HOSPITAL CASE MANAGEMENT

COVERING CASE MANAGEMENT ACROSS THE CARE CONTINUUM

INSIDE

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Chatbots and Technology Make Case Management Affordable, Efficient

By Melinda Young

The nation's increasing focus on value-based care and population health has led to a greater need for case managers. But the economics of paying for these positions remains challenging. One health system found a way to extend and improve case management through a technological solution.

It is hard to hire enough managers to handle all the patients who need longitudinal care management, according to **Mark Schario**, MS, RN, FACHE, vice president of population health and president of the University Hospitals (UH) Quality Care Network, UH Coordinated Care Organization, and UH Accountable Care Organization, Inc., of University Hospitals Health System in Cleveland.

> THE CHATBOT ENABLES CASE MANAGERS TO SPEND MORE TIME ON HIGH-VALUE INTERACTIONS WHERE CLINICAL JUDGMENT IS NECESSARY.

Collaboration with a technology company can provide solutions and tools that help case managers extend their reach and work with patients more efficiently. Technology enhances communication between nurse case managers and patients.

Technology can add a lot of extra power to one individual case manager, Schario notes. The health system's technological tool is a chatbot that sends daily text messages to patients with specific diseases and chronic

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conditions. These messages educate patients on self-care behaviors and ask them about their weight, blood pressure, and other health factors.[1]

Chatbot Aids Disease Management

The chatbot outreach and educational messages are sent to thousands of patients with congestive heart failure (CHF), chronic obstructive pulmonary disease, pneumonia, acute myocardial infarction, stroke, generic post-acute issues, asthma, type 2 diabetes, and hypertension. Each chatbot message includes a short educational message.[1]

Schario and colleagues found chatbots interact frequently with patients, communicating asynchronously so patients can manage these on their own schedule. The chatbot enables case managers to spend more time on high-value interactions where clinical judgment is necessary.[1]

"We have a large population with many folks with chronic disease," says **Carol Bahner**, BSN, RN, CCM, study co-author and manager for care management in population health with University Hospitals in Cleveland. "When we enroll someone into one of our chronic disease [categories], the chatbot will automatically text or email the patient daily or every few days, depending on their disease state. It asks them how they're doing, how is their breathing, and what is their blood pressure."

The chatbot also provides information on why it is important for CHF patients to weigh themselves daily and eat a low-sodium diet.

"Their responses are sent out to nurse case managers," Bahner says.

Risk Levels

The technology analyzes patients' responses and divides them into categories of green, for patients who are doing well with managing their condition; yellow, for patients who need a little intervention or follow-up to prevent a crisis; and red, for patients who need medical attention through a 24/7 nursing hotline.

If a rising or elevated risk is detected, nurse case managers contact the patients. "They might say, 'I see your blood pressure was a little elevated today; let's talk about that,'" Bahner says.

Yellow also might indicate the patient did not refill a prescription. The nurse case manager would ask why the patient did not take the medication.

EXECUTIVE SUMMARY

Technology can help extend case management, improving efficiency and costs when managing large populations of at-risk patients.

- A chatbot tool can send patients daily text messages that provide information on self-care behaviors and ask them about their current health status.
- The technology can analyze responses and flag patients who need medical attention or follow-up.
- Case managers can review the tool's patient data and target interventions based on what they find.

"If there is a green response, it means the patient is doing great and doesn't need outreach or a phone call that day," Bahner explains. "Red is the highest escalation and means the patient has a concerning response. The patient is either directed to call the 24/7 nurse advice line, or the nurse could call the patient to help them problem-solve."

The chatbot would send the patient the nursing hotline number the patient could automatically dial by clicking on that number if he or she receives chatbot messages via cellphone. If the patient receives email messages, the chatbot will provide them with a number to call. Whenever patients call the nursing hotline, the technology records how the patient made the call. Nurse case managers also can see whether patients visited a provider or were seen in the emergency department (ED).

"We do not get very many red responses," Bahner says. "We view chatbot as a screening and educational platform."

The chatbot's helpful educational tips include reminding patients to weigh themselves each day and to wear the same clothing for a more accurate weight. "We want to reinforce the habit of weighing and reporting weight," Bahner notes.

The chatbot program began in late 2019 and provided some unanticipated benefits during the COVID-19 pandemic's initial national shutdown. For instance, some patients who received daily chatbot messages reported this was their only daily connection in a world of isolation.

"It was a positive consequence," Schario says. "Even if the chat sequence would end, they wanted to re-enroll because they kept engaged with someone about their care."

The chatbot technology continues to serve patient populations well, he adds.

Asynchronous Communication a Plus

Patients and case managers also have liked the tool and the asynchronous connection aspect of chatbots, Schario and Bahner say. What this means is the technology sends messages and records patients' responses whenever the patient wants to respond. The patient might respond at 2 a.m. or 6 a.m., and the response is not dependent on a case manager's hours and timing of the follow-up phone call.

"Care managers can be very frustrated by leaving outreach call messages. Trying to connect at any moment in time is very difficult," Schario explains. "If someone wants to engage at 3 a.m., the computer is waiting for them, and they could do this."

Initially, the case management team expected red messages in the middle of the night. This did not happen.

"That's one of the powerful parts of the chatbot that has gone beyond traditional care management," Schario says. "Whether one person is trying to do outreach at one moment in time or trying to connect with patients between 9 a.m. and 5 p.m., it's not always convenient for patients."

The chatbot always is convenient. "Patients say they feel so much safer because they know a nurse will call them if something happens," Bahner says. "In the beginning, some of our staff said, 'No one will want to talk with a machine. They want to talk to us.' But they were surprised. We're in a society that wants to text right now, and we had a lot of people who engaged more readily through text than through a phone call."

Even older patients have enjoyed using the text messages or emails. "When you study research, you see that people into their 80s are well engaged in mobile technologies," Schario says. "Clearly, people who don't have the cognitive ability can't do it, but people in their 80s are fully involved with some level of technology."

Chatbot technology might not work in all cases of older, at-risk patients. For instance, it might not be the best approach for follow-up of patients in nursing homes because they could mistake the messages as coming from staff in the facility.

The goal is for the technology to help case managers and providers identify at-risk patients before a health crisis. If the chatbot indicates patients are in the yellow zone, or even the red zone, then case managers can intervene and potentially prevent a crisis.

"A patient just may need one little change, and that could be done by having the case manager talk to the primary care provider about making a small medication change," Schario explains.

Nurses can quickly identify the person with concerns and help them manage their care and receive services.

"Nurses are able to reach out to the right people at the right time," Bahner says. "The nurses love it. Even those who were skeptical in the beginning love the technology that lets them see what's happening with patients. Our nurses are all about wanting to help people feel better and manage self-care, and this helps them do it." ■

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Addressing Vaccine Hesitancy Among Staff and Patients

By Melinda Young

Healthcare workers were hailed as heroes in 2020 during the early months of the pandemic. They were shown in memes in superhero costumes. People delivered pizzas to hospitals. Strangers praised healthcare workers and thanked them for their service — much as they would a person in military uniform.

That changed in 2021 after the COVID-19 vaccines became widely available. Unvaccinated COVID-19 patients continued to flood emergency departments and fill hospital beds, and people objecting to vaccine and mask mandates held protests, sometimes even in front of hospital doors.

"Now, it seems people have forgotten that [healthcare workers] are still putting their lives on the line every single day," says **Kathleen Moreo**, RN-BC, BSN, BHSA, CCM, CDMS, founder of PRIME Education, LLC, in Fort Lauderdale, FL. "Now, you have polarization of what this disease has done to us as a society. Regardless of where your thought process is or whether you believe in vaccines, look at the folks coming into the hospital, and realize that every day they come into work they are facing an ethical dilemma. Every single day."

This is a new phenomenon and extremely challenging for case managers and other healthcare professionals.

In other national crises when lives were at stake, including the 9/11 terrorist attacks and World War II, the nation pulled together and largely embraced restrictions and calls to action. In the case of the COVID-19 pandemic, with the death toll heading toward 1 million Americans, many are placing their individual beliefs or desires ahead of public health and the national welfare. Healthcare professionals are caught in the middle of the fight over vaccines and masking mandates.

"You have people who are sophisticated individuals who still will not get vaccinated," Moreo laments.

> "IT SEEMS PEOPLE HAVE FORGOTTEN THAT [HEALTHCARE WORKERS] ARE STILL PUTTING THEIR LIVES ON THE LINE EVERY SINGLE DAY."

At the same time, health system leaders have to navigate between confusing federal and state instructions. Some states prohibit them from mandating vaccination, while the federal government requires it for all organizations that receive federal funding, such as Medicare and Medicaid. This leaves case management directors and other health system leaders with too little direction and help in preventing the spread of the highly contagious COVID-19 omicron variant.

"If everyone were vaccinated, health systems would be in a way better place right now," says **Stephen Colodny**, MD, FIDSA, FACP, chief of infection control and prevention at St. Clair Hospital in Pittsburgh. "The incidence of hospitalization after vaccination is much lower than incidence of hospitalization among unvaccinated patients."

Vaccines prevent serious infection, but masking and social distancing prevent people from coming into contact with the virus, Colodny says.

Staff members who have not been vaccinated complicate work schedules and infection prevention for leaders. For example, if a case management leader's employee has not taken the vaccine, this employee could be out of work for days or weeks if he or she is exposed to the virus.

"If we lived in an ideal world where everyone listened to infectious disease physicians, then every employee would be vaccinated and get their booster," Colodny says. "Incidences of exposures and infections among staff would be much less and put much less pressure on staffing levels."

Because of misinformation about the COVID-19 vaccines and the cultural and political fight over vaccine mandates, incentives and educational sessions are not as effective at convincing vaccine-hesitant people to take the shot.

"The only things that have been successful are mandates," Colodny says. "I'm interested to see if omicron has a different effect because fear seems to be a better motivator than information."

When hospital healthcare workers deal with patients and co-workers who refuse vaccination, they have a moral and ethical responsibility to provide safe care to patients. But

when they are at the bedside, how do they feel about it?

"There's a dichotomy of thought process that hangs over our heads every day we go into work," Moreo says. "We're a mess right now, and it's not anything we could have anticipated." Case managers and healthcare leaders should suspend their judgment when dealing with unvaccinated patients and staff, she adds.

Be careful to not present vaccination as a right and wrong belief because many people who are vaccine hesitant have received inaccurate information from their leaders, politicians, and the media, as it often misinterprets research. This makes people very skeptical.[1]

"Everyone is quoting the science, and it's appalling to me that you have media interpreting science," Moreo says.

From a case management perspective, all they can do is educate patients and families. "We're at a crossroads where we have a greater responsibility than ever before to educate patients appropriately, and it's inevitable that we'll hit ethical dilemmas in doing this," Moreo says.

Case management leaders should look to their own biases about vaccination. It is natural to feel resentful toward patients who are in the hospital with an illness that vaccination could have prevented. This influx of patients is exhausting hospital staff and has resulted in some case managers having to work in COVID-19 units.

"It's a tough time, and many case managers are being pulled from their jobs and being put on the floor, so you can imagine the resentment they're experiencing," Moreo says.

The entire situation is unfair to staff and managers. They have little control over decisions about mandates and workflow changes. Manage resentment and biases and treat co-workers and patients with patience and empathy — even when people have made poor decisions that helped contribute to the crisis hitting hospitals.

"It's a really unfair situation. I feel so sorry for our middle management people because they really don't have the support they need," Moreo says. "They're on an island, making decisions on their own."

Managers can provide unvaccinated staff with information, but it is likely persuasion will not work because vaccine hesitancy has become a cultural issue. There is considerable mistrust among those who refuse vaccination for COVID-19.

"Anytime you have a negotiation, the best place to start is from a position of neutrality," Moreo says. "Say, 'Help me understand where you are in your thought process. What are the top three things that concern you about vaccination?'"

Another tactic is to hold a staff meeting or a lunch-and-learn where people can discuss their reasons for taking the vaccine or their reasons for not doing so.

"It's important to verbalize what your thoughts are and encourage the team to do the same," Moreo says. "This is way beyond understanding this is a disease, or pandemic, or public health; people's biases are very intertwined in this process."

As omicron spreads and scientists learn more about its effect on both vaccinated and unvaccinated people, public health officials will offer more suggestions on how to prevent infection and reduce risk of serious illness.

"We'll know more in six months than we know now," Moreo says. "Even if you can't offer solutions, you can offer a sounding board to your staff because it's important for them to know that other people are struggling with this." ■

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Study Author Explains How Care Coordination Failures Create Healthcare Waste

By Melinda Young

Hospital Case Management asked **Joseph J. Fifer**, FHFMA, CPA, president and chief executive officer of Healthcare Financial Management Association, about his findings that failures in care coordination lead to costly waste in the healthcare industry in the following interview, which has been lightly edited for length and clarity.

HCM: According to your new paper about healthcare changes resulting from the COVID-19 pandemic, failures in care coordination create up to $78 billion in waste each year.[1,2] How do these failures result in such costly waste?

Fifer: Current limitations on interoperability among healthcare providers make it hard for providers to share electronic health record information with each other. Quick example of potential savings: New York state's health information exchange reduced unnecessary spending by up to $195 million per year by helping participating clinicians quickly access and share medical records.[3]

It's not only about sharing between hospitals in different health systems — it's also about sharing with rehab or subacute care, skilled nursing facilities, and community service agencies. Case managers who are involved in discharge planning understand these issues well.

Providers should demand greater interoperability from vendors. In some cases, providers need to reframe this issue. The benefits of sharing health information, in terms of improving quality of care and reducing unnecessary spending, outweigh any competitive advantage of keeping the information within a health system. That's not the way to maintain patient loyalty.

'Health Debt' Is Growing

HCM: Would you please explain what the "health debt" of the pandemic is and how it may affect hospitals, case management, and care coordination in the next decade?

Fifer: When COVID-19 started spreading in the United States in early 2020, a lot of healthcare was put on hold. In part, that was due to hospitals being forced to cancel scheduled procedures to have all hands on deck for COVID-19 patients. Many patients were inclined to avoid healthcare settings for fear of catching COVID-19. But, of course, other healthcare issues didn't wait for the pandemic to end. The net result: Missing out on those healthcare services will have ripple effects for years to come. That is what's meant by the term pandemic "health debt."

For example, fewer physician office visits for management of chronic conditions, such as diabetes and hypertension, raises the risk of complications that could occur months or years down the road. This was mitigated to some extent by the increase in telehealth and virtual visits. The acceleration of virtual health will be a lasting silver lining of the pandemic. However, despite the role of virtual health, hospitals are reporting treating patients who are much sicker than they would be if they had previously received necessary monitoring and care.

Another example: Consider the impact of missing months — and, in some cases, years — of cancer screenings, such as mammograms and colonoscopies. As a result, cancer is being diagnosed at more advanced stages. This is not just based on anecdotal accounts; about two-thirds of radiation oncologists surveyed by a medical specialty society in early 2021 reported that patients were presenting with more advanced cancers, as compared with the previous year, and that existing patients had experienced treatment interruptions.[4]

Not all of the health debt from the pandemic is the result of missing healthcare. Some of it is due to an increase in mental health and behavioral health issues. The stress and loss associated with the pandemic has resulted in reduced physical activity, higher alcohol consumption, and more people of all ages reporting depression and anxiety. About one-third of all U.S. adults experienced symptoms of depression in the first half of 2021, up from about 9% before the pandemic, and also higher than it was in the first year of the pandemic.[5]

HCM: What are your predictions for how health systems and community providers may do a better job of incorporating social determinants of health into their care? How is this tied to value-based care and payment?

Fifer: First, the background: Health status is not a function

of healthcare alone. The biggest influencer — 60% — is social determinants of health, which include security of all kinds (such as food, employment, domestic relationships, and neighborhood), other environmental factors, and behavioral factors. Improving social determinants is a major undertaking that requires a high degree of collaboration. No one entity can do it alone, and it is unreasonable to assign responsibility for addressing broad societal issues solely to the provider community.[6]

We at the Healthcare Financial Management Association convened a meeting of thought leaders in 2019 that focused on social determinants, including who should take the lead on these initiatives. There was no consensus on that, and there still isn't.[7]

Meanwhile, provider organizations that invest in addressing social determinants are typically not getting paid for doing so, under the prevailing fee-for-service payment model, and adoption of value-based payment, which is more conducive to factoring in social determinants, has been slow. Healthcare leaders who seek to pursue social determinant initiatives for the good of their communities often see their ideas wither on the vine because it's difficult to get a return on that investment.

But the reality is that we, as a society, have to figure out how to address social determinants of health more effectively and sustainably. Value-based payment models are one route to achieving this goal. Forward-thinking healthcare organizations are taking the long view and inspiring others. That's a start.

HCM: What other long-term effects will the pandemic have on population health/case management and care coordination in the United States?

Fifer: The pandemic has a disproportionate impact on people of color, which shined a spotlight on health inequities that existed long before COVID-19 was a known disease entity. To the extent that attention and resources shift to reducing health disparities, that will be a silver lining of the pandemic.

"THE REALITY IS THAT WE, AS A SOCIETY, HAVE TO FIGURE OUT HOW TO ADDRESS SOCIAL DETERMINANTS OF HEALTH MORE EFFECTIVELY AND SUSTAINABLY."

These health disparities range from social determinants of health to access to healthcare and to health insurance. Case managers can play a very important role in improving health equity. The pandemic may be a catalyst, but the impact goes way beyond that.

Also, the future of investment in public health remains unclear. Months ago, it was conventional wisdom in some healthcare circles that public health would be an area of greater focus post-pandemic. Public health should play a prominent role in population health, by definition. However, recent rhetoric sheds doubt on the prospects for rallying around additional investment in public health. Like many other issues, public health spending has become more politicized as opposed to less so. That is disappointing because of the complex nature of population health and the previously mentioned need for engagement by multiple entities at all levels.

Overall, I believe the pandemic will shed light on many flaws in our society's approach to population health. Improving it will necessitate strong leadership and payment reform.

HCM: Is there anything else you would like to note about new trends in healthcare?

Fifer: First, all the trends in healthcare support the importance of what case managers do. I speak for the finance professionals who make up our association's membership when I say how much we appreciate the professionalism, expertise, and dedication case managers bring to their roles, especially during these challenging times. Case managers are valuable members of the healthcare team, as my own family's personal experience has shown. When done well, case management is wonderful. Our healthcare system will not get simpler, but people may experience it that way if case managers play a larger role in the delivery of care.

Second, there is clearly a movement, at long last, toward more consumer-friendly processes and practices in healthcare. Granted, we still have a long way to go compared to other industries. However, there is a trend, supported within legacy healthcare organizations and by newcomers, such as those funded by private equity, venture capital, or investments by mega corporations, toward ease of use by consumers. I am encouraged by these trends, and believe the ease of use within healthcare will look much different five years from now. ■

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Childhood Trauma Is an Overlooked Social Determinants of Health Factor

By Melinda Young

Research demonstrates strong connections between exposure to adverse childhood experiences (ACEs), chronic stress, and poor health, including frailty in older adults.[1-4]

The Centers for Disease Control and Prevention (CDC) estimates three in five adults have experienced at least one type of ACE and about one in six have experienced four or more types.[5]

"Exposure to ACE and chronic stress can result in an increase in inflammatory processes, including increases in cancer, lung disease, obesity, diabetes, heart disease, substance use disorders, suicidal ideation, and suicide attempts as well as increased depression, anxiety, and post-traumatic stress disorder," says **Laura E. Gultekin**, PhD, FNP-BC, RN, clinical assistant professor at the University of Michigan School of Nursing. "In healthcare, we're so reactive to things, and we're not great about being preventive."

For example, health systems could make it a priority for providers and case managers to identify ACEs among adult populations and ask for better integrated services and models of care to serve this group.

"We could think about how physical health and mental health [fit] together," Gultekin says. "We don't have good models in this country for how that can look, and those integrative models are important to tie together."

ACEs and Frailty

One example of how ACEs can affect physical health involves frailty in older adults. A new study of Canadians, ages 45 to 85 years, revealed people exposed to ACEs showed elevated levels of the frailty index (FI) than those who were not exposed to childhood trauma.[1]

The biggest difference observed was for neglect. The study's findings suggest screening for ACEs may be useful in identifying people at risk of frailty.

"We need models where mental health professionals are ready to partner with physical health providers so there's an easy warm handoff between services and solid communication between systems," Gultekin says. "We do see this in some models, like adolescent medicine, where they've done a good job of connecting physical health to behavioral health. But it's not standard in most adult models."

Barriers to this integrated model are challenges in terms of payment models and the tremendous shortage of mental health providers. "We don't have a good system for payment for the intervention," Gultekin says.

People with physical health and mental health problems connected to ACEs could be engaged in mental health services and receive medication for depression. But they often do not receive therapy in an integrated model.

"Talk therapy, group therapy, cognitive behavioral intervention tend to be poorly funded in our standard insurance," Gultekin says. "Not having enough providers or reimbursement means most people don't have access to high-level, trauma-informed mental health services."

From a case management perspective, the first step is to screen

patients for ACEs. For example, the CDC provides online information about ACEs as well as a behavioral risk factor surveillance system.[5]

"The next step is after someone screens positive for ACEs," Gultekin says. "We need to recognize their reactivity and try not to mislabel it so we can respond to it appropriately."

Stress Response and De-escalation

People with ACEs are more reactive to stress. "They misperceive situations and think they are threatening more so than someone who doesn't have ACEs or traumatic stress," Gultekin explains. "Cortisone and adrenaline are released and increase their blood pressure as part of the flight or fight response."

For instance, when someone with an ACE hears a healthcare professional discuss their weight, eating behaviors, or drinking behavior, they are more likely to feel that discussion is a threat against them. They tend to become more reactive and self-protective than would patients who have not experienced an ACE.

"This makes them louder, angrier," Gultekin explains. "We see that with COVID when people are separated from their loved ones and can't see someone in the hospital, or when they're being told they have to manage this illness alone."

This is a situation in which a patient might experience a high-intensity stress response. "Someone who doesn't have high-intensity trauma might say, 'This is bad, but I can talk to people on the phone,'" she says. "But those who have trauma may be more reactive and sometimes be aggressive, physically or verbally, to staff."

Healthcare providers can interpret that behavior as an aggressive response when it is just a patient's attempt to keep himself or herself safe. "When someone is in an escalating moment, they don't always recognize they're in an escalating moment and are [reacting] to the fight or flight response," Gultekin says.

When this happens, the provider must ensure his or her own safety. They need to make sure they are not in a situation in which they are confronting a patient who is angry and aggressive on their own, and in a manner in which they could be hurt by the patient.

"Leave the door open and have other people with you," Gultekin advises. "When the patient responds in a negative manner, rather than escalating the situation, try to de-escalate by talking more quietly and trying to soothe the situation rather than make it more stressful."

A de-escalating response could be to tell the patient: "I can't bring you a family member right now or get you to that location, but I can connect you with another family member or talk to your provider," Gultekin explains. "Help them recognize that you're working with them and not against them."

When people are in the middle of the fight-or-flight response, they are not going to respond rationally to what is happening. The right words can help them calm down.

For instance, a case manager could say, "You seem really upset. This is an important topic, so I'm going to give you some time and come back to talk with you," Gultekin says. "This is a way to create safety for you and the patient."

"Acknowledge what you're seeing and feeling, saying, 'I'm seeing that you are upset, that this is a different topic for you,'" she adds. "'This is a tough situation. I need some space for myself to think, and I would like to offer you some space to think. Do you want five minutes, and I'll come back? Or, do you want me to return tomorrow?'"

Offering patients some balancing of power by letting them make choices can help. It is the same tactic parents offer young children.

Case managers also should remember people who have experienced trauma need transparency.

"Say, 'I know you have this type of insurance and you want to go to this facility. But the last time we worked with someone with your insurance, they didn't accept someone with your insurance at this facility. What else could we do if this doesn't work out?'" Gultekin explains. "Planning ahead and being transparent is important. You can help them set expectations and let them be a part of decision-making." ■

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Universal Method Needed to Collect Social Determinants of Health Information

By Melinda Young

Healthcare professionals seek a standardized universal method for collecting and using social determinants of health (SDOH) data, according to new research.[1]

"Social determinants of health contribute to 50% of health outcomes," says **Sophia Kostelanetz**, MD, MPH, lead study author and assistant clinical professor at Vanderbilt University School of Medicine. "Although the relative impact of one social determinant of health over another remains unclear, their relationship with a patient's overall health is indisputable."

The issue is that SDOH data collection is inconsistent in clinical practice. "This study demonstrates that healthcare professionals seek a standardized universal strategy for collecting, leveraging, and disseminating social determinants of health data," she says.

Kostelanetz and colleagues determined healthcare professionals across all disciplines reported important barriers to screening for SDOH, including:

- Lack of resources to address social needs;
- Lack of time to ask about SDOH;
- Lack of support staff to ask about social needs;
- Lack of training to respond to social needs once identified.

"Qualitative interviews supported survey findings and described barriers, including lack of time, resources, standardized approaches, and professional burnout," Kostelanetz explains. "On a systems level, the lack of a standardized universal approach would certainly require institutional leadership and funding for implementation, although these themes were not explored in this study."

Kostelanetz and colleagues found nearly all survey respondents identified social workers as the most appropriate people to screen for social needs, and that information about patient's social needs could be used to improve patient care and communication with patients. Survey respondents also agreed patients' SDOH information could be used to improve trust, and screening for SDOH should be a standard part of care.

The researchers also determined health professionals screened more routinely for health behaviors, such as alcohol and drug use, than for SDOH.

"We were surprised that health professionals readily identified the discrepancy between the social determinants of health domains they identified as important, such as health literacy, housing, and

financial strain, and those domains that are routinely assessed in their clinical setting," Kostelanetz says. "Notably, social workers perceived barriers to implementation the least. These findings suggest the greater knowledge of assessing and addressing social determinants of health may play a critical role in facilitating universal screening for social determinants of health."

Based on the findings, the most important factors to consider when implementing universal SDOH screening include:

- Providing appropriate health system resources for screening, support services, and referral to institutional resources, community organizations, and public health agencies;
- Partnering with community organizations to bolster resources;
- Health professional education to improve provider awareness and use of existing resources;
- Addressing barriers related to healthcare professionals' perceived inability to address needs;
- Leveraging the unique expertise of social workers;
- Focusing on the SDOH most likely to affect outcomes, such as food insecurity, transportation, and housing;
- Providing each team member access to SDOH information in a shared electronic health record (EHR) platform.

An EHR-based assessment with documentation and dissemination of social needs could serve as a driver for increasing health professional awareness, Kostelanetz says.

Improving screening and collection of SDOH data requires funding. This may be improving.

"Notably, the changing landscape of payment models may provide incentive for these needed systems changes," Kostelanetz explains. "In the fee-for-service environment, limited resources existed to provide compensation for assessing and addressing social determinants of health."

But as payment models increasingly shift to value-based systems of accountable care organizations and bundled payments that target outcomes improvements, health systems will have greater incentive to address patients' social needs and allocate resources to improve outcomes.

"New legislation and national coalitions have formed with increasing attention to advancing the funding and policy agenda as well as electronic health record functionality for social determinants of health assessment, and coding with Z-codes and data interoperability," Kostelanetz adds. ■

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'Why Not Home?' Program Improves Efficiency of Care Transitions

By Melinda Young

Why Not Home? is a new program designed to encourage more transitions from hospital to home with healthcare support instead of from the hospital to skilled nursing facilities (SNFs). Data show a positive effect on costs.[1]

Research showed the rate of SNF discharges per 1,000 patients declined from 73 per 1,000 to 70 per 1,000 patients in the postintervention period. The total SNF cost increased by 3% postintervention, despite the overall growth of 10% among the patient population in the same period.

"The results of our study imply that this multifaceted intervention was aimed to shift that traditional care and discharge planning paradigm to consider the question of Why Not Home? and to wrap around resources in the least restrictive environment," says **Kelli A. Chovanec**, DNP, RN, NE-BC, lead study author and system director for care navigation of ProMedica health system in Toledo, OH.

A segment of the population will always require a SNF level of care, but some of those sent to SNFs could do as well or better at home with home health services. The program aims to send each patient to the best level of care for that person.

"We help to make that shift of value-based care, and it's an effective strategy for accountable care organizations [ACOs] that are hoping to ensure patients are getting the right level of care at the right time, and to improve utilization and expenditure of post-acute care services," Chovanec says.

Case management leaders discovered the need for a change after reviewing discharge data. "When we were looking at our skilled nursing facility discharges across different populations, specific to the ACO, we realized we were sending a high volume of patients to the skilled nursing facility level of care, compared with other benchmarks," Chovanec says. "We looked at what's driving our volume of patients to SNF discharges and identified an opportunity to implement the Why Not Home? strategy to make sure patients are going to the least restrictive site of care."

> PATIENTS SENT TO AN SNF WERE FIVE TIMES MORE LIKELY TO BE READMITTED THAN WERE THOSE WHO WENT HOME WITH HOME HEALTHCARE.

A retroactive claims review compared patient outcomes between those who were discharged from the hospital to SNFs and those discharged from the hospital to home healthcare. Investigators found the patients sent to an SNF were five times more likely to be readmitted than were those who went home with home healthcare.[2]

"We know outcomes are optimal when patients go to the least restrictive level of care, and this started us on the Why Not Home? campaign," she adds.

Asking Why Not Home?

The first step was to staff Why Not Home? with interdisciplinary team members, including case managers, discharge planners, social workers, and therapists (including speech therapy, occupational therapy, and physical therapy).

"We targeted them for the educational component of this and focused on providing an overview of the value-based care tenet," Chovanec says. "We provided information about the previous study on how patients discharged to the home setting were five times less likely to be readmitted."

Leaders asked team members to ask Why Not Home? during interdisciplinary team meetings.

"The goal is asking Why Not Home? in order to make sure we're getting folks to the right place of care," says **Amanda Beck**, ABS, director of care transformation at ProMedica. "For those who can go home, then that's the right place for them. But how do we get them there? How do we get the folks who need a skilled nursing facility there?"

Before launching Why Not Home?, case management leaders recognized variation in clinicians' recommendations and referrals.

"Some clinicians aimed for the highest level of care," Chovanec says. "Within the value-based paradigm, which is what we're all, hopefully, marching toward, it's the opposite.

We want to be prudent users of healthcare dollars, and we want the least level of care and wraparound services that the patient needs."

The team's mantra is to give patients the right level of care in the right place and at the right time.

Understanding Barriers

In starting the Why Not Home? team, it was important to make sure the leaders understood the goals. "Kelli and I did a road show, [going] hospital to hospital with these leaders and having conversations where we're open to outcomes and findings, and open to understanding the frontline barriers they encounter every day," Beck explains.

Barriers include financial challenges, social determinants of health, home condition barriers, and other things that impede moving patients to the next level of care.

"We knew we had to present the data to them and make a compelling case for them," Chovanec says. "We had to show that clinical outcomes were really great when they were discharged to the home care setting. The leaders responded very well to those data."

Early on, the case management team recognized the Why Not Home? program would drive a paradigm shift and send higher-acuity patients home.

"We engaged our home health team members with part of this and challenged them," Chovanec explains. "We said, 'If we're sending higher-acuity patients to your setting, what is your capacity to serve them?'"

The home health agencies provided specialized training and education for their home health clinicians so they could handle these higher-acuity cases.

"It's important to note that in our study, the total accountable care organization-attributed patient population increased by 10%," Chovanec says. "But the SNF cost only increased by 3%."

This suggests the ACO saved hundreds of thousands of dollars in costs because patients were sent home when clinically appropriate.

"What we discerned from this study is our Why Not Home? campaign was directionally making an impact for the ACO population in terms of volume of patients discharged to skilled nursing facilities or home care," Chovanec says. "Since the study period in 2019, this trend has accelerated even more as the COVID-19 pandemic has served as a catalyst for this project. We would expect to see an even larger decrease in transitions to SNFs in 2021."

Why Not Home? has resulted in patient benefits, as many patients prefer discharge home with supportive services instead of discharge to a SNF. It has provided cost benefits.

"The primary reason we feel so passionately about this is it's the right thing to do," Chovanec adds. ■

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HIT Changes and Case Management

By Jeni Miller

While health information technology (HIT) is ever-changing, case managers should have an idea of how new (or improved) solutions might affect their practice. **Kathleen Parry**, RN, BSN, CCM, manager of complex case management at Kaiser Permanente of Washington, took the time to reflect on a new system and shared how this, or a similar platform, might affect the day-to-day work of case managers and their patients.

"Overall, it is daunting the number of HIT systems available," Parry says. "There are multiple platforms for case management, depending on the arena that they work in."

Parry learned an integrated health system that uses the Health Connect (Epic) platform to integrate the case management platform with the electronic medical record (EMR). Her case management department transitioned to this platform from a different one over the past year. She notes that while both technologies work well, the new platform offers case management activity visibility to the whole healthcare team.

"In our role at Kaiser, the integrated record assists in the entire team having visibility to the patient status and following through the transition of care," Parry explains. This helps the care team provide "additional input for the patient to improve their goals of care."

This higher level of collaboration can improve the quality of care for patients as well as the relationship between members of the care team.

Case managers face many challenges when working with facilities that are on "different platforms with the inability to have access to these platforms," Parry notes. Using the newer forms of HIT has been an overall positive experience for her, resulting in "overall process improvement for managing care of patients and assisting with transition over the continuum" as well as "streamlined processes and improved documentation."

From the perspective of hospital systems, improved technology solutions in case management can result in significant gains, such as better visibility between hospital systems and outpatient delivery systems if they are using the same platform, explained Parry.

While these solutions indirectly result in increased quality of care for patients, Parry notes this care would be enhanced further "if there was improved visibility to their EMR to not duplicate care that has happened."

As these technology solutions continue to evolve and progress, perhaps there will soon be solutions that help support the patient experience further and allow for more visibility for their EMR, especially as it can be accessed across providers, whether inpatient or outpatient. ■

Screening Ineffective for Identifying HCWs with Respiratory Illness

By Gary Evans, Medical Writer

Ubiquitous employee temperature screening and symptom questions upon entry during the pandemic have not yielded much success in identifying sick healthcare workers (HCWs) and reducing the long-standing problem of presenteeism, according to **David Kuhar**, MD, of the CDC's Division of Healthcare Quality Promotion.

"When I say presenteeism, I mean the act of attending work while ill and potentially infectious to others," Kuhar said at the IDWeek 2021 virtual meeting. "Presenteeism among healthcare personnel is actually very well reported in the literature."

For example, during the 2009 H1N1 influenza A pandemic, one facility reported 65% of HCWs reported working with symptoms of influenza-like illness.[1] In a recently published Swiss study conducted over two flu seasons that included 152 HCWs, 68% reported working with symptoms of influenza at some point.[2]

The reasons HCWs come to work sick are complex. "It can depend upon the job of the employee, their social status in the organization, and the care demands of their work," Kuhar said. "Commonly identified reasons include local [work] culture, an unwillingness to disappoint colleagues, even a fear of consequences for taking days off. Are you going to develop a reputation for leaving work to colleagues? Someone's individual work ethic can affect this."

There might be financial pressures if the institution does not grant paid sick days to HCWs. "If you're going to miss a paycheck when you stay home, people aren't going to stay home," Kuhar said. "In the same vein, for facilities that have policies with combined vacation and sick days — people are pulling from one pool of days they can use — people don't want to replace a vacation day with a sick day. Really, any policies that limit time off due to illness can discourage people from taking time off when they're ill."

Yet among HCWs, there is a lack of perceived risk, with many thinking their symptoms are not a threat to patients or colleagues. "Many [sick workers] are highly contagious and can actually cause severe illness," Kuhar said. "Roughly a third of community-acquired pneumonias can be from respiratory viruses or viral pneumonias. Depending on the population you look at, it could actually be up to half of them. That is a large number. Viral infections can predispose people to bacterial superinfections. They can also cause severe illness, especially among those who are predisposed to it — immunosuppressed people, those with pulmonary disease, cardiovascular disease. The very people who are often [receiving] healthcare."

With other viruses circulating and seasonal influenza historically causing 9 million to 36 million cases annually, infected HCWs have caused hospital outbreaks or been infected during them.

"There are numerous reports of outbreaks in healthcare, such as in long-term care settings, where even the common cold, like a rhinovirus, can cause outbreaks, [including] some associated with severe illness among their residents," Kuhar said.

During the COVID-19 pandemic, a common ritual at facility entry is checking temperatures and assessing symptoms for respiratory illness.

"Perhaps surprisingly, there are very few publications about the ability to detect cases among healthcare personnel [during the pandemic]," Kuhar noted. "However, we received anecdotal reports from professional societies, state and local health departments and facilities, that temperature screening was just not identifying many cases, if any cases at all."

Airports have widely implemented screening among passengers, but modeling estimates show they are missing at least half the cases, Kuhar said. Another healthcare report indicated that among patients who were admitted with SARS-CoV-2 with positive tests, only 16 out of 68 had a fever.[3]

"Temperature screening during the pandemic has not efficiently identified cases, and it is not likely an efficient strategy for detection of other respiratory illnesses," Kuhar said. "We know that people can have influenza and not have fevers, [even though] there may be pre-symptomatic [viral] shedding."

Symptom screening looks for more data points, such as a sore throat, shortness of breath, and cough. "You're able to cast a wider net," Kuhar said. "The biggest cons are that it is not objective, and symptom screening really is only ever as good as people are aware of [symptoms] and willing to share them."

Some hospitals started using electronic reporting of symptoms to speed the process and allow those with no symptoms to enter quickly. "There are minimal reports of symptom screening alone detecting infected healthcare personnel, which I found a little surprising," he said. "However, from anecdotal reports, we heard from many facilities as well as health departments that very few cases were being identified with symptom screening at all, with some places reporting none."

That does not necessarily mean there is no value to symptom screening, Kuhar added, noting it still might discourage presenteeism. "Active screening may end up discouraging personnel with symptoms from even testing the [facility] doorway and just staying home," he said.

This can be complemented by more passive approaches, like encouraging workers not to report to work if they are ill. "There are a lot of limitations for temperature and symptom screening," Kuhar said. "I can't help but keep going back to focus on the underlying causes of presenteeism."

One of the biggest problems is the culture of a facility, which must be set by the hospital administration. "Only leadership can really affect facility culture and effect change," Kuhar said. "Without it coming from the top, it's generally not going to happen."

For example, leadership can remove barriers to taking sick days, like providing pay for those days to remove the financial pressure that drives presenteeism.

"Create policies that require restriction from work when ill," he said. "It's very different when the message is 'We don't want you to come to work when you are sick' vs. 'If you're not feeling well, you don't have to come to work.' It's really a different message when it's clearly, 'Do not do this.'"

Another option is for employee health to provide rapid-access medical evaluations for staff. "Have someone make the determination — 'This may be a contagious disease and you should go home,' or 'We feel very good that it's not [contagious] and you can proceed to work,'" Kuhar said. "This could prevent people from working when sick, while allowing some people who might have taken a day off to come in."

The current challenge of staffing certainly is a factor, but there always has been some element of threadbare resources and limited backup in many facilities.

"There are actually reports of healthcare workers coming to work when ill — even with respiratory symptoms — and they have paid sick days that they simply haven't taken," Kuhar said. "If there's no backup, if there's no person to cover their job, people are going to be much less likely to stay out of work when they're sick." ■

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COMING IN FUTURE MONTHS

- Best practices in ED acute care utilization review
- New model helps with dementia care coordination
- HIV-geriatrics program improves quality of life
- Case managers could prevent issues with dementia screening

HOSPITAL CASE MANAGEMENT

CE QUESTIONS

1. **The most effective way to ensure all staff are fully vaccinated in light of the current omicron variant of COVID-19 is to:**

   a. provide $25 gift card incentives for downloading a vaccination card into the system.
   b. hold staff lunch-and-learns about the pandemic and the science behind the COVID-19 vaccines.
   c. mandate vaccination for all employees.
   d. make vaccination optional but mandate weekly testing for those who are not vaccinated for COVID-19.

2. **The authors of a 2019 meta-analysis found failures in care coordination were the second-biggest source of what in the U.S. healthcare system, according to Joseph J. Fifer, FHFMA, CPA?**

   a. Medical errors
   b. Staff turnover
   c. Waste
   d. Patient rehospitalizations

3. **Research from Brown University shows what percentage of all U.S. adults experienced symptoms of depression in the first half of 2021?**

   a. One-third
   b. One-half
   c. One-quarter
   d. One-fifth

4. **One of the most overlooked social determinants of health that can lead to an increase in inflammatory processes, substance use disorders, and suicidal attempts is:**

   a. mental and behavioral health.
   b. adverse childhood experiences.
   c. homelessness.
   d. food insecurity.

5. **Recent research shows which is a major barrier to healthcare professionals screening patients for social determinants of health?**

   a. Lack of interest in collecting more data on patients.
   b. Lack of electronic health record technology.
   c. Too little information about the importance of social determinants of health.
   d. Lack of time to ask about social determinants of health.

6. **A chatbot technological solution can help case managers by:**

   a. communicating with patients' electronic blood pressure and weight machines, sending instant information to case managers.
   b. patients wearing it like a bracelet or ring to provide 24/7 heart rate, temperature, and fitness data to a case management command center.
   c. allowing case managers to communicate seamlessly with each other and make case notes through voice activation technology, such as Siri or Alexa.
   d. sending daily text messages that educate patients on self-care behaviors and ask them about their weight, blood pressure, and other health factors.