HOSPITAL CASE MANAGEMENT

COVERING CASE MANAGEMENT ACROSS THE CARE CONTINUUM

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INSIDE

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From Homelessness to Self-Sufficiency, Case Management-Style Program Works

By Melinda Young

Case managers increasingly recognize the importance of addressing social determinants of health among patients across the care continuum, but evidence-based interventions are scarce.

One new program seeks to change this with tactics to address one of the most prevalent social determinants of health: Poverty.

A novel care transition and community case management program provides an evidence-based standard of care to treat poverty as an environmentally based and treatable condition, says **Marcella Wilson**, PhD, chief executive officer and founder of Transition to Success (TTS).

> "THE RELATIONSHIP BETWEEN SOCIAL DETERMINANTS OF HEALTH, POVERTY, AND BEHAVIORAL HEALTH ISSUES IS DIRECT AND IRREFUTABLE."

"The foundation for all that we do is to first try to change the understanding of poverty from character flaw to a treatable condition," Wilson says. "We want to undermine the character flaw mentality and shame, which are rooted in racism and bias."

Poverty and mental health issues affect a person's overall physical health and their medical costs. For instance, data show monthly healthcare expenditures for people with chronic conditions are 54% greater if they also are diagnosed with comorbid depression. There is a 67% increase in expenditures

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if they have both chronic conditions and anxiety.[1]

"When you think about poverty, it exacerbates all of that," Wilson says. "The relationship between social determinants of health, poverty, and behavioral health issues is direct and irrefutable. It makes common sense."

The healthcare industry is leading the world in showing a connection between poverty and disease. It is the first industry to provide coding to those social determinants exposures.

"The care management industry is purposely positioned to pioneer social determinants of health response," Wilson says. "Case management organizations like CCMC [Commission for Case Manager Certification] can pioneer incredible improved outcomes as well as significant cost savings related to social determinants of health response."

This is the upcoming frontier of healthcare, she adds.

NEXT Memphis in Tennessee is a community-based organization that used TTS framework as part of its work with families in crisis.

"TTS is an evidence-based practice, using a person-centered approach that includes motivational interviewing, trauma-informed care, and warm handoff," says **Brooke Churchill**, care coordinator supervisor with NEXT Memphis.

The approach also addresses adverse childhood experiences (ACE). Care coordinators' training and knowledge of trauma-informed care and ACE often are important to help people make positive and sustainable changes.

Care-coordinating coaches receive more than 20 hours of coaches training, providing them with an overview, tools, and skills in the framework. One facet of training is education about the different types of poverty, including generational poverty, urban poverty, and rural poverty.

"When we work to help families address barriers and economic insecurities, we're ultimately helping children achieve health and educational goals for their future," Churchill says. "While the child is in the [preschool] classroom, we work with best practices with the teacher."

Care coordinators help empower parents, and instructional coaches work with teachers at the child care center to enhance their childhood experience for the client.

"Our clients are parents, and we work with them to empower them for healthy and optimal lifestyles for their children," Churchill says. *(See story in*

EXECUTIVE SUMMARY

Social determinants of health increasingly affect the health of patients and the living circumstances of people in poverty. One novel care transition and community case management program seeks to help people improve their physical and mental health through focus on social determinants and poverty reduction techniques.

- Monthly healthcare costs for people with chronic conditions are higher if the person also is diagnosed with comorbid depression.
- Case managers are well positioned to lead the healthcare industry in pioneering responses to social determinants of health.
- The Transitions to Success framework is evidence-based and uses a person-centered approach, including motivational interviewing.

this issue about how care coordination helped a client escape homelessness.)

The person-centered approach means care coordinators respect parents as the experts in their lives and in the lives of their families. "If that parent is interested in quitting smoking, we'll provide all the resources and referrals they need to stop," Churchill says. "Substance use is part of our assessment. We've had people come asking for help in that area, but we don't push referrals on them until they're ready for that referral."

Research involving TTS found the model has statistically significant results in improving the social conditions in Head Start and at an outpatient Medicaid behavioral health clinic.[2]

The TTS method offers people the opportunity to coordinate all resources effectively to support their health, including behavioral health. "In one study, we trained master-level clinicians in a Medicaid clinic in Detroit on how to integrate care management, volunteerism, peer mentoring, and financial literacy with their patients," Wilson says. "In an average length of stay of six visits, they saw improved outcomes at a cost of less than $600."[2]

A TTS clinician tool includes a survey that lists 21 different life areas, including food, housing, budgeting, racism/bigotry, parenting skills, and legal issues. Each life area is assessed according to a five-point scale from one, which equals the person living in crisis, to five, which equals the person feeling empowered. Three equals safe, two is for those who are vulnerable, and four is for building capacity.[3]

Here is one example of a life area (safety) and corresponding five-point scale notes:

- **Score 1 (in crisis):** "Home or residence is not safe; immediate level of lethality is extremely high; possible Child Protective Services involvement."
- **Score 2 (vulnerable):** "Safety threatened; temporary protection available; level of lethality is high."
- **Score 3 (safe):** "Current level of safety minimally adequate; ongoing safety planning essential."
- **Score 4 (building capacity):** "Environment safe; however, future of such uncertain; safety planning important."
- **Score 5 (empowered):** "Environment apparently safe and stable."

For each life area, there are listed options for ICD-10-CM codes that can be used for payer reimbursement. For example, under the life area of money, in reference to score 1, there is an ICD-10-CM code of Z59.5 for extreme poverty. For people who are scored from two to four, there is the code of Z59.6 for low income. Some life areas, such as drugs/alcohol use and disabilities, need a clinical diagnosis.[3]

Social determinants of health are tied to significant health risks, such as diabetes, high blood pressure, increased rates of depression, child abuse, child neglect, and domestic violence and crime.

"Make no mistake — exposures to these social determinants, health conditions and social conditions can cause trauma," Wilson says. "The relationship between social determinants of health and trauma is very evident, but what's not evident is how we respond to it. That's where care managers come in."

Care managers create the connective tissue between healthcare delivery systems that are siloed in their funding. "This is how we're going to change the nation. No one chooses to be poor," Wilson explains. "We have the most expensive delivery system in the world at our fingertips, and it's care managers who bring it together for the health and welfare of our patients." ■

REFERENCES

1. Wilson M. Behavioral health and social determinants connections. Presented at the Commission for Case Manager Certification 2021 Virtual Symposium, Oct. 12-14, 2021.
2. Francis L, DePriest K, Wilson M, Gross D. Child poverty, toxic stress, and social determinants of health: Screening and care coordination. *Online J Issues Nurs* 2018;23:2.
3. Transition to Success Life Area Survey: Clinician Tool (w/ICD-10-CM x-ref). Transition to Success Map of My Dreams. 2021:1-13. https://bit.ly/30zMvQr

Case Study Shows Positive Results of Intensive Care Coordination

By Melinda Young

For one client, care coordination assistance through a Transition to Success (TTS) framework helped her go from being homeless to housed within 86 days, says **Brooke Churchill**, care coordinator supervisor with NEXT Memphis in Tennessee.

"Accessibility and affordability of housing in our area is a major challenge," Churchill notes. "The waiting list on low-income housing and voucher programs is ridiculous. Having someone with limited income find affordable housing in 86 days is a huge win."

This particular client had spent 30 days in a hotel with her young children, storing food in a mini fridge and preparing meals under those challenging circumstances. Her job paid less than $8 per hour, Churchill explains.

But the woman persevered and applied for a GED course. She obtained a higher-paying job and found an affordable home for her family.

The client's story began when she attended a parent meeting at a day care center and told a care coordinator she needed help in different areas of her life, recalls **Carla Watson**, care coordinator with NEXT Memphis. Once connected with care coordination, the woman described her basic needs, including legal issues.

"We were able to address that legal issue, and by addressing it, she gained trust with me and shared more of her story," Watson says. "She was very guarded and was worried about sharing too much information."

The woman continued to meet with the care coordinator. Over time, Watson realized the woman was not safe in her home because of intimate partner violence. She helped the woman create a plan to make herself and her children safer.

Breaking the Cycles

A first step was to connect her with an agency that could help her become financially independent. This was challenging because the woman had not completed her education and needed help understanding various documents.

"She followed all the steps and got her family into a shelter," Watson adds. "She said it was the first night all of them slept through the night."

Watson continued to listen to the woman, treating the case as a puzzle she needed to solve. "She gave me pieces, and I was trying to figure out how to put the puzzle together because she wasn't sharing everything," she says. "By my allowing her to talk every time she called and wanted to talk, she'd share a piece of her story, and I'd write it down. Eventually, she shared the whole puzzle."

Part of the puzzle involved adverse childhood experiences. The woman decided those needed to end with her generation, so becoming independent from her extended family was important — even if it meant she would have no family support as she transitioned to independence.

"Taking the initiative to engage with a mental health specialist is important because she does not have a large support network like family because of many relationships that were pretty abusive," Churchill says. "There was a cycle of abuse she was trying to break."

Within three months, the woman and her children were able to move into a three-bedroom, two-bathroom apartment in a safe environment, and they are doing well, Watson says.

It was not easy, but Watson supported the woman as she visited apartment complexes, personally assessing their safety for her family. When the client found one place she knew would be a good environment, Watson helped her talk with the leasing office about her financial circumstances and how she had been homeless. They agreed to have her live in their facility, despite some factors that worked against her leasing application.

"She was so excited," Watson recalls. "Things have changed — it's wonderful."

The new and stable housing also has helped the client's children, the eldest of whom went from poor grades to honor roll.

Supportive Care Coordination

Care coordination also helped the woman gain confidence to improve her working conditions and future job prospects. She spoke with the supervisor at a hotel where she had been staying prior to landing the apartment, and she asked if she could apply for a job there. They hired her at a higher pay rate than she had been making, Watson says.

"She exhibited a lot of resilience while homeless and was engaged with mental health services and a financial coach," Churchill says. "She learned her situation is temporary. She's working poor now, but it's not at the end of the road yet because she's working on improving outcomes for her family, and she has more tools in her pocket for self-advocacy."

TTS care coordination helps clients with dream mapping. "When you are trying to meet basic means on a daily basis, you're not in a position to dream yet," Churchill notes. "Once the bottom-level needs are met, you're in a position to begin dreaming."

It takes supportive care coordination for people to gain confidence in dreams. For instance, Watson used a technique of going back to the client's care plan and showing her how she had already accomplished some of her goals.

"I told her she was strong and had already done this, so we can keep moving," Watson says. "She had forgotten a lot of things she had accomplished, so we pushed forward every time."

Once the woman had obtained safe housing and a job that made the apartment possible, she began focusing on her goals to obtain a GED, improve her professional status, and buy her own home.

"She is looking forward to having a backyard for her children," Watson adds. ■

Project ECHO Reduces Readmissions, Shortens SNF Length of Stay

By Melinda Young

A new care transition program successfully improved outcomes for patients discharged to skilled nursing facilities (SNFs).

Project Extension for Community Healthcare Outcomes (ECHO) connected multidisciplinary SNF teams with a multidisciplinary team at the discharging hospital via videoconferencing. The program proved effective in reducing patient readmissions and shortening SNF length of stay.[1]

"Care transitions from hospital to post-acute care is particularly dangerous for older people," says **Lewis Lipsitz**, MD, professor of medicine at Harvard Medical School and chief academic officer and director with the Marcus Institute for Aging Research.

Poor communication during transitions can cause miscommunication over medications, appointments, goals of care, and additional problems. "Quite a few errors are made. As a result, adverse outcomes occur when patients are transitioned from one place to another," Lipsitz adds.

Project ECHO started in 2003 as a way to improve care of rural people with hepatitis C who could not access modern medical care for the disease, Lipsitz notes. At the University of New Mexico, Sanjeev Arora, MD, MACP, FACG, set up a video camera in the rural setting and used it to communicate with physicians at an academic health system, where hepatitis C treatment was well established.[2]

"We adopted that model for the care of older people with dementia, who were living in nursing homes where their physicians and nurses were relatively isolated from up-to-date geriatric information," Lipsitz says. "We taught the caregivers how to manage dementia and behavioral problems from an academic perspective, and learned from them how our recommendations needed to be adapted to the realities of the nursing home care environment."

Building on this positive experience, researchers at Beth Israel Deaconess Medical Center developed ECHO-Care Transitions to improve communication and reduce errors when patients were transferred from the acute care hospital to post-acute care SNFs.

"This provided a mechanism for better communication between the hospital team of clinicians, pharmacist, and case manager, and the multidisciplinary team at each SNF," Lipsitz says. "The weekly videoconferences include brief discussions of each patient who was transferred to the participating SNF that week, including information about patients' medications, allergies, goals of care, and care plans."

ECHO-Care Transitions reduced hospitalization costs. "We showed in our first study that we were able to reduce patients' length of stay in the SNF and reduce hospitalizations, amounting to a savings of about $2,600 per case discussed, compared to the healthcare costs of patients who were not discussed in ECHO sessions," Lipsitz says.[3]

ECHO-Care Transitions' hospital team includes hospitalists, pharmacists, social workers, case

managers, and residents. Hospitalists, case managers, and pharmacists are the chief members.

To keep the teleconferences from dragging on too long, they are formatted as bulleted, structured discussions, he adds.

Problems Arise from Lack of Communication

When there is inadequate communication between hospitals and SNFs, problems can occur, including omitted medications or pills, such as blood thinners, that are left on a list even though they can cause drug interactions.

"That may not have been recognized and reported to the nursing home," Lipsitz says. "Also, patients might be on the wrong dose because of renal failure, and no one recognized the issue."

In other cases, a patient might have decided to not undergo a certain procedure or be readmitted to the hospital and asked for a do-not-hospitalize order, and the nursing home did not recognize or know that.

"Or, a patient may need a follow-up because of stitches after an operation, and no one communicated a follow-up with the surgeon," he adds.

As a result, the patient could have stitches for a long time. "These are the problems that could be missed," Lipsitz says.

The bullet point-style narrative in these videoconferences rely on summarizing key issues in one or two sentences, such as: "The patient had CHF [congestive heart failure]; found fluid in lungs; given a diuretic and another medication; weakened in hospital, and now needs rehab."

"That's an intro statement," Lipsitz adds. "Then, we review the medications, and the pharmacist may say the patient is on XYZ and the dose should be reduced because of renal failure."

The hospital team will recommend a particular dose and note the team reviewed the patient's advance directives and plans of care and will say whether the patient chose to be Do Not Resuscitate and/or not to be hospitalized.

"We talk about appointments, follow-up with the surgeon in two weeks, and how the patient is doing in the nursing facility," Lipsitz says. "The nurse may talk about how the patient can now walk 100 feet without assistance, and then we ask if there are any questions."

During the 2020 spring surge of COVID-19, the videoconferences were suspended for two months because the nurses were overwhelmed with COVID-19 patients.

"Nobody had time to do it, and many of our nurses got sick and couldn't [work], so there was a labor shortage," Lipsitz says. "Everyone wanted to resume the sessions, but we had to suspend them."

With evidence that ECHO works, the next challenge is paying for it. "We think it does save money, so the best place it can be paid for is within shared savings plans," he says.

Any insurance plan that uses savings from healthcare efficiencies to pay for supportive care, such as case management, could fund an ECHO program.

"If there is that type of organization, it would be a no-brainer for them to support this type of activity," Lipsitz says. "For the hospital to support it, they are banking on savings from fewer admissions and [shorter] length of stay, but it's hard to prove to hospitals that it should be supported."

ECHO costs about $100,000 a year, and it includes the cost of participation among all the doctors and nurses. "This is a model that makes perfect sense: Talk to each other," he says. "People can say, 'Why not use the telephone?' But the video helps create a relationship."

Through video interactions, team members build trust and relationships. "After a period of time, they get to know each other and care about each other," Lipsitz says. "It's a bonding experience that results in better care, and that's the advantage of doing it as video communication." ■

EXECUTIVE SUMMARY

The Project Extension for Community Healthcare Outcomes (ECHO) connects multidisciplinary skilled nursing facility teams with a multidisciplinary hospital team via videoconferencing.

- The program effectively reduces patient readmissions and SNF length of stay.
- With better communication through the program, healthcare professionals can avoid miscommunication over medications, appointments, and goals of care.
- The videoconferences include a short, bullet point-style narrative that relies on key issues summarized in one or two sentences.

REFERENCES

1. Junge-Maughan L, Moore A, Lipsitz L. Key strategies for improving transitions of care collaboration: Lessons from the ECHO-Care

Transitions program. *J Interprof Care* 2021;35:633-636.
2. Arora S, Thornton K, Jenkusky SM, et al. Project ECHO: Linking university specialists with rural and prison-based clinicians to improve care for people with chronic hepatitis C in New Mexico. *Public Health Rep* 2007;122 Suppl 2:74-77.
3. Moore AB, Krupp JE, Dufour AB, et al. Improving transitions to postacute care for elderly patients using a novel video-conferencing program: ECHO-Care Transitions. *Am J Med* 2017;130:1199-1204.

Researchers Identify High Costs of Various Conditions

By Melinda Young

Researchers recently identified predictors of high-cost hospital stays related to ambulatory care-sensitive conditions (ACSCs). The highest median cost of care is related to heart failure, followed by diabetes and COPD.[1]

The researchers studied data for Medicaid patients and found the median cost of care for this population was $793, says **Susan B. Roman**, MPH, RN, lead author of the study and director of care coordination and integrated support programs with Fair Haven Community Health Care in New Haven, CT.

"We were looking at specific ACSCs because they have a higher rate of utilization and cost associated with them," Roman explains. "We also found [being] male was an independent predictor; males of higher ages, who had various conditions, were also associated with higher costs."

Gender, age, and an ACSC diagnosis were associated with higher costs, but race and ethnicity were not.

Roman's purpose for the study was to improve care coordination by showing its value with certain high-cost conditions. "I was interested in moving forward to look at how we could show a return on investment," she explains.

The researcher accomplished this. "If organizations invest in care coordination, they will see a return on investment because this group will be able to help manage symptoms," she says.

Case managers and care coordinators also look at patients' social determinants of health and can collaborate to affect patients' health and well-being, she adds.

Much of Roman's research involved the pediatric population. "I could tell you in the pediatric population what are the top 10 conditions with high utilization rates and high costs," she says. "It's a very small percentage of pediatric children who have higher costs, but adults are different from pediatrics."

Targeted Coordination Reduces Costs

Investigators examined 15 months of claims data of about 8,000 patients from mid-2018 to early 2020. They studied a variety of diagnoses, including hypertension, asthma, urinary tract infections, community-acquired pneumonia, diabetes, COPD, and heart failure. They used prevention quality indicators from the Agency for Healthcare Research and Quality (AHRQ) to identify ACSCs. A high-cost episode of care — in the top quartile within a seven-day period — for an ACSC was the primary outcome.

The research demonstrates care coordination and case management efforts that target people — particularly older men — with heart failure, diabetes, and/or COPD could improve their care and reduce costs.

"Overall, in thinking about how care coordination could have an impact, I'd like to develop tools where we're looking at these high utilizers, whether we look at risk scores or claims, and start to have robust care coordination plans that have buy-in from all providers involved with that patient or that cohort," Roman says. "Going upstream, care coordination is what happens outside the visit, between those visits and the emergency department visits and hospitalizations. It's where you're really looking at improving health and well-being by impacting social determinants that [affect] well-being and getting people the services they need in the community."

It requires ample collaboration between healthcare providers and community-based organizations. Patients served by this type of targeted care coordination

often experience multiple social determinants of health issues, including homelessness and transportation issues. They also have nutrition problems.

"We have to work around their medical care with providers, asking whether they received their COVID-19 shots, their flu shots," Roman says.

Case managers and care coordinators can help patients find stable housing and connect them with food pantries. They might help with heating and other utility problems and identify issues related to intimate partner violence.

"They help families with diagnoses and getting the services they need," Roman says.

Providers and community-based organizations can refer patients to care coordination. When coordinators work with patients with specific health conditions, they focus on outcome measures. For example, with diabetes, they will see if a patient's A1c levels have decreased and whether the change is directly affected by the care coordination program.

"We know if we are helping someone get the right food, they'll get better," Roman says. ■

REFERENCE

1. Roman SB, Whitmire L, Reynolds L, et al. Demographic and clinical correlates of the cost of potentially preventable hospital encounters in a community health center cohort. *Popul Health Manag* 2021; Aug 31. doi: 10.1089/pop.2021.0169. [Online ahead of print].

Link Found Between Stroke Patient Readmission Disparities and Minority Status

By Melinda Young

Black stroke patients are more likely to be readmitted to the hospital than white stroke patients, but this gap closes in hospitals with better nurse staffing levels, investigators found.[1]

"When we hear about nursing staffing and ratios, we hear that nurses are caring for too many patients, and patient safety is at risk or in peril," says **J. Margo Brooks Carthon**, PhD, RN, FAAN, lead study author and Tyson Family Endowed Term Chair for Gerontological Research and associate professor of nursing at the University of Pennsylvania School of Nursing.

"My research looks at historically vulnerable patients, who — when entering hospitals — typically come with increased comorbidities or medical conditions and increased severity of illness," Carthon says.

These patients could experience better outcomes if hospitals allocate nursing resources in a way that appropriately addresses their additional, extenuating concerns and issues.

"If you look at nursing staffing ratios in hospitals where Black and white ischemic stroke patients are cared for, the average nurse-patient ratio for Black and white stroke patients was essentially the same," Carthon explains. "But even at that equal level of staffing, you saw disparities in Black and white patients and readmissions."

This disparity disappears in hospitals with the richest staffing resources and where nurses are caring for two patients per shift.

"This is an important point: What are the system levers we can deploy to eliminate inequities?" Carthon asks. "If our goal was systemic equality, we could say we reached it because Black and white patients have equal staffing ratios. But the goal is equity because some patients need more resources; they have more clinical and social needs."

The study results suggest hospitals need to intensify nursing care for some patients, depending on their clinical presentation. "Black patients may come in with a different set of social and cultural vulnerabilities, so we need to think about allocation of resources to more appropriately address those care needs," she explains. "Allocation of staffing could be thought of as a systemic intervention to address systemic inequities."

Focus on Systemic Inequities

Addressing systemic inequities requires studying the allocation of resources, including nurse staffing. "Nursing is the largest resource in healthcare settings," Carthon says. "When nurses are caring for too many patients and resources are not supporting nursing care, then care is missed, like discharge instructions."

When inadequate nurse staffing reduces the ability for nurses to provide adequate care, that has particular implications for ethnic and racial minorities because they have greater care needs. "The consequences of missed care [for minorities] will be greater," she says.

This is not the same as saying all Black patients need extra care, and it does not refer to racial/ethnic medical issues. The data showing that minority patients are affected by lower nurse staffing levels points to systemic factors that affect patients' overall health, such as social determinants of health.

"We need to look at the full picture of how they're more likely to have social needs," Carthon says. "When people are pressed for time, they prioritize medical issues over social issues. Electronic medical records are just beginning to address social determinants of health."

Without a stronger focus on social determinants of health in nursing and case management, it is questionable how well nurse case managers integrate social determinants of health assessments in care planning, especially when they are caring for too many patients.

"When you address social determinants of health, are you empowered to do anything about it?" Carthon asks.

Nurses are trained to assess social needs and provide care. But if they work in a health system where they do not have the bandwidth to do so adequately, care transitions can suffer.

"Are they able to connect the dots between what's going to happen in terms of post-discharge care and specialty care?" she asks. "Do patients have transportation to get to their appointment? Do they really understand the needs of their chronic disease management?"

For case managers to perform the work they have been trained for requires system-level investment in the workforce so they can partner with patients in holistic care, Carthon says.

Case management and care transition work is happening in both acute care and in community care, where case/care management teams are working in concert with one another. They think about both clinical and social needs.

"WHEN PEOPLE ARE PRESSED FOR TIME, THEY PRIORITIZE MEDICAL ISSUES OVER SOCIAL ISSUES. ELECTRONIC MEDICAL RECORDS ARE JUST BEGINNING TO ADDRESS SOCIAL DETERMINANTS OF HEALTH."

"We bolster and intensify our case management services," Carthon says. "Case managers are talking to each other, creating systems that are interoperable to create communication across sectors."

Health systems can improve continuum of care work through innovative programs. A collaboration between healthcare research organizations and providers can address solutions to healthcare disparities. For example, one hospital found stark inequities for patients insured by Medicaid, Carthon says.

"They are more likely to be readmitted and return to the emergency department within 30 days," she explains. "We asked nurses, case managers, social workers, community health workers, home health workers, and patients about their experience [in continuum of care] and the patient's recovery journey."

They found there was a breakdown in communication and coordination, and many social needs were never addressed.

A solution is a clinical pathway that includes the community. Case managers can initiate the referral and identify Medicaid patients who are hospitalized and need a home care referral.

"That's a big deal because prior to this, only one in five people insured by Medicaid received a home care referral," Carthon says. "It was because case managers applied to Medicaid patients the Medicare regulations that a person had to be homebound."

But under Medicaid rules, a person who is discharged from the hospital can receive home care. Providers and case managers did not know the difference.

"We said we have to do something because we are not doing what we need to, and people are falling through the cracks," she says. "One out of five patients were not receiving the social support and clinical intensity they needed in their home environment."

Under a program to address this issue, case managers identify patients in need of home care services and assist with a referral. Also, hospitalists and discharging hospital physicians will accept responsibility for patients and extend their role until patients are connected to primary care.

"The home care nurse can call the hospitalist with any problems until the person receives primary care and primary care is the ongoing gatekeeper," Carthon says. "In that intersection between the hospital and primary care, which can last two to four weeks until the patient gets a primary care provider, you have someone to help."

The burden on hospitalists is low. In at least one experience with this care continuum project, hospitalists were willing to bridge the care gap for up to one month.

"It's a great solution," Carthon says. "Case managers initiate the referral and are involved in weekly case conferences. Patients continue to get skilled nursing through home care and have intensive oversight and case management."

Case managers are represented at weekly interdisciplinary acute care/community case conferences, which provides a feedback loop. ■

REFERENCE

1. Carthon JMB, Brom H, McHugh M, et al. Racial disparities in stroke readmissions reduced in hospitals with better nurse staffing. *Nurse Res* 2021; Sep 15. doi: 10.1097/NNR.0000000000000552. [Online ahead of print].

New Research Supports Use of a Prenatal Case Management-Style Intervention

By Melinda Young

A new study of an intervention that used care management techniques to help women improve prenatal health revealed women made some positive changes, including reduced consumption of sugary drinks, increases in physical activity, and a decrease in pregnancy-related anxiety.[1]

Called the First 1,000 Days, the systems-oriented program, which starts in early pregnancy and lasts through the first 24 months of infancy, is for low-income mother/infant pairs. It is designed to help women and their children eliminate obesity risk factors. Patient navigators called women, and health coaches worked with high-risk women.

"We implemented the program in several health centers in the greater Boston area with the goal of really improving obesity and related risk factors for low-income mothers," says **Meg Simione**, PhD, lead study author and research scientist in the division of general academic pediatrics at Massachusetts General Hospital and instructor of pediatrics at Harvard Medical School. "Our major findings were looking at obesity risk factors, and we saw [positive] changes in diet, screen time, anxiety, physical activity, and enrollment in WIC among the pregnant women. The study focused on women who lived in low-income communities."

One of the reasons for targeting a low-income population was weight-related disparities for women and children who live in low-income communities. "We didn't specifically target any other characteristics," Simione says. "The vast majority of our women were identified as Latinx."

Another study of the First 1,000 Days program revealed the intervention, combined with coaching, was associated with improved infant weight and maternal postpartum care.[2] A third study involving the program showed the systems-change intervention was associated with modest reduction in excess gestational weight gain among women who were overweight before pregnancy.[3]

The authors focused on a systems-level approach, which differentiates it from similar research. "There are other studies that have shown to improve behaviors and gestational weight gain, but they were targeted at an individual level," Simione explains. "We brought together a group of stakeholders and tried to change the system."

The intervention focused on these five behavior targets:

- Eating a balanced, nutritional diet;
- Drinking predominantly water and avoiding sugary drinks;
- Becoming physically active;
- Getting recommended amounts of sleep;
- Reducing stress through social supports.

Women received booklets, available in four languages, with information about how to meet the goals. They contained sections on gestational weight gain recommendations and behavior-changed goal-setting.

"The booklets provided to patients had information about what their behavior target should be, and steps to achieve that," Simione says.

For example, one booklet item advises physical activity most days,

meaning at least 30 minutes per day of moderate-intensity exercise like fast walking. The colorful bullet point information, which also includes photos of a pregnant woman jogging and another pregnant woman swimming, includes these points:

• Activity and exercise during pregnancy is good for most women.

• Exercise can:

- Give you more energy;

- Help relieve stress;

- Help you not gain too much weight;

- Make you feel better and happier;

- Make you stronger for labor and delivery.

The section on exercise also includes tips, such as staying active with a friend and to walk to the store, children's school, or daycare center.

Health information also was delivered through posters hanging in health centers and public health offices.

A third tactic involved a text messaging program in which women would receive two to three messages during their pregnancy.

"The text messages provided behavior change support and education," Simione says. "We also had videos available to them."

Patient navigators and health coaches also helped reinforce behavior change through phone calls and ensuring women were connected to resources. They answered any questions about the educational materials.

In addition to the goal of helping women change their behaviors, Simione and colleagues studied anxiety as an obesity risk factor. "We need to think about things beyond nutrition and physical activity," she explains.

Women were assessed with a pregnancy anxiety score that focused on five topics:

• The extent of worry about their health during pregnancy;

• Worry about their baby's health and normal growth and development;

• Worry about losing the baby;

• Concern about a hard labor or difficult delivery;

• Concern about taking care of a new baby.

Based on the pregnancy anxiety scores, researchers found the pregnancy-related anxiety score decreased from baseline to after the intervention.

"Women's well-being is critically important, so ensuring that they have the skills to reduce their anxiety and stress can lead to better maternal outcomes and also lead to better child health outcomes." ■

REFERENCES

1. Simione M, Moreno-Galarraga L, Perkins M, et al. Effects of the First 1,000 days program, a systems-change intervention, on obesity risk factors during pregnancy. *BMC Pregnancy Childbirth* 2021;21:729.
2. Taveras EM, Perkins ME, Boudreau AA, et al. Twelve-month outcomes of the First 1,000 Days program on infant weight status. *Pediatrics* 2021 Aug;148(2):e2020046706. doi: 10.1542/peds.2020-046706.
3. Blake-Lamb T, Boudreau AA, Matathia S, et al. Association of the First 1,000 Days systems-change intervention on maternal gestational weight gain. *Obstet Gynecol* 2021;135:1047-1057.

Addressing Healthcare Disparities

By Jeni Miller

Case management professionals typically work with a variety of people from day to day, and the work is broad and diverse.

For some patients, there exists certain health disparities — "preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities," as defined by the CDC.[1] Case managers are in a unique position to address these challenges as they serve as a more concrete bridge between healthcare and the patient.

"[The definition] speaks to gaps that are unjust or avoidable, or unfair," explains **Laurie Signorelli**, DBH, MSW, LMSW, AC, consultant for the Center for Case Management. "There is also a difference between equality and equity. In the U.S., we are speaking more of barrier eradication."

Kiandra Florence, a journalist covering health disparities among minority groups in America, agrees, adding health equity is concerned with "connecting people with the resources that they deserve."

She also notes there is a "fine line when it comes to opportunities for everyone to reach their full potential,

and it depends on resources and things that are available to them."

Since the topic itself can be contentious, many believe it is best to focus on what can be done at any given level to minimize the effects of these health disparities and help close the gaps in opportunities for appropriate healthcare.

"It's such a multilayered and multifaceted thing that moves from the basics of what case management tries to do to effect the health and outcomes for an individual patient, to a larger scale like community development, then to advocacy around national pollicies," Signorelli says. "But addressing the barriers to care — even transportation can be a barrier to healthcare — is important because there are so many aspects of health that are intertwined in order to gain equity for a population."

Understanding the Barriers

Florence, who has primarily studied the Black population's access to healthcare, notes the importance of finding "providers who are understanding of cultural barriers."

There is a difference between practical barriers and personal barriers, she says, but both need to be acknowledged and addressed to help move people toward receiving appropriate healthcare — and, hopefully, achieving their own personal best health possible.

According to Signorelli and Florence, practical barriers include:

• Inadequate access to basic needs like food, heat, cooling, shelter, transportation, and safety due to violence, trauma, neglect, or exploitation. "If patients are worried about these things, it's simply hard to focus on following a treatment regimen," Signorelli says.

• Mental health issues.

• Substance abuse issues. According to a report from the Kaiser Family Foundation, Mental health and substance use disorders together were the leading cause of disease burden in 2015, more so than cardiovascular disease and cancer.[2]

• Health literacy.

• Education.

• Health behaviors, such as exercise, walking, etc.

• Social isolation, especially for elderly people. "We saw this during COVID," Signorelli adds. "It greatly impairs access to healthcare."

• Lack of support from state governments, including lack of funding

• Portability of insurance. "Many private insurances and state Medicaid do not work when patients cross state borders," Signorelli notes. "If you have someone coming in from a neighboring state with Medicaid and they need a nursing facility, they may not pay for it as it needs to be in their own state. That creates a barrier for getting the access that they need."

There also is a focus on personal barriers to healthcare, which vary from person to person. "The first is mistrust, which comes from years of abuse in the medical system for people of color and [those in] low socio-economic parts of society," Florence explains. "With people of color, there is distrust that the [COVID] vaccine is actually going to help because of a history of medical providers illegally practicing on Black people, like in the Tuskegee Experiment."

For some patients, Florence says, symptoms are neglected or dismissed due to a myth that people of color have a higher tolerance for pain. Patients of color, especially those with a history of abuse or trauma, often are "more comfortable working with providers who look like them and talk like them, but there is a lack of access to people like that who understand," she notes. "If someone does not look like you, or represent you, it's a hard barrier to get over. They may feel that if they see only white doctors, there is no care there for them."

Some patients might experience a similar situation when it comes to the religious aspect of some hospitals. "So many hospitals are Christian or Catholic hospitals, and there can be a stigma that comes with that," Florence says. "There are studies that show that with Black and Hispanic people, there can be a stigma around mental health — in their religion, they're taught to follow through with the church and seek guidance and relief there, not seek out professional counseling."

These hospital structures often "cater more to those with Christian beliefs, which adds to the mistrust and lack of representation," Florence adds.

"If they don't relate, they might not open up as much," she says. "That can be another barrier between the healthcare provider and the patient."

Unconscious bias can play a part in the reception of appropriate healthcare, even among case managers.

For example, "One's perception that they have seen something happen more often with people of color than they have with Caucasian, middle-class people, predisposition to violence or substance usage, or one's perceptions of people of color or those from a cultures not their own, can impact their quality of care," Signorelli says. "Another example might be the perception that someone with a history of substance abuse is automatically drug-seeking, even if they have a real need for pain medication."

Who and Where

Both Florence and Signorelli agree those most affected by these barriers

include people of color and the socioeconomically disadvantaged, as well as those who are living in:

- impoverished areas or an area considered a food desert;
- non-healthy environments, like spaces with many fast food restaurants;
- unsafe neighborhoods with high crime rates;
- places with little to no access to mental health or medical facilities.

"A lot of this is happening in urban areas, where there is a lot more people of color represented," Florence says. "In these areas, people often have a lack of access to mental health facilities because the nearest one is 30 or 40 minutes away, and there is no bus access. Often, this is the area that suffers the most with mental health issues, especially among the homeless population."

In some areas, Signorelli says, homeless shelters are "set far away from community services that people need," or mental health facility "waiting lists go on and on forever and never meet the need of the population."

In some places, care coordinators can struggle to schedule appointments or care for people that simply meet their basic needs, she says.

Case Management's Role

Case management professionals can help mitigate some of these barriers and challenges just by staying mindful within their own role and taking the time to care for the patient as a whole person.

"Evaluations are very important," Signorelli explains. "We're particularly charged with looking at all social determinants of health, including healthcare literacy and education. We know that an informed patient is in a much better place."

Likewise, planning ahead and broadly can help case managers provide the best possible care to all people, but those who are especially affected by these barriers. It also helps to be sensitive to the experiences of others, even if those experiences are unlike the case manager's own.

"As a case manager, I have to start from where the patient and family are based on their experience," Signorelli says. "Case managers are in a position to be able to get people the right information so that they can make a good decision. They can tailor the patient's plan to the outcome of the assessment."

Signorelli also recommends case managers go above and beyond when planning for their patients.

"If possible, do a more robust plan," she adds. "If the patient is stable, ask, 'Do they have the right services? Will anything pose an issue to them in following their plan of care?' Look more in depth and consider both a short-term and long-term plan. We have to ask, 'What's the plan after the first 30 days of medication runs out?' Case managers should think longitudinally about attacking those barriers."

It also is important for case managers to establish good connections and networks throughout the community so they can provide their patients with the best possible opportunities while minimizing barriers.

"Many facilities are in value-based care arrangements," Signorelli explains. "Reimbursement streams reward efficient care and collaboration for care. Case management leaders are a very integral part of identifying gaps in the community and in other leadership. They can work to organize those networks and collaboratives, eradicating those gaps."

For example, "If only one place in the community can take someone with dementia and the beds are usually full, how can you look together with people in the community to solve this problem?" she asks. "Community leaders are often at the forefront, looking for these gaps, and case managers can help play a part."

Simple Compassion and Empathy

The case management role is about more than just planning for discharge.

"It's a plan of care, education, resource allocation, and it all starts with the person we are there to serve," Signorelli says. "We have to put the person at the center, who they are, what their goals are, what resources and information they are going to need. If we remember this, we'll be in a better position for advocating for them."

Likewise, Florence describes how a little empathy goes a long way.

"It's so intertwined," she says. "If you have someone leading the care and compassion in leadership, if you're a leader of a case management department and you're seeing these issues, be the change. Advocate for the patient in the best way possible. Go the distance for them. Speak to leadership. Take control over the lack of care that you're seeing. Be the change you want to see."

Signorelli acknowledges "when people are feeling pressure, empathy often goes right out the window. There can be lots of pressure on length of stay and more. But it all starts with compassion and empathy. These are people, not widgets. We have to be mentors in this regard."

There are many benefits to showing compassion and empathy, even in the difficult or stressful moments of healthcare. Doing so can make positive changes that reverberate throughout the community.

"Listening goes a long way, and there is a difference between hearing someone and listening to them," Florence shares. "Case managers are in a high-stress environment, but being sure to listen will lead to being more apt to understand the patient and do what is needed to truly help them. It helps address mistrust issues when [healthcare providers are] being more understanding. When you learn more about who you're working with, and who is involved in the community, it might lead to case managers going to other departments in the hospital and taking the initiative in areas where they can't make the change alone."

Signorelli agrees, adding, "We have to have an extensive knowledge of resources, of course, but we have to first understand the needs of the person."

The good news she says, is "we are more alike than different."

"Most people want safety, comfort, food, and shelter. Think about the commonality of the human experience and look at everyone that way," Signorelli says. "It really helps toward having compassion and understanding for someone whose experience may be different than your own." ■

REFERENCES

1. Centers for Disease Control and Prevention. Health disparities. Updated Jan. 31, 2017. https://bit.ly/3FAZFw3
2. Kaiser Family Foundation. Visualizing health policy: The costs and outcomes of mental health and substance use disorders in the US. Aug. 1, 2017. https://bit.ly/3cDnfvv

Changes in Senior Care Post-COVID-19

By Jeni Miller

Although the COVID-19 pandemic is not over, it is not too early to see changes to senior care because of what was learned in 2020 and beyond.

"Over the last 19 months, COVID-19 has disrupted how care is sought and provided in all levels of care," says **Colleen O'Rourke**, senior vice president of network and clinical solutions for naviHealth. "Regardless of setting, all healthcare institutions and providers have been stretched to their maximum to meet the needs of those most ill."

In long-term care (LTC), case managers should note changes in occupancy and staffing at these facilities.

"Unfortunately, there have been close to 140,000 resident deaths in nursing homes due to COVID, representing approximately 11% of the nursing home population," O'Rourke says.

In November 2021, the number of vaccinated LTC residents per facility hovered around 86.2% nationwide.[1] But as of now, the effects of COVID-19 remain significant.

"Decreased occupancy due to resident death puts the LTC facilities at risk financially," O'Rourke says. "LTC staffing shortages put the residents living in these facilities at risk for suboptimal care because skilled and non-skilled care hours decrease."

Worry over nursing home placement remains "significant, resulting in many more patients, who would normally qualify for LTC, to remain at home with additional support of family or home health services," she notes. Likewise, rehabilitation facilities were affected by the pandemic. Delivery of these services have had to adapt over the last nearly two years.

"Rehabilitation delivery has varied significantly in skilled nursing facilities over the course of the pandemic," O'Rourke explains. "Initially, due to isolation, many residents were offered limited or modified therapy programs in their rooms instead of rehabilitation gyms. Some treatments were virtual — with a therapist on an iPad — and some treatments didn't occur at all. All of these factors impacted a patient's ability to make timely functional gains and discharge to home successfully."

With both vaccinations and personal protective equipment largely available, rehabilitation gyms should reopen, especially considering the "practice of good infection control technique and cleaning schedules should allow service delivery in the most optimal environment," she says.

Staffing issues remain a concern in many areas of the country. This can affect the quality of care.

"We are hearing, in some pockets of the country, that there is a shortage of rehabilitation professionals in [skilled nursing facilities]," said O'Rourke. "It is unclear if this is a direct result of the

pandemic and therapists are leaving the workforce, or if it is related to the downsizing of rehabilitation departments in 2018-2019 when CMS reimbursement was no longer tied to therapy intensity. Regardless, rehabilitation is a critical component to a patient's ability to recover from a hospitalization and return to the community. Skilled nursing facilities that accept patients for rehabilitation services must be able to provide the level of care and service a patient needs to recover timely."

With many care facilities unable to accept as many patients as usual, case managers need to be more diligent in creating discharge plans.

"Case managers discharging patients to skilled nursing facilities must be acutely aware of the facility's ability to meet the patient's needs," O'Rourke says. "Reputable [facilities] that are struggling with staffing levels or a COVID-19 crisis may decide to temporarily delay admissions to their facility. We should respect this decision, as it is in the best interest of current and future patients."

For patients with complex needs, "Case managers should be comfortable seeking confirmation that the skilled nursing facility has the ability to care for the new patient," she notes. "Further, it is perfectly acceptable to clearly outline the specific expectations for care in the referral and discharge documentation. During these challenging times, this extra diligence is a requirement and will help prevent readmissions and negative outcomes for patients."

According to O'Rourke, these are several ways case managers can ease care transitions:

• Remaining open and honest with the patient and family throughout the process;

• Ensuring the patient's needs can be met safely at home with support and/or services;

• Encouraging the families to tour a potential facility in advance;

• Considering staffing ratios, COVID-19 cases, admission protocols, and visitor policies at skilled nursing facilities;

• Empowering families to advocate on behalf of their loved one.

Recent Changes to Case Management Practices

Even as informal changes take place, there are other formal considerations for case managers to keep in mind as they work with senior patients during and post-COVID-19.

"First, COVID waivers for admission to skilled nursing facilities without authorization vary significantly from state to state and from health plan to health plan," O'Rourke explains. "It is important for case managers to be up to date on policies and procedures that are specific to their region."

Changes in skilled nursing facility admission practices are a second area in which case managers should be well-informed.

"Patients may require the first dose of the vaccination before entry," O'Rourke says. "The facility may have tighter time frames for admission — day shift only or Monday through Friday — because of staffing or other issues, to avoid any backups of patients in the hospital. [Skilled nursing facilities] likely need a more coordinated effort."

While the entire healthcare field has felt the reverberations of the COVID-19 pandemic, senior-focused facilities like long-term care, skilled nursing, and rehabilitation have been "hit particularly hard," O'Rourke laments. Worst of all, these hits are personal for staff and residents.

"They have lost long-term care residents who they came to love and treat like family," O'Rourke shares. "They have faced the most scrutiny from our federal government compared to any other care delivery provider. They were the first to have requirements for staff vaccination. They face an unprecedented staffing shortage. Yet, despite all of this, skilled nursing facilities' dedicated professionals show up every day to take care of our moms, dads, grandmothers, and grandfathers with care and compassion."

Case managers can follow the example of these patient healthcare providers. "Professional courtesy, grace, and empathy is needed," O'Rourke says. "Teamwork and doing whatever is in the patient's best interest has never been more important." ■

REFERENCE

1. Centers for Medicare & Medicaid Services. COVID-19 nursing home data. Updated Nov. 17, 2021. https://bit.ly/3x7032o

COMING IN FUTURE MONTHS

- Trauma is overlooked social determinant of health
- Best practices in ED acute care utilization review and case management
- HIV-geriatrics program improves quality of life for patients with HIV
- Team approach to value-based care

HOSPITAL
CASE MANAGEMENT

CE QUESTIONS

1. **New research that focuses on social determinants of health, poverty, and mental health issues shows monthly healthcare expenditures for people with chronic conditions are different in what way if the person is diagnosed with comorbid depression?**

   a. Expenditures are lower for people with both chronic conditions and depression.
   b. Expenditures are 32% higher for people with both chronic conditions and depression.
   c. Expenditures are 54% higher for people with both chronic conditions and depression.
   d. Expenditures are 67% higher for people with both chronic conditions and depression.

2. **Project Extension for Community Healthcare Outcomes is designed to improve care transition between discharging hospitals and skilled nursing facilities (SNFs), using:**

   a. videoconferencing between SNF multidisciplinary teams and hospital teams of clinicians, pharmacist, and case manager.
   b. case management liaisons who work to facilitate accurate and timely communication between hospitals and SNFs.
   c. a text messaging program between hospital and SNF care coordinators.
   d. physician weekly rounding via videoconferencing.

3. **Researchers found several specific characteristics associated with high-cost hospital stays. Which characteristic is associated with high-cost hospital stays, and which condition has the highest median cost of care?**

   a. Lung disease is the highest cost, and race/ethnicity was associated with higher costs.
   b. Hip surgery is the highest cost, and people younger than age 50 years were associated with higher costs.
   c. Heart failure is the highest cost, and older men are associated with higher costs.
   d. Strokes are the highest cost, and post-menopausal women are associated with higher costs.

4. **A new study revealed Black ischemic stroke patients have hospital readmission disparities compared with white patients, unless hospital staffing is:**

   a. a physician-to-nurse ratio of one physician per 15 nurses.
   b. a nursing ratio of one nurse caring for two patients per shift.
   c. a hospital workforce that includes one case manager per 10 patient beds.
   d. a nursing ratio of one nurse caring for four patients per shift.

5. **The First 1,000 Days intervention focuses on helping pregnant women make improvements in five behavior target areas, including diet, exercise, sleep, drinking water, and:**

   a. relationship-building.
   b. reducing stress.
   c. lowering depression.
   d. learning parenting skills.