;25:596-612.


# Beta-Blockers and Case Management Help Reduce Readmissions of Heart Failure Patients

*By Melinda Young*

Ninety-day mortality and readmission rates are significantly lower for older patients with heart failure and reduced ejection fraction when they receive a beta-blocker after hospitalization.[1]

"People with heart failure who take beta-blockers live longer and are less likely to be readmitted than people who don't," says **Lauren Gilstrap**, MD, MPH, assistant professor of cardiology at Dartmouth-Hitchcock Medical Center in Lebanon, NH. Gilstrap also is an assistant professor of healthcare policy at Dartmouth University's Geisel School of Medicine.

"The magnitude of benefits also do not decrease with age," Gilstrap adds. "These therapies should be tried in people admitted for heart failure [unless there is a strong clinical indication otherwise]."

Regular heart failure education also is critical. This is where case managers can help.

It is crucial for patients to learn how to monitor their salt and fluid intake and when to call their provider if their weight begins to increase, Gilstrap says. Case managers also can reinforce the provider's information about common medication side effects and what issues and changes they should look for.

"It requires an ongoing relationship with patients," Gilstrap says. "This is where case managers come in, because heart failure is a chronic disease, and it requires an ongoing, continuous conversation between the patient, their family, the care manager, and the physician."

It is much easier to handle little problems than to wait until they become bigger problems. The more case managers and providers communicate with patients, the sooner they will know about health issues related to their heart condition.

"We need to educate them about standard heart failure management and anticipated side effects," Gilstrap says.

Case managers can show patients how to advocate for themselves, and for their families to advocate for them as well. "We need to put all the tools in place and encourage our patients to communicate with us, but on some level, they need to take a degree of responsibility," Gilstrap says. "My case managers call every patient with heart failure within three days of discharge. The most important thing they do is medication reconciliation — figuring out who is doing the medications is key."

Case managers also ensure any medication changes are filled, the pills are affordable, and that the patient can access them. Case managers also ask patients how they are doing and whether they are experiencing swelling, shortness of breath, or weight gain. They make sure patients know their follow-up appointments and will see their providers within 14 days.

"We try to set them up to see a [provider] close to home. If the care manager is worried based on their conversation with a patient, then we call the primary care provider office and help get them an [earlier] appointment," Gilstrap explains. "When [this case management system] works the way it is supposed to work, it helps with early intervention; the sooner you deal with it, the easier it is going to be to solve."

Beta-blockers and angiotensin-

converting enzyme (ACE) inhibitors are important for heart failure patients, but there are side effects and risks. "The potential side effects of these two classes of drugs increase as people get older and frailer, and as they acquire other comorbidities, particularly kidney disease," Gilstrap explains.

The question Gilstrap and colleagues investigated was whether heart failure patients hit a tipping point, based on their age and frailty, in which the risks of side effects of these drugs outweighed the potential benefits.

"We want to do the right thing for somebody from a heart failure perspective, but we don't want to expose them to the risks," Gilstrap adds. "Side effects are low heart rate and passing out, which can be extremely dangerous for older folks."

A main adverse event with ACE inhibitors is kidney failure/problems. Gilstrap and colleagues found the benefit of beta-blockers did not appear to wane with age, and all patients with heart failure should attempt beta-blocker therapy at discharge, regardless of age, unless there is a strong contraindication.

Older patients appear to benefit as much from the beta-blocker therapy as younger patients. "The reality is, the 85-year-olds benefited just as much as the 65-year-olds," Gilstrap says. ■

### REFERENCE

1. Gilstrap L, Austin AM, O'Malley AJ, et al. Association between beta-blockers and mortality and readmission in older patients with heart failure: An instrumental variable analysis. *J Gen Intern Med* 2021;36:2361-2369.

# Maintaining Case Management Certification

*By Jeni Miller*

The world of case management continues to evolve. Those who have been along for the ride over the past few decades have seen quite a bit of progress.

One of those areas of advancement is certification. While not every case manager is board-certified, the prospect of certification is a hot topic and a worthwhile endeavor.

**Vivian Campagna**, DNP, RN-BC, CCM, chief industry relations officer for The Commission for Case Manager Certification, has been in case management since the early 1990s and has earned a doctorate focusing on the value of certification.

"Certification sets someone apart from others in the profession, showing that they have the competence to take the knowledge they've gained and apply it in their profession," she explains. "It's an important piece of the professional toolkit that a case manager has that makes you more marketable, improves your professionalism, and can make you an all-around better case manager."

Although it is not required in every place, thousands of case managers across the country are certified, and the number continues to grow. Campagna says the "goal is to get as many certified as possible," adding it is "helpful for case managers to gain the newest knowledge that is available, engaging in lifelong learning that helps them better serve in an ever-changing healthcare landscape."

## A Few Hurdles

As with continuing education and certification in other fields, several barriers can prevent case managers from seeking or maintaining their certification, including:

• **Lack of support.** Some employers discourage or do not encourage certification, making it less likely that a case manager will work toward it. "If the case manager has the support of an employer, especially financially or with regard to study time and materials, it can make a difference," Campagna shares.

• **Finances.** Especially over the last 18 months, with healthcare workers seeing reductions in hours, furloughs, and other issues, it can be a challenge to cover the fees required for certifications, renewals, and continuing education credits.

• **Case management population.** As Campagna notes, many case managers are older, which can lead to a higher level of test anxiety as many have not tested in quite some time.

## Preparation

As case managers prepare for certification or recertification, Campagna suggests they first determine in which areas they are most and least familiar with the material in the exam blueprint.

"What do you not know much about?" she asks. "The answer to that question then informs how much you will need to study. There are lots of

materials out there — a reading list and core curriculum to give lots of information. Focusing on learning what you don't know will help case managers to be confident when they go in for the test. Studying is absolutely critical, so first find where your weaknesses are and focus there."

The 180 multiple-choice-question test itself typically takes about three hours to complete. Organizations like Campagna's consult with case managers to help them prepare.

"We have a full education team that works with potential applicants to review the blueprint domains and subdomains as well as how to study," she explains. "Some come to us when they've taken the test and not passed it, but don't know where they went wrong, so we will work with them individually as well. It helps to narrow down what to focus on, where to study, and where to enhance their skills. Not everyone will be successful on the exam. Some don't have the experience or knowledge behind it to be successful."

Recertification does not always require retaking the test. Campagna explains many case managers choose to recertify by earning the required continuing education credits instead, then pay the renewal fee for the recertification.

## The Benefits

However, it is worth the effort. The certification process can help prepare case managers to serve in a variety of settings, which is especially important when moving from one area of case management to another, more nuanced area.

"What the case manager does in the hospital is different from other places," Campagna says. "The case management process is applied in different ways. For instance, acute case management has a different focus than in a workers' comp setting, but the board-certified case manager is adaptable and able to distinguish the differences in application to be effective."

Maintaining certification is fairly accessible for most case managers. Recertifications occur every five years, within which time they need 80 continuing education units. Numerous programs and courses are preapproved for these units.

Campagna also mentions that once case managers have completed the work to become certified, it is rare they would not recertify because of the increasing importance employers have placed on certification.

"Very few opt out for the sake of opting out," she says. "Certification is becoming more recognizable by employers. Often, certification is preferred or required; thus, recertification will be necessary. When they have a choice between two candidates, one certified and one not certified, more likely they will choose the certified candidate."

With the rapidly changing world of healthcare — especially considering the changes brought on by COVID-19 — case managers are finding it more necessary to seek certification to keep abreast of updates to the role and the healthcare system.

"The pandemic piece — with telehealth taking a major focus — if case managers don't keep up with how that plays out, it can create a problem for them. If they're not able to function in the same way as they did when everything was face to face, and keep up with trends and what's new, it will be harder for them to know how to adapt their role and functions moving forward, because it's evolving fast." ■

# Case Management at the Entry Points: Ensuring Reimbursement Through Appropriate Surveillance

*By Jeni Miller*

At a time when capacity and reimbursement are more important than ever, case managers play a key role in helping operations run smoothly.

One way this happens is through monitoring the entry points of the hospital — what **Bonnie Geld**, MSW, president and chief executive officer of The Center for Case Management, describes as "those points of access [that] are the various portals for patients to enter into the system."

These points include the emergency department (ED), post-anesthesia care unit (PACU), direct admission to the units, or transfers from other facilities. This is not to say case managers should now add "security guard" to their extensive list of roles and tasks; rather, they are uniquely positioned to survey the whole picture, including how entry points are used.

## Surveying the Landscape

"Surveillance is the opportunity to ensure the patient meets medical necessity criteria for admission to the level of care they are being admitted to," Geld shares. "This can be inpatient, observation, or outpatient in a bed."

This surveillance is critically important not only for reasons of capacity and patient flow, but also for its effect on reimbursement. Since medical necessity is a criterion used by payers, ensuring patients meet that condition can help provide the validation needed for reimbursement. For the case manager and the hospital, this situation follows the adage that an ounce of prevention is worth a pound of cure. During a pandemic, preventing admissions without medical necessity can make all the difference — for the hospital and for the patients.

"These portals are the entrance to inpatient beds," Geld says. "Most hospitals, today, are nearing or at capacity. It is critical to ensure that patients who are being admitted are necessary. This surveillance also gives case management the opportunity to identify and find alternative dispositions to avoid unnecessary hospitalization."

## Unfortunate Effects

"We call RN case management/utilization review the 'clinical arm of the revenue cycle,'" Geld says. When case managers do not ensure medical necessity for admissions, reimbursement can be negatively affected. Some of those effects include:

- CMS delegates the hospital to perform medical necessity surveillance. Follow-up audits and claims data might show risk, subjecting the hospital to penalties. The hospital also is responsible for reviewing claims and self-denials when a patient does not meet the appropriate criteria.
- Commercial payers will deny payment for lack of medical necessity. This is largely based on documentation and the appropriate admission decision. These issues must be monitored by case management to ensure and validate reimbursement. Additionally, some insurers might attempt to underpay if no clear evidence of inpatient need is present.

Another downstream effect from poor flow is the creation of bottlenecks and long waits in the ED, which leads to patients leaving without being seen.

## The What and the How

It is well established that case managers should prioritize using appropriate surveillance to guard inpatient beds that might be in high demand. But how is this best carried out?

Case managers "should be assigned to or have some responsibility for surveillance at all entry points. This includes the emergency department, PACU, transfer center, and direct admissions," Geld explains. "It also means the ICU, as many of these patients must transition to an acute bed where, in fact, there is the highest volume of competition for the bed. Once positioned correctly, they are able to support the teams in guiding physicians to the appropriate level of care and status."

The next step for case managers is finding and facilitating an alternative disposition for patients who do not meet acute care or observation care criteria.

Geld also suggests hospitals "ensure [the presence of] an RN case manager who performs utilization review functions at all of the entry points. It is important for the physician to feel that the case manager is a good clinical partner and appropriately guides information

about status and medical necessity, not recommending it, as it is ultimately the physician's decision."

The role of case managers should not be underestimated as they can help make or break the efficiency of the hospital at the entry points. This can affect efficiency in other parts of the facility.

"Case management and social work at the entry points provide a vital and valuable resource for all providers in these areas," Geld says. "They support appropriate decision-making and status for admissions, help avoid unnecessary admissions through alternative disposition planning, and they manage patients who are high utilizers, helping them return to community providers and support services." ■

# Using EMR Data to Identify Patients at Risk of Frequent ED Visits

*By Jeni Miller*

Case managers are at an advantage when they can make informed decisions from electronic medical record (EMR) data and other sources. One way they can use the data is by identifying patients who might be at risk of frequent emergency department (ED) visits.

These repeated visits certainly affect the patient's quality of life, but also affect health system costs, availability of beds, and overwork for the ED staff.

"There are several data elements that can be leveraged, and medical records today are coming out with new, compelling technologies in machine learning to break the cycle of emergency room overutilization as well as socially motivated visits," notes **Jeff Echternach**, MBA, AAS, NRP, technology officer for The Center for Case Management.

According to Echternach, some key data factors can help identify patients in this situation. Case managers should consider:

- history of frequent visits and/or patterns;
- recent no-show visits from the primary care provider (PCP) or specialist;
- inability to schedule an appointment with PCP or specialist within 45 days of request;
- inability to afford medication;
- access to transportation;
- no PCP and has one or more chronic condition;
- visit history reports and utilization pattern reports;
- ED visit reports;
- no-show reports.

## Taking Notice

Quickly identifying high ED utilization early is key to finding a way to end the cycle. There are several ways case managers can look for this activity.

First, Echternach says, "risk factors for high utilization can be recognized in the ambulatory setting or through pre-screening programs conducted by ambulatory or outpatient case managers. These might include social determinants of health, whether the patient can afford their medication, and whether they have access to a PCP."

Second, risk factors like unaddressed chronic conditions can be recognized via payor case management programs and risk surveillance.

"When a patient has a chronic diagnosis without a PCP, or the lack of a timely PCP visit, it can lead to increasing utilization," Echternach notes.

Working to see the patient as a whole person, considering his or her past and current circumstances, is necessary to gain insight on their needs and habits.

"When patients are missed by these first two programs, they often land in the emergency room. An assessment that includes components of chart review and external record review, such as prior questions from ambulatory encounters, is the best tactic to leverage all data available to form a complete picture," Echternach explains. "A social determinants of health assessment is equally beneficial for a low-risk case."

"Oftentimes, reporting and trends are the first catch for these patients," he adds. "This can include information-sharing from ambulatory environments as well as payors. High utilization and rising risk utilization reports are sometimes a case manager's best friend when creating a flag for patients who need follow-up."

## Preventing High Costs

Of course, identifying the patient is only half the battle. The real objective is to help create a plan to

break the cycle of overutilization, which is a positive change for the patient, but also can prevent high system costs.

"Transitioning a patient from using the emergency room to a more appropriate care setting is not only beneficial to the patient, but is helpful to the hospital because the emergency room is the single-most expensive care setting secondary to the operating room," Echternach shares. "In some cases, a frequent utilizer of emergency room care is taking up space for a patient who is experiencing a critical life threat. At times, these visits may not even be reimbursed, depending on the situation. There are numerous advantages to connecting the patient with the right location for their care."

Once a patient in this situation is discovered, the case manager can learn more about the root causes of ED utilization and create an action plan among the patient, PCP, and case manager.

"Ambulatory case managers have the ability to triage overall risk and, when necessary, escalate a patient's case for timely outpatient follow-up to mitigate future emergency room use and activate a sustainable plan," Echternach says. "Ambulatory case managers often work together with payor case managers and emergency room case managers to support the needs of patients with increasing emergency room utilization."

## Tips for Interpretation

How can a busy case manager take the time to accurately identify these patients and create an action plan? They should not handle this task alone.

According to Echternach, help from the hospital is key to setting the stage for accessing and interpreting the data.

"Hospitals should establish guidelines that help case managers objectively identify high-risk and rising risk cases for high emergency room utilization. [They] should also consider building indicators into the electronic record whenever possible. Many of these indicators are covered in question one."

Data analysts are another resource. "Case managers should work with data analysts to prepare reports on emergency room visit utilization by patient and visit disposition with consideration given for the initial visit acuity and other key factors," Echternach says. "These reports should be detailed, and teams within case management should consider how they can review these reports for high utilization."

Ambulatory case management programs also can establish similar reporting mechanisms for missed appointments and coverage of formulary changes whenever known.

"Patients with newly identified chronic conditions that are on a phone call or screening list should be asked key questions about access to transportation and affordability of medications," Echternach notes. "A review of recent utilization should be performed. These data elements can be pulled together in a report to identify when a patient is increasing in utilization frequency, or when the patient appears to have difficulties getting access to primary care, which are warning signs for high utilization."

## Worth the Time

Echternach admits "the data analysis and maintenance of algorithms can be somewhat challenging" for case managers who already have full plates and might not have the technical expertise to carry out the work in a timely manner.

"However, this burden can be maintained by technical staff with more time returned to case management professionals to interpret the information and act upon the data," he says. "Taking action on reports can take some time, depending on the accuracy of the tools that have been developed, and there can be even more potential risk identified in the ambulatory setting than in an ED report. In situations like these, case managers and their leaders should set a cutoff point at the utilization level or risk level they desire to intervene on."

Overall, it seems to be worth the investment of time for the case manager to act on the data at their fingertips and make a plan for patients that will benefit them — and the hospital staff — now and in the future.

"One of the major opportunities that is lost when high utilization risk and rising risk data are not acted upon is the ability to influence health outcomes of the patients in your population," Echternach says. ■

HOSPITAL
CASE MANAGEMENT





# CE QUESTIONS

1. **A study on the Geriatric Emergency care Applied Research (GEAR) Network revealed ED care transition intervention studies often address at least one social need of patients. Which are the most common?**

   a. Transportation and loneliness
   b. Access to food and medicine
   c. Mental health and exercise
   d. Lack of caregiver and opioid use

2. **When comparing patients with acute ischemic strokes in states that expanded Medicaid and states that did not, researchers found:**

   a. lower overall health costs for stroke patients in Medicaid expansion states.
   b. higher morbidity and mortality in stroke patients in non-expansion states.
   c. Medicaid expansion was associated with fewer hospitalizations among the uninsured and more rehabilitation at skilled nursing facilities.
   d. not expanding Medicaid was associated with greater flexibility in care transitions and more options for post-acute care.

3. **Which is the biggest barrier for case managers to seeking certification?**

   a. Not interested in continuing education/certification.
   b. Lack of support.
   c. No opportunities available.
   d. Employers are not seeking certified case managers.

4. **When should case managers or other healthcare professionals provide older patients with advance care planning education?**

   a. On the day patients are admitted to the hospital
   b. At discharge from the inpatient setting
   c. In community care follow-up appointments
   d. At every hospital admission and ongoing because their wishes and needs can change

5. **The results of a new study show most older patients presenting to the hospital for a traumatic injury, including falls, do not have:**

   a. a primary care provider.
   b. advance directive documentation.
   c. insurance.
   d. a competent caregiver.

6. **How do advanced practice nurse case managers improve discharge efficiency?**

   a. They can make discharges happen without long waits for a physician's sign-off.
   b. They complete their work faster because of advanced education.
   c. They can connect hospital patients with home care, post-acute rehab, and other ambulatory resources.
   d. They have learned advanced leadership and communication skills that lead to faster transitions of care.