Case Management ADVISOR™
Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

Face-to-face contacts help build relationships

Get to know your patients

As providers struggle with that small percentage of patients who consume the majority of healthcare dollars, they're finding that having care coordinators who work face to face with patients often can help patients navigate the healthcare system and follow their treatment plan.

Getting to know patients in a face-to-face relationship makes it much easier for case managers to gain their cooperation as they coordinate care and help them adhere to their treatment plan, points out **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"Patients are more likely to pay attention if the information is coming from someone they know and trust," she says. In addition, when case managers see patients in person, they can watch their facial expressions and body language to gain an insight into whether the patient understands and if he or she agrees with what the case manager is saying, she adds.

"In the case of elderly patients, many may have hearing or cognitive deficits, and seeing them in person helps the case manager know if they understand," she says.

Getting to know their case manager in person often prompts patients to reveal information that they'd never tell to a disembodied

EXECUTIVE SUMMARY

Face-to-face care coordination is beneficial for patients who need extra help navigating the healthcare system and adhering to their treatment plan.
- Personal contact helps build a trusting relationship.
- Facial expressions and body language provide insight into the patient's understanding and attitude about what is being said.
- The process is satisfying to patients as well as staff.

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voice over the telephone, Kizziar says. From the case manager's standpoint, having a close relationship helps case managers determine the best way to help patients make the changes necessary to adhere to their treatment plan, she says. For instance, if you know the family's cultural practices, you can help the patient choose a diet that he or she will enjoy and that doesn't require that the entire family make major changes in their eating habits.

When case managers see patients in person, they put a face on the health plan and start to build a trusting relationship, points out **Cassandra Holloway**, RN, MBA, CCM, senior manager of utilization manager for Keystone Mercy Health Plan and supervisor of the Philadelphia-based health plan's Acute Care Transitions program. The program embeds case managers in hospital emergency departments to work with patients who seek treatment or are hospitalized. The Acute Care Transitions program reduced emergency department visits by 21% and hospital inpatient admissions by 32%. *(For details, see related article on page 4.)*

Andrew Kolbasovsky, PsyD, MBA, director of provider group clinical management for EmblemHealth, a New York-based health plan, calls the health plan's decision to embed a team of care coordinators in physician practices "a win-win situation for us as a health plan, for the members, the doctors, and the case managers." The plan's pilot project, which embedded a nurse case manager, a social worker, a pharmacist, and two health navigators into a large medical practice, was so successful that the project has been replicated at other medical groups. *(For details, see related article on page 3.)*

"Traditionally, we have provided case management telephonically, calling the members, and trying to provide services. There were limitations because it's hard to reach members and when case managers call the first time, there's no personal connection," he says.

Enrollment rates for telephonic case managers and disease managers tend to be low, he says. "When patients are in the hospital, it's sometimes the only time we know where to reach them. By being connected to a physician office, we've been able to enroll 93% of the targeted members," Kolbasovsky says.

The program has slashed 30-day readmission rates, the number of hospitalizations, and the total number of hospitalized days.

Patients love the program, Kolbasovsky says. "I've seen frail elderly members come up and hug their case managers. They often bring the team cakes, pies, flowers, and other gifts. We're not serving a wealthy community so these tokens of appreciation really mean a lot," he says.

Members report that the team helps them find way to save money, such as working with the doctors to find generic alternatives to their medication or linking them to resources. "We get a lot of positive feedback. It makes the staff feel wonderful," he says.

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Tufts Health Plan provides face-to-face case managers in physician practices for the highest-risk members of Tufts Medicare Preferred, its Medicare Advantage plan. Eligible members have complex needs including chronic conditions, cognitive issues, incontinence, fall risks, polypharmacy issues, or a combination of problems. *(For details, see related article on page 5.)*

"These patients have multiple comorbidities, psychosocial issues, and functional deficits and a high rate of morbidity," says **Jonathan Harding**, MD, medical director for the Watertown, MA, health plan.

"Either the health plan or the medical group and the IPAs in our network are at risk for the total medical expenses throughout the continuum of care. We have a financial imperative to reduce the total cost of care," Harding says. ■

Face-to-face approach pays dividends

Health plan cuts readmissions

EmblemHealth's team approach to providing face-to-face care coordination after hospitalization resulted in a 31% reduction in the 30-day readmission rate for members who received the interventions when compared to a baseline group.

In a study, after the New York-based health plan embedded a nurse case manager, a social worker, a pharmacist, and two health navigators into a large medical group to coordinate transitional care, the total number of readmissions per member dropped by almost 37% and the total number of hospitalized days was reduced by 43%. The savings were more than sufficient to cover the cost of the project, says **Andrew Kolbasovsky**, PsyD, MBA, director of provider group clinical management.

The pilot project, conducted at Manhattan's Physician Group, was so successful that the health plan has rolled the model out at four offices of the medical group in Manhattan, two large offices at Staten Island Physician Practice, one office of Preferred Health Partners in Brooklyn and worked with Queens-Long Island Medical Group to train its staff to follow the same model.

The health plan explored ways to reduce the cost of hospitalization, the largest driver of health care expenses, Kolbasovsky says. "There were limitations in reaching our members via telephonic case management. It's often harder to reach members and hard to engage them over the telephone," he says.

For the pilot project, the health plan identified a large medical group with several offices in Manhattan where a significant number of members were treated. Instead of embedding only a nurse, EmblemHealth decided to embed a team to take care of the diverse needs of members.

"With this arrangement, the care managers and other team members can see the members in person and call in other members of the team as needed. The situation offers the advantage of quick interaction with the physicians if the case managers needed to talk with them," Kolbasovsky says.

The team includes a nurse case manager, a social worker, a pharmacist, and two health navigators. "Some of our members have social needs, mental health issues, and financial problems, which makes a social worker a valuable person on the team. We also saw a growing need for a pharmacist to help with medication reconciliation," he says. The health navigators are not clinicians but have experience working with members, have good communication skills, and are knowledgeable about the kind of information that members need.

Every day, the EmblemHealth headquarters reviews data from hospitals and identifies members who are medically hospitalized and shares the information with a member of the point-of-care team. The list includes all members, with the exception of maternity patients, who are being treated at the office where the team is embedded. Medicare, Medicaid, and commercial members are included. A high percentage of hospitalized patients are older members who receive Medicare benefits.

The health plan reaches out to any member who has been hospitalized. The team makes its first contact when the member still is in the hospital and begins

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EmblemHealth, located in New York City, places teams of healthcare professionals in physician practices to coordinate care for patients being discharged from the hospital.

- In addition to a case manager, the teams include a social worker, a pharmacist, and two health navigators.
- A team member contacts patients while they still are in the hospital and enrolls them in the program.
- They work together to make sure the patients have follow-up appointments, understand their medication regimen, and have access to any needed community services.

providing interventions. Some already have a stable home environment and the resources they need. Others have extensive needs.

One of the primary objectives is making sure the patient has a follow-up appointment within seven days of discharge. The case managers or other team members tell patients they work with their doctors and are going to make sure they have everything they need. They make arrangements to meet with the patient before the follow-up doctor's appointment.

"This is our chance to prepare the members for their first visits with their doctor and help them decide what questions to ask. If the member is confused about his treatment plan or medication regimen, the case manager or other team member will give the doctor a heads up," Kolbasovsky says.

Although the team works together, one person takes ownership of the case and is the primary contact for the patient but is backed up by the other team members. "Each member of the team can bring the others in. It allows us to help a lot of people," he says.

The health navigators typically work with the members with less complex needs and call in other team members when needed. For instance, if the member is on a lot of medications or has had a change of medication, the pharmacist goes over the medication either in person or over the telephone. If the person seems to be depressed or needs community resources, the social worker steps in.

As people are being discharged from the hospital, the team makes sure they have a timely follow-up appointment, makes sure they understand their medication and know how to fill their prescriptions, and tries to identify cost issues and work them out. The team member working with the patient conducts a needs assessment and links the member to needed resources. In addition to community resources, the team may refer members to health plan services such as disease management or hospice care, or medical group resources such as a nutritionist or diabetes educator.

"We are finding a lot of members who have difficulty traveling to the doctor's appointments, and others who need assistance with housing or meals. We help all of those qualify for and access community programs," Kolbasovsky says.

The team works with physicians to identify red flags for readmissions. "A lot of patients don't call their doctors until their symptoms get so bad they need to be hospitalized. Our care management team teaches them how to identify early warning signs and build a plan for action," he says.

Members typically are in the point-of care program for 30 to 60 days at a time.

"We constantly assess the members' risks and needs and connect them with whatever services they need," he says.

The program started out with the goal of reducing 30-day readmissions. "We've seen a nice reduction in readmissions, but what surprised us was the other impacts we made on members and their families," he says.

The team makes connections with the members' families and works with them as well. "Family members often feel alone and afraid when their loved one has been in the hospital, and they welcome having someone to advocate for them and help them navigate the healthcare system. Because the case managers and other team members see the patient in person, often with their caregivers, they can create strong bonds," Kolbasovsky says. ■

Acute Care Transitions program cuts ED visits

Embedded CMs work with patients in hospital

Keystone Mercy Health Plan's Acute Care Transitions program, which embeds case managers in hospital emergency departments to work with patients who seek treatment or are hospitalized, reduced emergency department visits by 21% and hospital inpatient admissions by 32% over the course of a year among members who received interventions when compared to a control group.

The initiative also reduced per-member, per-month costs for participants by 24% over a

EXECUTIVE SUMMARY

Keystone Mercy Health Plan embeds case managers in hospital emergency departments to work with patients who are admitted or who seek treatment in the ED.

- People with chronic conditions are targeted, but the case managers touch base with all patients to make sure they have everything they need.
- They work with the inpatients case managers and treatment team to make sure patients have a smooth transition to the next level of care.
- When patients use the emergency department inappropriately, they educate them on seeking treatment at a lower level of care.

one-year period at one participating hospital. By contrast, the per-member per-month cost for the group that did not receive an intervention dropped just 1.3% in the same time period.

When the Acute Care Transitions program was instituted, the health plan embedded case managers in the emergency department at Mercy Fitzgerald Hospital in Darby, PA. After the success of the program, the health plan placed Acute Care Transition case managers in two other hospitals where a large majority of Keystone Mercy members receive treatment, according to **Cassandra Holloway**, RN, MBA CCM, senior manager of utilization management and supervisor of the Acute Care Transitions program.

The program targets people who have heart failure, diabetes, asthma, and chronic obstructive pulmonary disease, but the Acute Care Transition case managers work with members who visit the emergency department or are hospitalized with other conditions. "They see everybody who is a Keystone Mercy member and reach out to them to make sure all is well," Holloway says.

The health plan mines its data to identify members who have the targeted conditions or have multiple emergency department visits. "If someone shows up in the emergency department, the case managers know it right away and can visit with them to find out if they need additional support," Holloway says.

The case managers cover the emergency department 8:30 a.m. to 5 p.m., Monday through Friday.

When the Acute Care Transition case managers come to work every day, they get a list of patients who visited the emergency department or were admitted overnight or over the weekend and follow up with them. They access the health plan's medical management system and review the patients' history, doctor visits, and pharmacy claims and determine if they need outreach. If patients are still in the hospital, they visit them in person.

When members have had an emergency department visit, the case managers contact them by phone, find out why they visited the emergency department instead of their doctor, educate them on their conditions and medication regimen, discuss the importance of regular visits to their primary care physician, and help them overcome barriers to following their care plan. They notify the primary care physician of the emergency department visit.

"The Acute Care Transition case managers are the first point of contact with patients, and by meeting with members in the emergency department and the hospital, they put a face on the health plan. It's a good way to begin to build rapport and identify the services that people need," Holloway says.

When members are hospitalized, the case managers reach out to find out if they need equipment, help with medication, or have other barriers to following their treatment plan and receiving follow up care. They work with the hospital case manager and the rest of the treatment team to coordinate the discharge and make sure the patients have everything they need after discharge.

The Acute Care Transition case managers send discharge instructions to the patients' primary care physicians within 48 hours after discharge. The case managers update the telephonic case manager, inform the patient if the case manager has been unable to reach them by telephone, and gets updated contact information. If the members don't have a telephonic case manager, they put the wheels in motion to get them assigned to the case management team.

When patients need additional help, the Acute Care Transition case managers will refer patients to the health plan's Rapid Response and Outreach Team for assistance with ongoing health or social support issues. The Rapid Response and Outreach Team helps patients access community services and follows them until they are stable.

"We help them get whatever they need to keep their condition under control and avoid emergency department visits and hospital admissions. Many times, it's a combination of a lot of things falling into place at the right time," she says. ■

Intensive CM keeps members out of hospital

High-risk members get face-to-face management

Since Tufts Health Plan launched its integrated care management model for Tufts Medicare Preferred, its Medicare Advantage plan, the Watertown, MA, health plan has seen significant reductions in hospital admissions and readmissions. The health plan began the program in mid-2011 to provide face-to-face case management for its high-risk Medicare Advantage members.

"We know that admission rates and readmission rates in 2012 were significantly lower than in 2011, but it's hard to know if we can attribute these reductions to this program because we don't have a comparable control group. Members who declined to participate are different so they are not comparable. We believe the program is having an impact because we have been working on readmissions since 2008, but they haven't budged until we started our integrated case management program," says **Jonathan Harding**, MD, medical director for senior products.

Some parts of the network were slower to implement the program and some of those provider organizations have not experienced the same amount of decrease in utilization, Harding adds.

The program provides face-to-face case management for the highest-risk population. Members eligible for the program may have a variety of chronic conditions, cognitive issues, incontinence, fall risks, polypharmacy issues, and other problems that geriatric patients face. They are identified through claims data and a predictive model and stratified as to complexity. Complex patients are assigned to a nurse case manager who has undergone additional training on managing members with geriatric conditions.

The health plan bases its program for complex patients on two nationally recognized care management programs. Case managers who work in physician practices follow the Guided Care model, developed at Johns Hopkins Bloomberg School of Public Heath to provide patient-centered, coordinated care to patients with multiple chronic conditions. When patients go from one level of care to another, the nurses have incorporated the Care Transitions Intervention developed at the University of Colorado, to facilitate transitions.

About two-thirds of the physician practices in Tufts Medicare Preferred integrated delivery network are de facto accountable care organizations and have their own case management support. Tufts Health Plan collaborates with other physician practices to embed its own case managers in physician practices that provide care for 2,500 or more Tufts Health Plan members. "The model is the same whether it's their care managers or our care manager. The care managers follow the same standards and same content regardless of who their employer is," he says. The complex care managers see the patients in person whenever they feel it's appropriate, although most of the contacts and follow up are on the telephone.

The health plan's case managers are assigned to physician groups depending on the size of the membership in the group. The case managers work in the field most of the time but come into the office every week for conferences, training, and to brainstorm and share ideas with their fellow case managers. They meet with the physicians and medical directors at each group practice to discuss complicated cases, problem solve, and analyze readmissions and process issues and to develop initiatives to improve outcomes.

The health plan also hosts a monthly meeting for the medical directors at all physician practices in its Medicare network. At the meeting, the group discusses changes in processes to improve outcomes and receives clinical education around geriatric care management. Representatives from the physician practices discuss their success stories and give their peers advice on how to initiate the same processes in their practices.

The team approach has helped to identify patients who have issues as they transition from one level of care to another and helped to address the issues to avoid unnecessary readmissions, Harding says.

Case managers throughout Tufts Health Plan have an average caseload of about 850 members. Case managers who work with the highest-risk population work with 80 to 100 members each.

The complex care managers follow the high-risk members in any setting. They see patients at their physician offices as well as going into members' homes to conduct a comprehensive assessment and meet with the family and caregivers. The comprehensive assessment in the home includes evaluating the members' home situations, screening members for depression, cognitive issues, and fall risks, and determining what the members need to stay healthy at home. The case managers work with the primary care providers on whatever services the members need, whether it's a referral to a community agency or for a physical therapist to conduct a home safety evaluation, says **Denise Kress**, MS, GNT, BC, CHIE, director of care management for senior products. When needed, they help the members access financial assistance for medications, help with transportation, and other resources.

They work closely with case managers at hospitals and collaborate on discharge planning. "We try to work with the hospital case managers to identify underlying factors that may have

caused the admission or readmission. In some cases, the member may have called their primary care physician and gotten a message to go to the emergency department. This is an opportunity for us to educate the member on choosing the appropriate level of care," Kress says.

The health plan originally contracted with a vendor to provide care coordination for at-risk members. "We got a decent return on investment, saving about $20 to $30 per member per month, but we believed that we could provide better care and generate more savings if we integrated the program with the other programs the health plan has to offer," he says.

The health plan also has wellness coordinators who make post-discharge follow up calls to all members two days and seven days after discharge. They follow standardized templates to find out if the members understand their treatment plans, have gotten their prescriptions filled, have follow-up appointments, and if they have questions or concerns. The wellness coordinators are not clinicians but are highly trained and can transfer the call to a nurse whenever appropriate.

Tufts Health Plan has developed standardized educational modules that care managers follow as they work with patients to improve self-management skills. They evaluate patients for health literacy and use the teach-back method as they coach members. The care managers work with the member to develop a member-centered action plan for meeting their goals.

"One of the challenges in healthcare is the tendency for clinicians to be paternalistic. We find out what is important to the members and use the information to develop goals,"Kress says.

The health plan's transitions program helps identify patients with the highest risk of being readmitted. The health plan care managers utilize a day-of-admissions report with flags that may indicate the patient is at risk and determine what issues could be addressed while the patient is in the hospital. The information is incorporated into the discharge plan with the goal of mitigating those risk factors, Kress says.

"We have a standardized approach set up as patients are being discharged to make sure the patients have a primary care appointment within seven days and that the primary care physician has the discharge summary and medication list in a timely manner," Harding says. If a member is being discharged to home from a skilled nursing facility, the health plan shares information on issues, like medication management with the visiting nurse, he says.

"If somebody goes home only to have to go back to the hospital, it's compounding the negative effect on the member's well being and health status," Harding says. The health plan has developed a readmission task force to look at how the system is driving readmissions. The team is working with preferred hospitals to make sure the discharge summaries are generated on a timely basis. "In many cases, hospital by-laws give physicians up to 30 days to write a discharge summary. We want to change this. One hospital system has committed to have the discharge summary completed and to the community provider within 24 hours," Harding says. ■

Look for careers beyond traditional CM roles

CM recognized for contributions to care

In today's climate of healthcare reform and with the growing emphasis on quality, there are more opportunities for case managers than ever before.

The trend toward embedding case managers in physician offices and hospitals is increasing in many areas of the country, says **Margaret Leonard,** MS, RN-BC, FNP, senior vice president for clinical services at Hudson Health Plan with headquarters in Tarrytown, NY.

In her area, case managers are not only being embedded in physician practices and hospitals but insurance companies are starting to place case managers in federally qualified health centers.

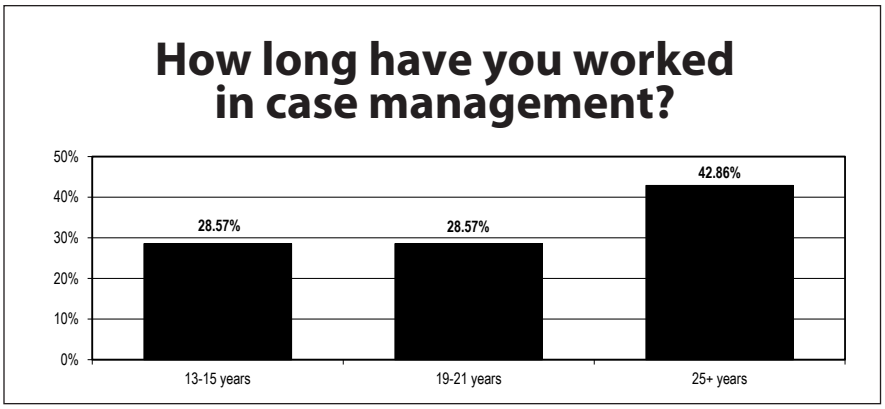
"There also is a growing demand in psychiatric settings as providers realized that while they can take care of a patient's psychosocial needs, many patients also have medical needs and can benefit from someone who can help them navigate the healthcare system and connect with a primary care medical home," Leonard says.

Health homes offer opportunities

The new initiative from the Centers for Medicare & Medicaid Services that encourages providers and payers to work together to create Medicaid health homes also offers

opportunities for case managers, Leonard adds. The Affordable Care Act provides a 90% funding match for organizations that become a health home, a model of care that emphasizes care coordination, she adds.

Larger payer organizations have professional case managers and have long appreciated the value of case management, adds **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm. In addition, physician practices are beginning to recognize the value of case management, especially if they are part of a medical home model or accountable care organization, she says.



"Case managers are a commodity right now, and the need will only grow over the next few years," says **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, and partner and consultant in Dallas-based Case Management Concepts.

She predicts that the demand for case managers will increase as case managers are employed across the continuum of care.

Not enough nurses

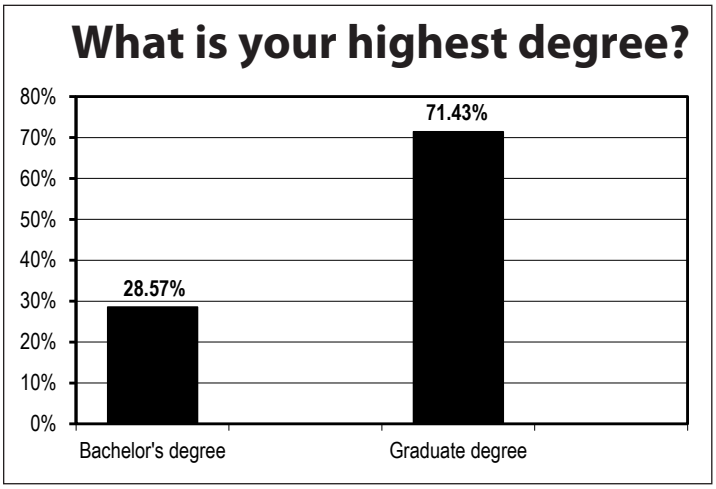
The only problem with the increased demand for case managers is that there aren't enough nurses and social workers to take care of everything some patients need, especially when patients need help accessing community resources, Leonard adds.

"My concern is that if physicians believe they can't afford adding a case manager to their staff, they're going to assign the job to a medical assistant or office staff. At present, there's nothing that adequately defines care coordination or the credentials of case managers," Kizziar adds.

Leonard points to an increase in the use of non-clinical staff called peer specialists or patient navigators who are well trained and are supervised by the case managers. "They can accompany patients to the pharmacy, help them sign up for medication assistance plans or go with them to the Housing Authority and guide them through the application process," Leonard says.

Today's healthcare environment offers numerous opportunities for case managers who want to work independently as individuals and companies seek help in navigating the complex healthcare system, Kizziar says.

"Case managers who want to be self-employed are going to have to create their own opportunities by selling the idea of case management to organizations that in the past may not have understood the need for it. The challenge in becoming an independent case manager is that nurses and social workers are not accustomed to marketing themselves," Kizziar says.



Coordinating care

Some case managers have started businesses that coordinate care for senior citizens whose relatives live in another part of the country, Kizziar says.

"The family members want someone to make sure their relatives are getting the medical care they need, that they have enough food and can live safely at home," Kizziar says. Case managers who want to be independent have numerous opportunities to contract with individuals or businesses, but they have to find their niche and

market themselves, Kizziar says.

Some employers are contracting with case managers to assist employees in choosing the best insurance plan for their individual situations. "They aren't selling the product. They're providing counsel to people who may not understand the array of benefits packages available," she says. Employers want their employees to have the policy that's best for them because, in the long run, it will save them money, she adds. "Having employees well and at work is a win-win situation for everyone," she says.

Leonard is part of a team from the Case Management Society of America (CMSA) who have been meeting with the Centers for Medicare & Medicaid Services on developing payment codes for case management services. "We are working to get reimbursement for case management services no matter where the care is delivered," she says.

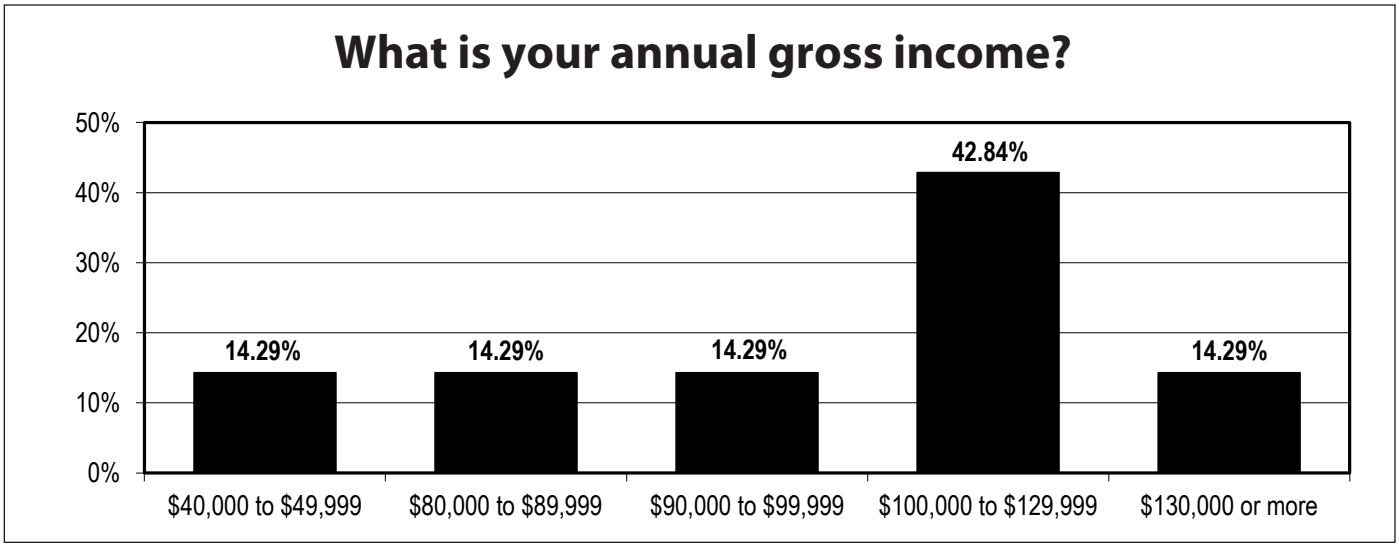
Kizziar, who works with hospitals around the country, reports that she hasn't seen much change in salaries and doesn't expect to until the economy improves.

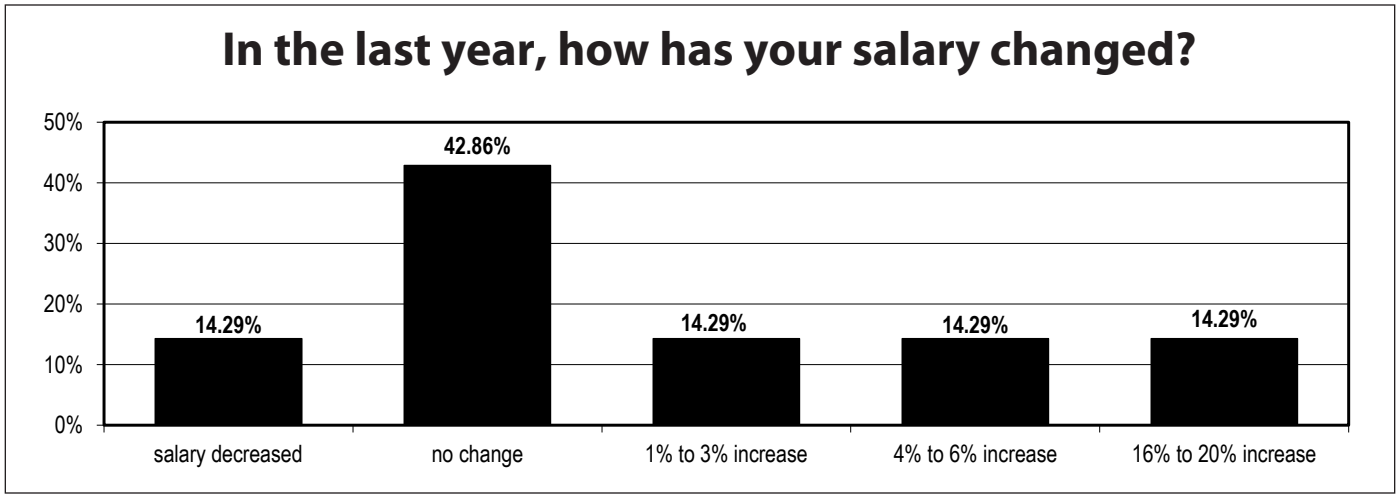
The majority of case managers who responded to *Case Management Advisor*'s annual salary survey (57%) reported salaries of $100,000 or more, and 42% reported that their salary didn't change last year.

Case managers who responded to the survey are older, experienced, and well educated, with 100% reporting 25 years or more in the healthcare field and 43% who report being a case manager 25 years or longer. The majority of respondents (71%) report holding a graduate degree and 85% are age 56 or older.

The good news for case managers is that while employers might not be adding more staff, they aren't laying off case managers either, Kizziar says.

"From what I hear from colleagues, the case management staff is not being affected when there are mergers and acquisitions. There is some consolidation, but the organizations are not touching the case management positions," Leonard adds. ■





ED navigators go beyond health needs

Approach relies on effective relationships between the navigators and ED staff

While studies show that most people come to the ED because of an urgent or emergent medical concern, some people wind up in an emergency setting because they are not plugged in to the kind of social or medical resources that could more appropriately meet their needs.

At Sutter General and Sutter Memorial Hospitals in Sacramento, CA, this problem became particularly acute at the height of the country's financial woes a few years ago. "People lost their jobs and lost their health insurance, and county clinics were closing," says **Holly Harper**, the regional community benefits manager for Sutter Health's Sacramento Sierra region. "We have many programs that meet the needs of under-served populations, but what we were finding was that the ED was flooded with people who were in there for non-urgent reasons."

To address the problem, Sutter partnered with The Effort, the local federally qualified health center (FQHC), to establish ED navigators on-site in each of the hospitals' EDs between 1 p.m. and 10 p.m., seven days a week. The way it works is ED staff will alert the navigators to patients who arrive with no insurance coverage or primary care home, as well as patients who have mental health problems or significant social needs.

The navigators, who are employees of The Effort, will then meet with the patients while they are still in the ED to explore what types of health care connections these patients have, says **Rodney Kennedy**, MFT, director of Behavioral Health Programs for The Effort. "A lot of these patients are either homeless or have mental health conditions, and they don't necessarily feel comfortable going to a regular health care provider," he explains. "So in working with them and engaging with them, we are able to assist in all those areas."

For example, for a patient who has no insurance coverage, the navigator will attempt to get him or her qualified for health care benefits and establish a follow-up appointment with a specific health care provider at one of The Effort's clinics. "We have five clinic sites in the Sacramento region," Kennedy says. "We also have blocks of medical appointments every day that are identified specifically for patients referred from Sutter EDs. The navigator can go right into our electronic health scheduling system and get the patient scheduled to see a provider that day, or the next day if it is in the evening."

Address 'the whole person'

Many of the patients have complex needs that require social and medical interventions. "We often have patients come in who are homeless, and one of the more common diagnoses that they present with is diabetes with insulin dependence that is poorly managed," says **Amber Salazar**, MSC, The Effort's healthcare access and case management program manager. "The insulin has to be refrigerated, which is difficult to do when you are homeless, so these patients will come through the ED frequently for a variety of issues related to their unmanaged diabetes."

The navigator will first link these patients up with a primary care provider (PCP), but then she will work on addressing the social needs. "We address the whole person, so we start with the medical condition and their case management needs; then we begin looking for a shelter or appropriate housing for them. We also address their mental health needs, so it is all integrated care," Salazar says. "Then we follow the client to ensure that they are continuing to engage with the PCP and with case management services."

The navigator program was pilot tested for a year before it got the green light to proceed on a permanent basis in November of 2011. Sutter pays The Effort $150,000 per year to run the program, and as a FQHC, The Effort receives reimbursement from the government to care for patients who have no insurance or who are on Medicaid.

The ED navigator program isn't the first Sutter/Effort collaboration. The organizations first established the Triage, Transport, and Treatment (T3) program, which targets frequent ED users with more complicated needs. Administrators credit that program with reducing return visits to the ED by 65%. The navigator program's approach is similar to the T3 program, and, in fact, ED navigators can refer patients who have more complicated needs

into the T3 program. In addition, many of the ED navigators — typically personnel with college degrees in human services-related fields — began working with patients as part of the T3 program before moving over to the newer navigator program.

"One of the reasons we believe our navigators are successful is because they are so closely linked with the T3 program where they can hand off individuals to that team when it is appropriate and provide an additional range of services, which includes supported housing," adds Kennedy.

Build effective relationships

To be effective, ED navigators have to earn the trust and respect of hospital personnel. "It is the relationship that gets developed with the hospital personnel that really facilitates our efforts to identify and engage with these patients," says Kennedy. "It is really kind of a teaming approach that makes it successful."

Further, as a program is being rolled out and fine-tuned, it is important for administrators at both organizations to work closely together. Kennedy notes that early on in the roll-out of the navigator program, there were regular meetings about what was working and not working, and administrators were able to remove barriers. For example, when one of the hospitals was undergoing renovations, the ED navigator got shuffled off to the radiology department, which didn't work too well, says Kennedy. With close communications between the two organizations, the problem was resolved quickly, he says.

It is also critical for the organization providing the navigators to be well-connected with community resources. "The more resources we can pull together, that really makes the navigator's job that much easier," says Kennedy.

Salazar adds that navigators should receive extensive on-the-job training. For example, she points out that The Effort's ED navigators spend time shadowing case managers, hospital staff, and the psychiatric response team.

Harper advises colleagues interested in establishing ED navigator programs to develop a solid relationship with the FQHCs in your region because they are a crucial point of access. "They will be a huge part of the capacity solution when health care reform kicks in," she says.

Salazar echoes this point, noting that The Effort's ED navigator and T3 programs are perfectly aligned with the mission of accountable care organizations and health care reform going forward. "That is really important, and more of the physicians and hospital administrators are recognizing that," she says.

SOURCES

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COMING IN FUTURE MONTHS

- How your peers are working to reduce hospital readmissions
- Successful ways to engage your patients
- Ways technology can make your job easier
- Reaching out to members with gaps in care

CNE QUESTIONS

1. According to B.K. Kizziar, RN-BC, CCM, CLP, owner of B.K. & Associates, seeing patients face to face makes it easier for case managers to coordinate care. Why is this?
   A. Facial expressions and body language give case managers clues to whether the patient understands and whether he or she will follow the treatment plan.
   B. Meeting people in person helps build a trusting relationship.
   C. Getting to know patients personally gives case managers clues about the best way to help patients make the changes necessary to adhere to their treatment plan.
   D. All of the above.

2. EmblemHealth embedded a nurse case manager, a social worker, a pharmacist, and two health navigators into a large medical group to coordinate transitional care.
   A. True
   B. False

3. Keystone Mercy's Acute Care Transitional case managers contact hospitalized patients' primary care physicians how soon after discharge?
   A. Within 24 hours.
   B. Within 48 hours.
   C. Within 72 hours.
   D. Within seven days.

4. What is the average caseload of Tufts Health Plan's care managers who work with the highest-risk population?
   A. 50 to 75.
   B. 70 to 80.
   C. 80 to 100.
   D. 100 to 120.

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.

CNE INSTRUCTIONS

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. ■