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Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

- Tackling inappropriate ED usage . . . . . cover
- Multiple initiatives target excess ED use 99
- In-home visits for special needs members 100
- Health plan analyzes ED usage 101
- Face-to-face CM for behavioral issues. 102
- First-case schizophrenia patients need quick care 103
- Limited-English patients best served in ED with interpreter. 105

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Health plans focus on inappropriate emergency department use

Interventions steer patients to appropriate levels of care

Faced with an increase in patients who seek care in the emergency departments for non-urgent conditions, health plans are looking for ways to reduce unnecessary visits to the emergency department and steer patients to more appropriate levels of care.

"We want patients to be treated at the right level of care and the right place. It's better for them and it's more cost-effective for the health plan when patients are treated in the appropriate level of care," says **Deb Smyers**, RN, BSN, senior director of program development for UPMC Health Plan, based in Pittsburgh, PA.

When patients use the emergency department for primary care, they don't have any continuity in care and conditions like elevated blood pressure that occur regularly may be overlooked if they come in for another complaint. In addition, seeing patients for non-emergencies sometimes ties up the clinical staff when patients come in with true emergencies.

Many patients who use the hospital as a primary care provider don't follow up with their primary care provider, even if they are instructed to do so, and don't receive the recommended preventive care, Smyers adds.

"We want people to visit the emergency department when they have

EXECUTIVE SUMMARY

Health plans are working on ways to ensure that their members get care at the appropriate level, rather than going to the emergency department for non-emergent conditions.

- Patients who use the emergency department for minor ailments don't get continuity in care and often don't follow up or receive preventative care.
- Some use the emergency department for primary care because they don't know about more appropriate options.
- Many don't have a medical home, don't have transportation, or don't like their primary care provider.

a true emergency, but we know that they get better continuity in care when they see their primary provider," she says.

Making sure patients have a medical home is a key part of ensuring that members receive care in the appropriate setting, adds **Anna Page**, RN, director of utilization management for Passport Health Plan, a Medicaid health plan based in Louisville, KY. "We want them to see their primary care provider regularly for preventative care and call their physician office when they don't feel well," she adds.

Some patients use the emergency room for primary care because that's what their mothers and grandmothers did, she adds. Others may not have a primary care provider or they may have one in an inconvenient location or one they don't like, or the primary care office is closed when they get off work. Some patients go to the emergency department because they don't have transportation to their physician office but can utilize an ambulance for an emergency department visit, Page adds.

"We're trying to get a handle on why members go to the emergency department as opposed to the primary care provider or urgent care center," she says. Passport's ER coordinator calls patients who have used the emergency department during normal primary care office hours and educates them on more appropriate locations to receive care. *(For details on Passport's emergency department utilization program, see related article on page 99).*

For some patients, coming to the emergency department is much easier than going to their primary care physician office, says **John Lovelace**, MS, MSIS, president of UPMC for You, the medical assistance program for UPMC Health Plan. "If they have to take a bus, they're likely to have a long journey, but they can call an ambulance that takes them right to their door. The emergency department waiting room is comfortable, the staff is nice, and often the wait is not as long as it would have been in a primary care setting," he adds.

UPMC has placed a patient navigator in the emergency department of a hospital within its health system that treats a lot of UPMC members. The health plan's care managers call patients who are frequent emergency department users and/or who have chronic illnesses and visit the emergency department for visits that could have been avoided if they managed their conditions better. In addition, the health plan sends a team of nurses and social workers to the homes of frequent users who are difficult to engage and have numerous psycho-social issues. *(For details on these programs, see related article on page 100).*

"When patients receive care in the appropriate setting, it's a win-win-win situation. The patient gets better care, the hospital emergency department can concentrate on treating patients with real emergencies, the health plan sees cost savings, and when patients go to their primary care providers, the physicians can do more effective clinical work," Lovelace says. ■

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Multi-pronged approach targets ED use

Initiative includes navigator, home visits

UPMC Health Plan in Pittsburgh, PA, takes a three-pronged approach to reducing unnecessary emergency department visits that includes outreach calls from care managers, stationing a patient navigator in an emergency department that serves a large UPMC population, and home visits by a nurse/social worker team for patients who need extra help in managing their healthcare.

Every day, the health plan receives a list of patients who have been in the emergency department the day before from hospitals that are part of the UMPC integrated delivery system and who see the majority of the health plan's members.

"We are getting real-time information on emergency department visits and use that to determine the people who will receive interventions. We get in on the front end, rather than waiting for claims which could take months," says **Deb Smyers**, RN, BSN, senior director of program development for the health plan.

The program targets Medicaid members who have been to the emergency department seven or more times in a 12-month period and patients enrolled in other UPMC Health Plan products who have visited the emergency department three or more times. The health plan also intervenes with patients with chronic conditions that could avoid emergency department visits if they managed their conditions well. Diabetes, asthma, chronic obstructive pulmonary disorder, heart failure, migraines, and low back pain are among the targeted conditions.

EXECUTIVE SUMMARY

UPMC Health Plan in Pittsburgh, PA, uses multiple strategies for reducing unnecessary emergency department visits.

- Care managers follow up with patients who frequently use the emergency department for non-urgent care.
- The health plan has stationed a patient navigator in a hospital that treats a large number of members to educate them on more appropriate venues of care.
- Clinicians visit the homes of hard-to-engage patients and give them extra help in managing their healthcare.

The health plan's care managers, either RNs or social workers, make outreach calls to members with excessive emergency department use, educate them on more appropriate levels of care, and encourage them to see their primary care provider regularly. They ask about barriers such as transportation and ask if they have been getting their prescriptions filled and are taking them as directed. They fax information to the primary care provider about the member's emergency department use and whatever care management or disease management interventions they are receiving.

The care coordinators educate the patients on alternatives to the emergency department, including urgent care clinics and their primary care provider and give them the hours they are open. "We encourage them to talk to their primary care provider if they are not feeling well and find out the doctor's recommendation of what to do," she says.

They discuss symptom management with patients with chronic conditions and, if appropriate, enroll them in a disease management program. For instance, when members have asthma, they teach them the triggers that indicate they should take their controller medicine along with the reliever medicine. "If they can identify symptoms and signs earlier and know what to do, they can avoid the emergency department," she says. In appropriate situations, they follow up with the patients again and help them manage the conditions that brought them to the emergency department.

The intervention has resulted in the reduction of 176 emergency department visits per quarter among members covered by all UPMC Health Plan products and a savings of $17 per member per month.

The health plan has placed a patient navigator in the emergency department at UPMC McKeesport in McKeesport, PA, a community hospital that treats a high volume of UPMC members and is the only hospital readily available to patients in that community. The navigator, who is a patient care technician who is attending nursing school at night, covers the emergency department from 8:30 a.m. to 5 p.m. weekdays because the health plan determined that is when the highest volume of unnecessary emergency department visits occurs.

"This hospital treats a high volume of our patients and is the only hospital available to patients in that community," says **John Lovelace**, MS, MSIS, president of UPMC for You. "The majority of patients they see are Medicaid or

Medicare beneficiaries or those who have no insurance."

After patients are triaged, the hospital staff refer those with minor ailments to the navigator. The navigator sees any patient, regardless of insurance, who is using the emergency department inappropriately. The navigator finds out the reason the patients came to the emergency department instead of seeing their primary care physicians, educates them on seeking care in the appropriate setting, and helps them make a follow-up appointment with their primary care provider.

In some cases, the navigator helps patients identify their primary care provider or helps them make a connection.

The health plan began the program three years ago using funds from a grant from the Centers for Medicare & Medicaid Services through the Pennsylvania Department of Public Welfare to cut down on unnecessary emergency care for Medicaid recipients. Although the grant has been completed, the program is continuing. "We're sharing the cost of the navigator with the hospital because we have a mutual interest," Lovelace says. "It doesn't help them to have low-acuity patients in the emergency department, either."

The health plan has publicized the emergency department navigator program and enhanced primary care access on billboards in the community, on television spots, and in mailings to members.

The patient navigator has had contact with more than 6,000 patients, and about 5,000 patients have seen either the nurse practitioner or the primary care provider. Patients seeing the navigator keep their primary care appointments 80% to 90% of the time.

With this initiative, the health plan has seen a reduction in emergency department visits in addition to an increase in primary care sick visits. ■

Home visits give support for at-risk members

Members need extra psychosocial support

When members in UPMC Health Plan's Special Needs Plan are experiencing excessive hospital admissions and/or emergency department visits, the health plan sends a team of social workers and nurses to their homes to assess the members' healthcare and psychosocial needs and get them the resources they need to stabilize their conditions.

Members targeted for the home visits are difficult to engage and need high-touch interventions. Many of them have social and/or behavioral issues or drug and alcohol abuse issues, according **Deb Smyers**, RN, BSN, senior director of program development for the Pittsburgh, PA-based health plan.

"They need a lot of psychosocial support from community organizations," she says. "Some live in poor housing conditions and have difficulty getting out because they have trouble navigating stairs. We have helped patients find housing and access housing assistance funds."

UPMC Health Plan's Special Needs Plan has 16,000 members enrolled. Almost 60% of these members are disabled and under the age of 65. Many of the members have multiple chronic conditions. More than one-third of members under age 65 have a serious mental illness. "Managing the health care burden of this population is a challenge," Smyers says.

The team assesses the members' living situations and helps them access whatever community resources they need. They check the cupboards and refrigerators to make sure that there is enough food in the house and assess the member's ability to manage their activities of daily living. They link members to community services such as light housekeeping services and Meals on Wheels if the members can't manage alone and don't have family support.

"By going into the homes, the team can build a relationship with the members and get a true picture of members' needs," Smyers says. "Then they do whatever is necessary to get the members stable and connected to their primary care provider."

The clinicians conduct medication assessment and educate patients on the importance of following their medication regimen.

Some of the members don't understand the benefits. For instance, they don't know that they can go to a physical therapist or other specialist. The team helps them get connected to services they need.

If the patients have a co-pay and have trouble paying it, the team calls in a pharmacist to conduct medication review and talk to the physician about changing medications. If the medication regimen is too complicated for the patient to follow, the pharmacist will talk to the physician about managing medication in a different way.

The clinicians help members create an emergency response plan that includes details on what to do when they experience symptoms, when to

call the physician, and when to go to the emergency department.

The team continues the home visits for several months until the patient is stable, then hands the patient over to another health plan case manager for additional case management or disease management by telephone. ■

Program targets ED use for non-urgent conditions

Patients educated on other options

When members of Passport Health Plan use the emergency department for non-urgent conditions, the health plan calls them to find out why they chose that level of care.

"We're trying to get a handle on why members go to the emergency department as opposed to the primary care provider or urgent care center, so we can determine what interventions may help," says **Anna Page**, RN, director of utilization management for Passport Health Plan, based in Louisville, KY.

The goal of the program is to analyze members' emergency department usage during the normal business hours of primary care offices and determine the reason members are seeking care for non-emergent conditions.

"We can assume a lot of things, but we don't know until we talk to patients the reason they are using the emergency department when the primary care provider offices are open," says **Maureen Ritchie**, RN, manager of clinical programs. "Right now, we're gathering information to decide what steps to take next. Meanwhile, we do provide education to the members on the appropriate use of the emergency department." Passport Health Plan identifies members through emergency department facility reports and through claims review. The calls are made by the health plan's ER coordinator, a non-clinician who has been with the health plan for 10 years. His duties include making outreach calls to members as well as the emergency department calls.

"We ask if they had treatment before going to the emergency department or if they contacted our 24-hour nurse line. Sometimes they don't know their primary care provider or the office is not convenient. In those cases, we help them identify their primary care provider or switch to one in a convenient location," Ritchie says. The ER coordinator educates patients on the appropriate use of the emergency department, plan benefits, and the use of immediate care centers. The coordinator also encourages patients to call their primary care providers or the health plan's 24-hour nurse line after hours.

In addition to the outreach calls, the plan sends direct mail to members to educate them about appropriate treatment options for specific non-emergent complaints. For instance, the materials about the common cold offer information on how to treat a cold at home and what symptoms indicate that they should call their provider. Members who frequently use the emergency department or those with asthma, diabetes, or high-risk pregnancy are referred to case management and disease management for follow up.

Passport also has case managers embedded in local primary care offices who meet with members face-to-face and educate them about appropriate levels of care if they have had a non-urgent emergency department visit.

In August, the health plan began a pilot project that locates a case manager in the emergency department of a small local hospital that treats a large number of health plan members. The Passport nurse in the emergency department conducts a brief interview with members to find out why they are using the emergency department and what barriers they have to receiving care in a more appropriate setting.

Among the questions she asks are: Do they know who their primary care provider is? Did they contact their primary care provider? How did they get to the emergency department?

The nurse educates patients about the health plan's 24-hour nurse line and other resources available to members such as case management and disease management services.

"Our goal is to analyze three months of data

EXECUTIVE SUMMARY

Passport Health Plan in Louisville, KY, contacts members to find out why they use the emergency department and educate them on other options.

- The goal is to gather information to determine what steps to take next.
- ER coordinator calls patients identified through facility reports and claims reviews.
- The health plan has just begun a program that places a pilot patient navigator in the emergency department at one hospital to educate patients on other options for care.

in order to determine and see if it's feasible to roll this out to other facilities where we have a lot of high emergency department rates," Page says. ■

CMs meet mental health clients face to face

Case managers work to establish rapport, trust

By meeting their clients face-to-face and building relationships, case managers at the Mental Health Association of Westchester County, NY, are able to help adults and children working through mental illness or emotional distress access the kind of help they need to stabilize their conditions, says **Amy Kohn**, PhD, chief executive officer of the private not-for-profit mental health multi-service organization in Tarrytown, NY.

Case managers have either a master's degree in social work or the equivalent or a bachelor's in social work with several years of experience in working with the population to which they are assigned. The case managers do not provide therapy; instead, they address social issues such as food, shelter, and transportation and help remove barriers to the patient's goal.

"A lot of what the case managers are doing is identifying community resources and helping the individual access them, whether it's a doctor's appointment, a job, housing, social programs, or going to a school meeting to get a child back in school if he's been suspended," Kohn says.

The organization offers a variety of programs that vary in intensity depending on the needs of the patients. About 90% of the financing for the programs is provided by public funding. "Regardless of the type of individual, the case managers begin by completing a detailed assessment and developing a care plan that helps the individual identify their hopes and dreams for the future and a way to fulfill them. The common denominator is that the case managers work with their clients face to face and develop a relationship that builds trust and credibility," Kohn says.

Successful case management is based on creating a good relationship, and it's difficult to do that over the telephone, particularly with individuals who are facing multiple challenges, Kohn adds.

"These are individuals and families for whom traditional services haven't worked, not necessarily through any fault of their own," she says. "They are coping with stress and are not able to connect with the kinds of systems that are available to them. They are distrustful of institutions and may reject the notion of help for numerous reasons. Face-to-face meetings are a must."

Case managers meet their clients in their homes, at libraries, parks, fast-food restaurants, or wherever else the clients are most comfortable. Seeing patients outside the clinic setting is more effective than seeing them in the clinic, Kohn points out. "The no-show rate in clinics is huge, whether they're mental health clinics or primary care clinics. Clients may not have transportation and no money to pay for it, they may lack childcare, or have to take a two-hour trip and change buses to get to a clinic. A lot of things get in the way, and that's why we see our clients in person," she says.

Case managers in the Care Coordination program provide intense case management for individuals who are not connected to any service provider and who frequently are admitted to the hospital, have multiple emergency department visits, and/or are confined to jails and other institutions. Many are homeless. Most have physical problems and social issues as well as behavioral health issues. "These patients have intense needs and have been referred to us because they are recognized as individuals who are disenfranchised," Kohn says.

Case managers in the Care Coordination program have a caseload of just 12 clients at a time and spend an average of one to two years working with the client. At first they may see them in person every day. As the client stabilizes, the visits may taper off. By the time patients are ready to be discharged from the program, the case managers may be calling them weekly and seeing them in person once a month.

When they get a new client, the case managers' first challenge is to find the person. "Sometimes

EXECUTIVE SUMMARY

Case managers at the Mental Health Association of Westchester, NY, who coordinate care for adults and children who are working through a mental illness or emotional distress, meet their clients in person.

- Case managers don't provide therapy but address barriers to care and help clients access the community resources they need.
- Patients with intense needs may receive visits every day at first and stay in the program for as long as two years.

we're lucky enough so the client is referred while they're still in a shelter, the hospital, or jail. Often the last known address isn't correct so the case manager has to literally go out looking for them, enlisting the help of relatives or other people who know them," Kohn says.

When the case managers locate the person, they set up a meeting and introduce the services. The case managers help the clients set goals and priorities and address all life issues one at a time. For instance, if the goal is to see a primary care provider, the case manager will set up an appointment and often accompany the client.

They help patients connect to a primary care clinic to receive medical care instead of waiting until their condition necessitates an emergency department visit or hospital stay. They connect them to mental health providers and assistance with medication. They help them find housing and help with the paperwork and bureaucracy involved in signing up for disability and social services.

Case managers also provide intensive case management for children who have been diagnosed with emotional disturbances and their families. "This is a very stressful situation for the family, and case managers almost always are called in at the moment of crisis," she says. For instance, the child may have been expelled from school and working parents don't have childcare so there's no one to supervise the child while they are at work. In many cases, the child has been discharged after an inpatient psychiatric stay.

When families are newly referred to the program, the case manager may visit the home several times a week to develop a care plan and stabilize the situation, then help link the family to programs and services in the community. "A lot of the case managers' work is assessing community resources and developing natural support systems," Kohn says. "For instance, a neighbor could be signed up to get paid a small amount and take care of the child while the parents work."

The case manager connects the family to a clinic where the child can receive treatment and the family will get emotional support. They act as an advocate for the child with the school system to ensure that the child can continue to get an education.

The organization also provides supportive case management for individuals who have a stable living situation and are less fragile psychiatrically but who need maintenance to make sure they are staying on track. These case managers use a combination of personal visits and telephone calls to help their clients manage problems as they occur. For instance, if the individual is working, the case manager may provide job coaching to help them work through problems with the boss or coworkers.

They may accompany clients to their first visit at a primary care clinic or go with them to sign up for social services or disability, helping them fill out the forms. "We operate in a very person-centered, motivational, and non-threatening way. We don't tell them we're going to get them a particular service," she says. "We provide support, rather than doing things for the individuals. We want to help them learn how to access services for themselves." ■

First-episode schizophrenia patients need care quickly

Rapid follow-up is key

Mental health experts believe that as with many acute medical conditions such as stroke and heart attack, early diagnosis and treatment can make a critical difference for patients with schizophrenia, potentially limiting the severity and progression of the disease. This is important to ED administrators and clinicians because the first opportunity to intervene in many of these cases often occurs in an emergency setting, although getting to a correct diagnosis may be difficult.

"A lot of these patients are extraordinarily anxious and they may be acting kind of odd," explains **Cheryl McCullumsmith**, MD, PhD, division director, Hospital Psychiatry, at the University of Alabama at Birmingham Medical Center (UABMC). "We also see patients who have more of what appear to be depressive symptoms. They may not be getting out of bed or going to school, and their parents are becoming increasingly concerned."

These types of symptoms can be due to substance abuse, intoxication, or other medical conditions, all of which need to be ruled out if this is a patient's first medical encounter, adds McCullumsmith. "It is very important to distinguish between psychosis and schizophrenia. Psychosis is a symptom like fever. Everyone with a fever doesn't have pneumonia, and everyone

with psychosis doesn't have schizophrenia," she explains. "We have seen youngsters taking diet pills or taking steroids for weight-lifting. They come in and they are psychotic, but that doesn't mean they are schizophrenic."

Consider patient and family needs

However, for new cases of suspected schizophrenia, which is often first observed in teenagers, UABMC now has an added resource available to the ED. The First Episode Schizophrenia Clinic, which opened in May of this year, is set up to initiate aggressive, comprehensive treatment shortly after diagnosis. The goal is to lessen the complications associated with schizophrenia for both patients and family, explains **Adrienne Lahti**, MD, the clinic's director.

"There is data showing that the quicker you can make an intervention with medication, the better the outcome," says Lahti. However, she stresses that effective treatment also depends on how well the family understands the illness.

When there is a first episode of schizophrenia, the patient is not the only one in crisis; the family is in crisis as well, adds Lahti. "You can imagine having a 17-year-old boy who was doing pretty well, and you thought he was going to go to college, and then his grades are falling and he is staying in his room," she explains. "So it is critical to work with the family and let them know there are things they need to do, and the first thing is to be an advocate for their son."

For example, family members are critical to making sure that a patient takes his medication and shows up for medical appointments. "We encourage patients to stay in school and to stay functional," says Lahti. "There are studies showing that the more you can keep people functional the better the outcomes."

The First Episode Schizophrenia Clinic will see patients who have been referred from the ED as outpatients, and it will also work with hospital physicians to transition admitted patients to the clinic once they have been discharged.

Educate staff

The First Episode Schizophrenia Clinic at UABMC is the only such clinic in Alabama, and it is one of only a handful of similar care settings in the country. However, even without this resource, there are steps that EDs can take to improve the care they provide to patients who present with the signs or symptoms of schizophrenia.

Staff education is very important, explains McCullumsmith, noting that she conducts several grand rounds every year with emergency medicine staff. "Also, because we have psychiatry present here, we do a lot of one-on-one [with clinicians] when we are seeing patients. We talk to them about [psychiatric] cases," she says. "If you don't have psychiatry available in your ED, that is more difficult to do."

McCullumsmith advises clinicians to utilize a psychiatric rating scale, such as the Brief Psychiatric Rating Scale (BPRS), for example, when they have a patient who they suspect may be schizophrenic. "It gets into some symptoms of psychosis. It may not pick up on everything for a first episode, so it is not ideal," she says, noting that the instrument is primarily used by mental health care providers. "However, it will provide information about how to ask the questions, and this can be difficult."

When referring a patient with psychiatric issues to an outside provider, make sure that you provide a comprehensive assessment of what is going on with the patient, stresses McCullumsmith. "If you just give patients a referral and tell them to go to the local community mental health center, they are not going to go there and say that they are psychotic," she says. "They may not even know why they have been referred."

Instead, the outside provider should receive a copy of your notes so that he or she knows what workups you have done and what your concerns about the patient are, explains McCullumsmith. Otherwise, it is difficult for the provider to begin treatment.

Arrange for rapid follow-up

Patients who present to the ED with psychiatric problems need to have follow-up appointments soon after their visit or they are likely to be back in the ED in short order, explains McCullumsmith. "We had trouble getting rapid follow-up, not just for first-break [schizophrenia] patients, but for all patients with mental illness, so we established our own transitional clinic," she says. "We find that if we can actually see people within three days of their ED visit, they don't come back to the ED nearly as often. It takes twice as long for them to come back for a psychiatric reason."

Typically, patients are seen in the transitional clinic a few times before they are transitioned

to their eventual mental health care provider. "We are working on showing that it is actually more cost-effective than ED visits," says McCullumsmith.

Not every ED is going to be able to establish a transitional clinic for patients with mental health problems, but McCullumsmith says administrators and clinicians can work toward establishing a means to rapid follow-up by building relationships with outside mental health providers. She is also a strong proponent of having social workers on staff who can work closely with patients who have mental health needs.

"We have a social worker who we have given the task of being our intensive case manager. She works with patients who are in distress and coming in frequently, and can't seem to make that next step of establishing regular care," McCullumsmith says. "She digs in and finds out more about their history, makes follow-up calls, reminds them about upcoming appointments, and contacts family members to help get them to the appointments."

In some cases, the hospital will provide taxi fares or bus tokens to patients who have no other way to get to their appointments, and staff will also help to get patients established on medication for free. "We do a lot of things from the ED to really help get patients started in a program and to help keep them going," McCullumsmith says.

SOURCES

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LEP patients best served with interpreter in ED

Data show fewer errors with interpreters

Hospitals that receive federal funds are required by law to offer language assistance to patients with limited English proficiency (LEP). There is good reason for such a requirement because census data suggest that more than 59 million Americans speak a language other than English at home, and more than 25 million have LEP. However, a new study suggests that the type of assistance provided can make a big difference in determining whether or not there are miscommunications that lead to clinical consequences.[1]

Researchers, led by **Glenn Flores**, MD, a professor and director of the division of general pediatrics at the University of Texas Southwestern Medical Center and Children's Medical Center of Dallas, scoured the audiotapes of 57 interactions involving LEP patients at two large pediatric EDs in Massachusetts. They discovered nearly 2,000 errors, 18% of which had potential clinical consequences. However, only 2% of these errors were associated with professional interpreters who had at least 100 hours of training. Interpreters with less training were associated with 12% of the errors, and ad hoc interpreters — typically family, friends, or staff who may be bilingual but have no training in medical interpretation — were associated with 22% of the clinically significant errors. The authors note that the error rate was, in fact, lower (20%) for patients who had no interpreters at all than for the patients who had ad hoc interpreters.

"We have shown in a number of studies that having no interpreters is suboptimal and having ad hoc interpreters is suboptimal because they don't have the training and they are not familiar with medical terminology," says Flores. Further, while it may be tempting to make use of a family member who is bilingual, this can present additional complications. "There can be embarrassing issues, particularly when you have a child interpreting for adults," explains Flores. "The adult may not want to talk about domestic abuse or drug abuse, and [he or she] may not want to talk about sexual issues, or depression."

Matthew Wynia, MD, director of the Center for Patient Safety at the American Medical Association and clinical assistant professor at the University of Chicago agrees, noting that the use of ad hoc interpreters is problematic in many respects. "If you use a family member or the janitor, or you just pull someone in who happens to speak the language but who doesn't have any training in how to be an interpreter, not only do you have some of the problems of confidentiality and professional ethics of interpretation, but you also have just plain quality control problems," says Wynia. "They can misreport what you say to the patient."

Identify patients with limited English

Communicating with the LEP population is challenging in all health care settings, but the ED has some unique characteristics that may heighten the risk for errors. "Even if you speak the same lan-

guage as your health care provider, when things happen fast and people have serious issues, it can be hard to understand what is going on, so when you add a language barrier to the mix, it really magnifies the challenges," says Flores. Nonetheless, he stresses there are things that ED administrators can and should do to minimize the chances that language barriers will lead to errors.

The first and most important step, says Flores, is to make sure that LEP patients are identified when they present to the ED for care. One way to do this is by asking all patients what primary language is spoken in their home. In cases where English is not the primary language, patients should be asked to rate their ability to speak English: very well, well, not well, or not at all. "Anything less than 'very well' is classified as LEP, and these patients need an interpreter," says Flores. "Don't just ask them if they need an interpreter because you will miss a lot of patients who don't speak sufficient English."

Keep in mind that many critical health care communications occur throughout a patient's visit to the ED, not just while he or she is being seen by a physician. This is where many health care organizations drop the ball, says Flores, noting that interpreters are not always present when they need to be. "Some of the most important communications occur at the end of the visit when the nurse or a medical assistant is signing the patient out," he says. "Also, you can imagine trying to get someone to sit still during an MRI [magnetic resonance imaging] or to get them in the right position for a chest X-ray without an interpreter."

Written communications, such as prescriptions or patient instructions, need to be printed in the patient's preferred language as well. "Have an option on the prescription pad when you can check off Spanish or some other language that is prevalent in your area so that the pharmacist knows how to print the instructions," says Flores. "Also, make sure that you have all of your patient instruction materials printed out in the most common languages so that people really do understand what they are supposed to do after discharge."

There should be plans in place for phone communications involving LEP patients as well, advises Flores. "Make sure that when patients call on the telephone that there are multilingual operators and phone trees for making appointments and follow-ups," he says.

Wynia agrees, noting that if a patient who does not speak English calls in, it is the hospital's responsibility to get an interpreter on the line. "Many patients just don't call because they know an interpreter isn't readily available," he says. "This is also why patients tend to cluster in [health care] settings where interpreters are available or where the staff speak their language."

Interpreter phone lines offer advantages

The literature suggests that the best way to communicate with LEP patients is through a professional interpreter or a bilingual provider, says Flores. Consequently, he advises ED administrators to identify staff who are bilingual, consider providing bonuses to personnel who are fluent in other languages, and to do more outreach to and recruitment of bilingual personnel.

While some large EDs have professional interpreters on staff 24/7 who speak Spanish or another language that is prevalent in the community, this is not practical in many settings, and it is impossible to have interpreter coverage for every language in any case. In instances where in-person interpreters are not available, most EDs rely on language lines where they can access trained interpreters via the telephone. "Typically, there are two handset phones that people can use so that both the patient and the doctor can be on the line with the interpreter at the same time," explains Wynia.

The phone lines can be inconvenient and cumbersome to use. And, of course, a phone-based interpreter will not able to pick up on any nonverbal cues or facial expressions that the patient may exhibit, but there can be some advantages to this approach as well, says Wynia. "When people are on the phone they may be willing to say things to the interpreter that they might not be willing to talk about if the interpreter is standing in the same room with them," he says.

In fact, Wynia, who is an HIV specialist, experienced this type of situation firsthand with a patient who always refused the assistance of a live interpreter. "Whenever she came in she preferred to not have an interpreter at all, but if there was anything of importance we had to discuss, I would get an interpreter on the phone, and she was OK with that because that interpreter wouldn't know her," he explains. "She was more willing to have that conversation with an interpreter on the phone than she would with a live interpreter."

In a true emergency, Wynia acknowledges that there may not be time to bring in a live interpreter or establish contact with a phone-based interpreter. "In an ideal setting you will have a rapid response way of getting an interpreter there, but regardless, you have to put the patient first and

not let the situation get out of hand. You do the best with what you've got," he says. "But that isn't the most common situation in the ED. Most of what we see in EDs is more urgent rather than emergent cases, and in an urgent case you probably can wait 15 to 20 minutes [to establish contact with an interpreter]."

Even in cases where it is inconvenient or inefficient to wait for the services of a professional interpreter, Wynia stresses that the data are very clear that this is a better option than doing without an interpreter or relying on an ad hoc or untrained interpreter.

A word about cost

Professional interpreters can add costs to any health care encounter, and currently only 13 states and the District of Columbia provide third-party reimbursement for interpreter services. While this is certainly an issue for hospital administrators, it should not be a factor for individual providers, stresses Wynia. "The physician who is making the decision on whether to call an interpreter does not face that cost," he says. "Physicians who are convinced that interpreters are important to providing quality care will use interpreters, and those who feel like the inconvenience overrides the relative improvement in quality of care may not use them. But I think you have to acknowledge that is a risky decision because God forbid something happens to a patient after they leave because they did not understand [patient instructions]."

Where costs can enter into the decision-making equation is if hospitals adopt methods or systems that are not very responsive, hard to use, or particularly inefficient. "If you have to wait a long time [for an interpreter], that will drive up the inconvenience factor," adds Wynia.

When contracting for the services of interpreters or interviewing candidates for interpreter positions, keep in mind that time spent in professional training is more important than years of experience. This, at least, is what Flores discovered in his study, and he believes it makes perfect sense. "If you never received any training, even if you were working on the job as an interpreter for 30 years, you were probably making the same mistakes over and over again," he says. "I think this really shows how important and powerful the training is."

Unfortunately, there is not yet a universal understanding of precisely what comprises a trained, professional interpreter, although there is a code of ethics for interpreter services which covers things like maintaining confidentiality, and interpreting exactly what the parties say, explains Wynia. Consequently, medical interpreter certification programs are not at a point where it is reasonable or practical for health care organizations to require that medical interpreters be certified. "The vast majority of interpreters aren't yet certified," he says. "They may have very good training, but there just weren't any national certification programs until about 18 months ago."

REFERENCE

1. Flores G, Abreu M, Barone C, et al. Errors of medical interpretation and their potential clinical consequences: A comparison of professional versus ad hoc versus no interpreters. *Annals of Emergency Medicine* 2012 Mar 14. [Epub ahead of print]

COMING IN FUTURE MONTHS

- How your peers are working to reduce readmissions
- New opportunities on the horizon for case managers
- Tips for engaging chronically ill patients
- Why it's useful to collaborate with other organizations

SOURCES

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CNE QUESTIONS

1. According to John Lovelace, MS, MSIS, president of UPMC for You, some patients use the emergency department for primary care because it's easier than going to their primary care physician office.
   A. True
   B. False

2. UPMC Health Plan makes outreach calls to patients with excess emergency department use. How many visits qualify as excess for their Medicaid members?
   A. Seven or more times in a 12-month period.
   B. Three or more times in a 12-month period.
   C. Three or more times in a quarter.
   D. More than once a month.

3. How does Passport Health Plan conduct outreach to members who use the emergency department inappropriately?
   A. Outreach telephone calls to educate members on appropriate levels of care.
   B. Mailings with information on treating minor conditions such as colds.
   C. Interaction with case managers embedded in primary care practices.
   D. All of the above

4. What is the caseload of care coordinators in the Mental Health Association of Westchester County, NY's Care Coordination program that provides face-to-face case management to individuals with intense needs?
   A. 10.
   B. 12.
   C. 15.
   D. 18.

CNE OBJECTIVES

After reading this issue, continuing education participants will be able to:
1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.

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Nurses participate in this continuing education program and earn credit for this activity by following these instructions.
1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■