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Covering Case Management Across The Entire Care Continuum

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When patients are challenging, try to understand

Take a deep breath and put yourself in their shoes

Regardless of the healthcare setting in which they work, case managers are likely to encounter challenging patients and family members — those who are irate, provocative, depressed, or just plain ornery.

"Dealing with difficult patients and family members simply comes with the territory. It's totally predictable that sooner or later case managers will work with unhappy patients, those who are angry, frustrated, or who suffer from mental illness or a personality disorder," says **John Banja**, PhD, professor of rehabilitation medicine, medical ethicist at Emory University's Center for Ethics and director of the Section on Ethics in Research at Emory's Atlanta Clinical and Translational Science Institute.

It doesn't matter if you see patients in the hospital, follow them by telephone after a hospital stay or when they have a chronic illness, coordinate care in a physician's office, or help a workers' compensation patient get back to work — they are likely to be sick, in pain, under stress, and/or fearful about their situation.

Banja points out that most challenging patients don't think they are being difficult. They're feeling overwhelmed, helpless, and depressed because of their situation and they project their feelings to those around them, he says.

When you encounter people who are uncooperative or grouchy, avoid the

EXECUTIVE SUMMARY

When case managers encounter challenging patients and family members, they shouldn't take it personally but should recognize that patients act that way because they are sick, in pain, under stress or fearful about their situation.

- Take time to understand your patients and present yourself as a supporter.
- When patients won't cooperate with their treatment plan, try to find out why.
- Keep your emotional health in good shape by educating yourself and getting trained on how to cope with difficult situations.

tendency to diagnose their personality flaws and put a label on them, cautions **Tammy Lenski**, EdD, chief executive officer of Tammy Lenski, LLC, a conflict resolution and negotiation consulting firm based in Peterborough, NH. "There's a huge difference between difficult people and people acting in difficult ways because of difficult circumstances. When case managers label them as difficult, they start treating them that way," she says.

The minute you start to think of someone as unfriendly or uncooperative, stop and think that you could be wrong about the person, she adds.

When you deal with a patient who is obviously distressed, the empathetic approach works better than ignoring it or being dismissive. Begin by validating the patient's feelings by saying, "You appear to be angry [or sad, or upset]. Could you talk about it? I would like to know what it's like to be you right now," Banja advises. Don't make the mistake of dominating the conversation rather than stopping to listen. Don't talk, except to make comments like "I hear you," or "That sounds like an important point. Tell me more."

For instance, workers compensation patients may not feel as if anyone but their lawyers is on their side. "When a healthcare professional asks patients what it's like for them, it usually elicits a positive response," Banja says.

Present yourself as a supporter and encourage the patients to share their frustration, disappointment and pain. "The biggest mistake we make is emotionally reacting to patients instead of trying to understand why they are acting that way," Lenski says.

Take the time to really understand and talk to your patients. "People in healthcare are asked to multi-task and they often don't take time to listen to their patients. You can save a lot of time on the back end by putting in time on the front end to find out what really is going on with patients and how they are feeling about their situation," Lenski adds.

One of the mistakes that case managers make in trying to get patients to be cooperative is assuming that if they are giving the client logical information, the patients are buying into it, she says.

When patients won't cooperate, stop giving them more and more information, Lenski advises. Instead, try to understand why they aren't cooperating and why they think your plan won't work. Don't interrogate the patient. Instead, say, "The discharge plan calls for X, Y, and Z but you won't do Z. What about Z isn't working in your life? Help me understand."

Resist the temptation to run or to fight when you encounter grumpy or combative patients. "Leaving the room or arguing with patients tends to escalate the situation and that will only make it worse in the future," she says.

If the situation escalates, Lenski advises taking a break. Tell the patient you think the conversation got off on the wrong foot and you're going to come back in 30 minutes and start over, she says.

If all else fails, consider firing your client, particularly if he or she is threatening or uses profane language, Banja suggests. "There are many legitimate reasons for case managers to tell their client that the relationship is not in their best interest or the client's. It should be a last resort, but it's nevertheless an option," he says.

But before it gets to that point, discuss the problem

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with the client. You might say, "I want to help you, but it's difficult when you are screaming at me or using that language." Or say, "I can't help you if you are going to threaten me."

It's very important to say it in a calm, non-threatening, non-judgmental, and respectful way, he says. Don't get angry or upset back at them.

When you document the conversation, be objective rather than judgmental. Don't say, "the client is unreasonable." Instead say, "He erupts whenever I mention…"

"It's very important for case managers to retain their objectivity and not use language in their documentation that someone could interpret as being biased or prejudiced," Banja says. Not only is it a violation of professional standards, if the client has an attorney it will be very easy for the attorney to show the representation the case manager made in the notes and make that case manager look unprofessional, Banja adds. ■

Don't let patients get you down

Don't get angry, take a break

Every healthcare professional needs to develop a basic set of skills to help them cope with difficult patients so they can get through the encounter and not come out emotionally bruised, says **John Banja**, PhD, professor of rehabilitation medicine, medical ethicist at Emory University's Center for Ethics and director of the Section on Ethics in Research at Emory's Atlanta Clinical and Translational Science Institute.

"The first human response when people feel uncomfortable is to defend themselves, rather than trying to understand what is going on with the patient. With difficult patients, this is probably the wrong thing to do, and it's probably why relationships between difficult patients and healthcare professionals don't tend to improve very much," he says.

Don't take it personally and resist the temptation to push back when patients lash out at you, adds **Tammy Lenski**, EdD, chief executive officer of Tammy Lenski, LLC, a conflict resolution and negotiation consulting firm based in Peterborough, NH. Remember that there is a huge difference between yelling at somebody and yelling towards somebody, she says. "Most people coping with an illness or injury are not combative because they don't like the person with whom they are dealing." Lenski points out. They're acting that way because they are on edge, frustrated with a lot of things, and everything is a major struggle.

"When people realize that the combative patient is yelling toward them and not at them, it helps them understand that the person yelling actually is expressing frustration and pain. Then the healthcare professional can have compassion for the patient's misery," she says.

Keep in mind that in some cases, the best thing you can do is to keep a difficult encounter from getting worse, Banja says. You may think at the end of the discussion that it went poorly, but remember that you're likely to have another conversation with the patient and it probably will go better, Banja says.

Once your emotional trip wires have been activated, it's time to take a break and do something different, Lenski says. "If you stay in a hot conversation, it doesn't get any cooler. It's better to take a half-hour break and do something to take your mind off the topic," she says.

Sit quietly and take deep breaths until your heart stops racing. Seek out a colleague and talk about a movie you saw, an upcoming event — anything but the problems you are having with your patient.

Acknowledge that dealing with challenging patients is a very real problem for everyone in the healthcare profession and that dealing with them can cause burnout, Banja says. Look for opportunities to educate yourself and develop a good skill set to cope with these patients.

Banja recommends that training programs for case managers include information on how to cope with difficult patients. "Nurses need to be better trained to react when they come across difficult patients, which probably happens every day," he says.

Evaluating a case manager's ability to cope with difficult situations should be part of the hiring process, he says. "It's a huge mistake to hire a case manager based only on their intellectual ability. They need to be able to cope with all the difficulties they are going to encounter. Someone who understands clinical medicine very well may not be able to negotiate a difficult relationship," he adds. ■

Transition nurses follow patients after discharge

PCPs team up with hospitals

To eliminate gaps in care after their members have been hospitalized, Cigna Medical Group has assigned RN care coordinators to local hospitals to

act as a bridge between the primary care practice and the hospital and has a dedicated team of physicians, pharmacists, and nurses who see the majority of patients for their first follow-up visit.

Cigna Medical Group is the medical practice division of Cigna Healthcare of Arizona and is a Level-3 NCQA-recognized Patient-Centered Medical Home with 23 healthcare centers and two convenience care centers located throughout Phoenix.

"We started the Transition of Care Nurse Program eight years ago because we were seeing some very significant gaps in care. We identified opportunities for improvement that included post-discharge follow-up and a clinically integrated model on the front end," says **Robert Flores**, MD, medical director, population health.

The organization began the Custom Care After the Hospital follow-up program in 2012 to ensure that patients being discharged from the hospital have a timely follow-up appointment.

"We know that the most crucial time for the patients is 24 to 72 hours after discharge. If something goes wrong and the patient doesn't have someone to deal with the problem, they wind up in the emergency department or back in the hospital," Flores says.

The organization determined that there were gaps in information between the hospitals, the primary care physicians, and specialists that constituted risks for patients being readmitted to the hospital. In addition, some patients were confused about their disease after discharge and were not receiving the recommended post-discharge services, he says.

The organization assigned six RN care coordinators to seven hospitals to work with its Medicare Advantage patients. "We wanted to establish communication between the hospital system, especially the emergency department physicians, and the primary care physicians," he says.

The idea was for the care coordinators to share information from the patient's primary care records that would help the physician make a decision about admitting the patient.

At the beginning, the plan was for the nurses to coordinate the full spectrum of care from the beginning of the stay and after discharge. "When we started, hospital systems were not ready to accept co-management of their patients. Now the healthcare world is starting to change and hospitals are realizing that there is great value to having utilization information on the front side of an admission. Hospitals have not always taken full advantage of the program until recently, but now hospitals are very much aligned with our interest in preventing readmissions as well as first hospitalizations," he says.

When primary care practices and hospitals share information, it results in better care for the patients, Flores says. "We can provide the results of tests that have been done, information on medication they are taking, and a list of problems. All of that is very helpful and it eliminates the hospital staff having to rely on patients for that information," he says.

The Transition of Care nurses are employed by the practice. Their primary role is to act as a bridge between the Cigna Medical Group's primary care practices and the hospitals. They visit the hospital and make rounds on the Medicare Advantage patients, interact with the patients and family members as well as the hospital case managers and hospitalists, and often case managers from the health plan.

"They are an extension of our office practice into the hospital," Flores says.

The Transition of Care nurses establish a relationship with the patients and work with the hospital case managers and hospitalists on a discharge plan. They let the patients know that they will contact them within 24 to 48 hours after discharge. The patients are receptive to the post-discharge calls because they are expecting them and because they have already have a relationship with the nurses.

The Transition of Care nurses make at least one post-discharge telephone call to the patients whether they are being discharged from the acute care hospital or a skilled nursing facility. If the patient needs additional support, the nurses may follow them for several weeks, or refer them to the physician group's general care coordinators, depending on the type and extent of their needs.

The nurses follow a specific set of questions during

EXECUTIVE SUMMARY

RN care coordinators employed by Cigna Medical Group in Phoenix work at local hospitals to coordinate care for members who have been hospitalized.

- The care coordinators share information from the patients' primary care physicians with the hospital staff and ensure that the primary care providers are informed about the hospital stay.
- They develop a relationship with patients during the hospital stay, work with the hospital-based case managers on the discharge plan, and make at least one follow-up call after patients are discharged.
- To ensure timely follow up, the physician practice has dedicated team of physicians, pharmacists, and nurses who see most patients for their first post-discharge visit.

the post-discharge calls to make sure nothing has been missed. They assess the patients' health stability, make sure that they are doing well at home, check to ensure that the durable medical equipment has arrived, verify that they have a caregiver and that they can perform activities of daily living. They ask questions about the patients' activity level to assess the need for physical therapy, occupational therapy, and other home health services. They go over the discharge orders, review medication, and conduct medication reconciliation.

They make sure the patients have follow-up visits scheduled with their primary care physicians, and specialty programs such as anticoagulation clinics. The nurses make sure there are no gaps in care and that the primary care practice has all records from the hospital stay as well as the discharge summary.

If the patients are discharged to a skilled nursing facility, the same nurse follows them and picks up after they are discharged. They make sure the patient doesn't have gaps in care as they transition from the acute care hospital to the skilled nursing facility and make sure the staff at the receiving facility have all the information they need to care for the patient.

Cigna Medical Group has begun a new program to ensure that patients have a timely follow-up visit with a primary care provider after discharge. Called Custom Care After the Hospital, the program includes a multidisciplinary team of caregivers who see the large majority of patients for the first post-discharge visit. The team is dedicated to the Custom Care program and includes pharmacists, and nurses in addition to physicians.

"One of the dilemmas of post-discharge follow-up is the ability to guarantee an available visit shortly after discharge. This special team fills that gap and gives the Transition of Care nurse another team of providers to refer patients to as they come out of the hospital," he says.

The team in the Custom Care program takes at least an hour to review the patient's medical history, medication regimen, and need for community resources and schedules further visits as needed. They typically follow patients for 30 days after discharge. "Nobody is in a rush. It's a satisfying visit for the patient and the team," Flores says.

After the visit, the team sends a summary of the visit to the primary care provider.

The organization has gotten positive feedback from both the patients and the hospital system on the program. "Patients are always amazed and pleased that their primary care provider is aware of and involved in care in the hospital," he says. ■

Navigators help patients manage their health

Interventions tailored to the individuals

Patients who participate in Hospital Sisters Health System Medical Group's Nurse Navigator Program have shown significantly fewer emergency department visits and hospital visits as well as better control of their chronic conditions than patients who are not being followed by a nurse navigator.

"This program provides one-on-one support to patients at moderate to high risk to help them learn to manage their conditions and access the community resources they need to stay healthy at home and avoid hospitalization and emergency department visits," says **Jonna Herring**, RN, executive director of quality and performance improvement for the Springfield, IL-based medical practice.

The program, based on a model developed by the Geisinger Health System in Pennsylvania, began in 2009 with a pilot in two medical practices with 11 physicians. The program had been expanded to nine medical group practices, and plans call for an additional 5 practices to come on board by July 1, 2013.

The program provides care coordination for at-risk patients with diabetes, chronic obstructive pulmonary disease, asthma, hyperlipidemia, coronary artery disease, hypertension, and heart failure. The nurse navigators and physicians search the patient database to determine which patients with chronic diseases would benefit from care coordination. "We have specific criteria based on clinical outcomes and measures," Herring says. For instance, if a patient with diabetes does not have his or her hemoglobin A1c level under control, that is an immediate trigger for the nurse navigator program.

EXECUTIVE SUMMARY

Nurse navigators who work in physician practices provide support to moderate-to-high-risk patients with chronic conditions.

- Physicians and nurse navigators identify patients who could benefit from the program.
- The nurses meet face-to-face with the patients in the physician offices, sometimes as often as several times week, and follow up by telephone as needed.
- They help patients access community resources and other services that will help them manage their healthcare.

Patients who have multiple comorbidities, who are being discharged from the hospital, who make multiple visits to the emergency department, or who have other significant heath care needs are also eligible for the program. "Sometimes the providers feel that patients need someone to rally around them and help them understand their condition and they refer these patients to the navigators," she says.

After patients are identified for the program, their physician talks to them about the services they will receive and how they will benefit. If patients agree to enroll, they meet with the nurse navigator.

The first meeting between the patient and the nurse navigators is up to an hour, depending on the level of concern the physician has. "The nurse navigator tailors the encounters to meet the specific needs of the patient. We know that when it comes to coordinating care for patients, there's no 'one-size-fits-all' formula," Herring says. For some patients, an initial meeting and follow-up phone calls are all that are needed. Some patients need a lot of extra help and the navigators meet with them at the physician office as often as two or three times a week in the beginning, then taper off. "Patients also know they can call the nurse navigators if they have questions or concerns," she says.

The nurse navigators educate patients on their treatment plan and motivate them to follow it and take control of their health. "The navigators are the cheerleaders for their patients," Herring says.

During every visit, the navigators assess their patients' conditions and add information to the electronic medical record to keep physicians and nurses up to date on what is going on with their patients.

When patients are due for a recommended procedure or test, the nurse navigators contact the patients and make sure the appointment is scheduled. They review the results and alert the physician if there is a change in the patient's condition.

The nurse navigators educate patients on how to manage their conditions and on signs and symptoms that indicate that they need to take action. For instance, with heart failure patients, the nurse navigators emphasize the importance of weighing every day and provide scales if needed. "We teach them what to do when they gain weight or their ankles swell and help them learn the triggers that indicate whether they should call the doctor or go to the emergency department."

Nurse navigators have helped patients with such diverse needs as identifying affordable healthy foods, finding low-cost exercise programs, and signing up for pharmacy assistance programs as well as educating them about their diseases and treatment plans.

"The nurse navigators build a very strong relationship with their patients. If the patients are interested and willing to participate, the navigators become their new best friend," she says.

The nurse navigators have a patient load of no more than 120 patients at a time, allowing them to spend as much time as necessary with patients who need it.

The physician practices are working to establish relationships and share information with community hospitals. The physicians and hospitals have been working together on a readmission and discharge program to ensure that patients have a follow-up appointment and are taking their medication as prescribed after a hospital discharge.

"The hospitals directly affiliated with us have the ability to share information on hospital admissions and emergency department visits. In addition to looking at patients who already are being treated at our practices, we are looking at those who haven't been a patient here but need a medical home. We want to keep these patients from falling through the cracks and help prevent readmissions," she says. ■

Health system rolls out care plans for ED

Care plans give ED providers a roadmap

The emergency medicine community has pushed hard against complaints that too many patients with non-urgent needs are being seen in the ED, but there is little doubt that so-called super-utilizers — patients who come to the ED regularly for one reason or another — are not receiving the kind of care they need in the most appropriate setting. Further, in cases in which there are finite emergency resources, such patients are taking time and space away from patients with urgent and acute care needs.

Addressing this problem cost-effectively is complicated in a fee-for-service environment that rewards volume, but as health care organizations inch toward different payer models that reward quality and satisfaction, new solutions are emerging that can help transition super-utilizers of the ED toward more effective, ongoing care pathways.

For example, the Red Carpet Care program, developed by the MetroHealth System in Cleveland, is addressing super-utilizers by turning a common response to these patients on its head. Rather than viewing them as a nuisance when they present to the

ED for the umpteenth time, the aim of this program is to roll out the "red carpet" to these patients by offering them easy access to care coordinators and other resources to help them connect with the kind of care and resources they really need.

Devise care plans

The program is actually just one component of larger efforts that have been going on at MetroHealth for more than two years, explains **Alice Petrulis**, MD, FACP, the medical director of managed care at MetroHealth and the clinical champion of the Red Carpet Care program. Beginning in 2010, the ED at MetroHealth Medical Center began sending the names of super-utilizers to Petrulis with the idea that she could set up a care plan for these often complex patients so that the ED would have guidance to follow when they come in for care.

For each patient, Petrulis tracked down the primary care provider (PCP), if there was one, and any other care providers involved with the individual's care, and they mapped out a care plan that was fairly rudimentary. "It would include things that the ED needed to know," says Petrulis, noting that the plan would point out what tests and procedures the patient had already undergone, whether the patient needed to be referred to his or her PCP, and whether the patient was a narcotic seeker.

Petrulis, who works out of the MetroHealth Medical Center, then entered the care plan into the health system's electronic medical record (EMR) under a special code, so that it would be flagged whenever the patient presented to the ED for care. "When the patient's name was pulled up by the ED physician, the name would be in red, and the provider would be prompted to click on the name to bring the care plan up," explains Petrulis.

This approach worked well, and was consequently enlarged for a project MetroHealth devised with the state's Medicaid program. "We took a handful of patients from each of the three Medicaid payers, and did the same thing," says Petrulis. "We put in care plans that would alert the ED, and we did intensive case management via the case managers at each of the three plans."

During the Medicaid project, Petrulis sat down with representatives from the three Medicaid payers every month to review each of the patient cases, update their care plans, and assess what impact the approach had made over time. "In a year, we were able to reduce ED utilization by 39% [among the super-utilizing Medicaid patients]," Petrulis says, explaining that the statistics were calculated by comparing utilization before and after the care plans were initiated. "Indeed, many of the patients had stopped using the ED, and they were actually quite grateful. They didn't know they could just call their PCP or get an appointment that easily."

The approach delivered many success stories, but it did not work well in every case, notes Petrulis. "Patients who were alcoholics were the toughest to get a hold of, and some others were difficult to find, too," she says. "They didn't answer their phones and didn't come to clinic appointments."

However, the approach was successful enough that Petrulis is continuing this work with two of the Medicaid payers. "Every four to six weeks we go over all of the patients who are on our list, update their care plans, and talk about how to better care for these patients, improve the quality of their care, and keep their ED utilization down," she says.

Take a welcoming approach

Further, the work has formed the basis for the Red Carpet Care program, which is being funded, in part, by a grant from the Robert Wood Johnson Foundation. Building on the earlier efforts, MetroHealth has hired two nurse practitioners (NP) to serve as care coordinators and contact persons for the super-utilizing ED patients who are identified for the program.

"They actually give the patients cell phones if they don't have a phone, and the NPs tell the patients that they can call them at any time. That way, the patients are not on the phone lines waiting in some sort of tree in order to get a hold of someone they can speak with to make an appointment," Petrulis says. "It is the same face every time so the patients can establish a relationship with that NP."

Developers have based many of the program's elements on input they received from previous patients who were super-utilizers. "We did a focus group with them before we started with recruitment for the new program," Petrulis says. "They wanted the same face every time and they wanted someone to take care of them who would give them good care, but also like them for who they are. It was very reassuring to hear that, so we thought the phrase 'red carpet care' would be a very successful name for this project."

As with the earlier efforts, the Red Carpet Care program relies on the ED at MetroHealth Medical Center, a level I trauma facility that sees 100,000 patients per year. Emergency providers identify patients who would be good candidates for the program. **Jonathan Siff**, MD, MBA, FACEP, the

director of informatics and associate director of emergency medicine operations for MetroHealth, has taken the lead in coordinating the Red Carpet Care program in the emergency setting.

"I am the person who the ED folks come to when they have someone to nominate for the program, and I communicate with Dr. Petrulis," Siff says. "Sometimes the patients meet her criteria, but we communicate back and forth to identify patients who can benefit from comprehensive case management at the hospital level."

Target patients with complex needs

Siff adds that while there are no "hard and fast" criteria that patients must meet to qualify for the program, it is generally designed for patients who use the ED frequently and who have problems or issues that are beyond the scope of the ED to address.

"These patients are generally very challenging if for no other reason than they do use the ED so frequently, and that often creates frustration for patients and for providers," he says.

Having access to the care plans is a plus for everyone involved, adds Siff. "It is better for the patients because they know what to expect," he says. "And it is better for the providers because they have a very clear roadmap of how to address the patient's usual needs without having to try and reach a PCP at 3 o'clock in the morning, and without having to spend hours trying to review a very complicated and lengthy chart."

It can be very difficult to get all the parties involved in a patient's care in the same room or involved in the same email trail to come up with a final cohesive plan, so it often takes time to get a care plan in place, Siff says. Social workers or case managers often need to be heavily involved because many of these patients have social issues such as language barriers or financial problems.

"Sometimes there needs to be investigation," says Siff. "We may need to call the patient and talk to him, or involve social services to go to the home and see what the situation is, so it can get very complicated," he says. "But ultimately, I think it always improves care for the patient."

For example, through this collaborative approach, the Red Carpet Care program can make sure patients are getting their medicines and that they have access to a physician who speaks their language. "They do whatever can be done ahead of time," says Siff, referring to the care planners involved with the program. "Then if a patient re-presents to the ED, for whatever reason, the program provides us with an easy link to a plan of action that we can follow."

In addition to identifying patients who might be good candidates for the program, emergency physicians also play a role in developing the care plans. However, Siff says there has been no resistance to the approach because it helps providers deal with many of the more complex patients. "It improves our ability to deal with these patients in an appropriate and expedient fashion," he says.

Furthermore, patients are responding well to the program, too. "They have been educated by the case managers, so they have an understanding of what they can expect to have done when they come to the ED," says Siff. "Prior to the program, I think many of these patients had expectations that were unrealistic or that were fostered by some of the barriers."

Since many of the barriers have already been addressed ahead of time when these patients come in to the ED, the patients receive better care coordination, Siff says. "The whole idea of the red carpet approach is that we want to roll out the red carpet for these patients and put them in the control seat," he says. "If they understand what their care plan is and if they are learning the tools to help manage their own care, they are going to be healthier and more satisfied."

Sources

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TJC releases new patient flow standards

Leaders accountable for establishing relationships

While new requirements are not always welcomed in the ED, to be sure, managers and front-line providers do have reason to feel optimistic about new standards, unveiled by The Joint Commission (TJC), regarding how hospitals manage patient flow.

Recognizing that patient flow does not necessarily begin and end in the ED, the accrediting agency is taking firm steps to hold hospital leaders accountable for measuring all the components of the patient flow process, and for setting goals for improvement. Further, beginning in 2014, hospital leaders have been

put on notice that they need to have referral options in place for the care of patients who present to the ED with behavioral health emergencies.

"Hospital leaders are going to have to establish relationships with community resources so that the ED can treat these patients and then move them to more appropriate settings," explains **Jeannie Kelly**, RN, MHA, LHRM, an expert on risk management and quality assurance at Soyring Consulting in St. Petersburg, FL. "You have to have these relationships at a higher level going on, so that all the parties can communicate and work with each other, and get out of the silos they are in now."

By providing hospital leaders with a year to gear up for these standards, it is clear that TJC recognizes that it will take time to forge relationships with other community providers. However, Kelly notes that it is also clear that the agency recognizes what busy EDs are up against on a daily basis.

"These people who work in the ED are overworked and stressed, and they are trying to shovel against the tide. There is a never-ending flow of people and problems coming in, and they are doing the best they can with what they have," she says. "I think The Joint Commission realizes this, so they are elevating the responsibility [for patient flow] and making hospital leadership more accountable."

Kelly adds that TJC is also being realistic about the time it takes to nurture ties with other provider organizations in a community. "The agency recognizes that physicians, nurses, and social workers can't just pick up the phone and establish this kind of community relationship. That has to come at a higher level."

Take note of added considerations

Already in place as of January 1, 2013 are standards requiring hospitals to have written plans in place for the care and treatment of patients who present to the ED with emotional or substance abuse problems. "There are several things that have to happen," says Kelly. "ED providers have to assess these patients for their medical and psychological problems, and they have to determine what kind of placement or treatment they might need."

In addition, while these patients await discharge or transfer to another facility, they need to be in an environment that is safe and well-monitored so that there is no danger of a patient hurting him- or herself or others. "ED providers can generally not leave these patients alone or out of sight, so there is a lot that is required above and beyond a typical patient who might be boarded in the ED for one reason or another," Kelly says. "They need a lot of extra care and extra considerations."

The sooner such patients can be transferred to a care environment that meets their needs, the better, says Kelly. This is where the community relationships become so important. "Knowing what kinds of resources are out there, and where these patients can be properly placed is paramount to the success [of these standards]," says Kelly. "Hospital leaders need to start initiating these relationships today."

While EDs are still struggling with the challenge of caring for behavioral health patients, Kelly observes that many clinicians and hospital administrators are encouraged that the issue is getting more attention by the public as well as accrediting organizations. "The reports of shootings by people who were unstable and didn't have access to community mental health resources have focused more attention on this," she says. "If we can get people the kind of health care they need, whether it is physical or mental health care, that will be a really good thing for the country."

Clear away barriers

Kelly notes that TJC surveyors will certainly want to document that hospitals have written policies and procedures in place regarding patient flow practices; however, she notes that the tougher test will be whether the hospitals are adhering to these procedures. "There can be barriers in place, such as crowding or not enough psych beds," she says. "It could be that someone has not been trained; they don't know what the psych resources are or they don't know what the plan is."

These are issues hospital leaders should consider when developing plans for complying with the patient flow standards. "There are many different barriers, and some of them are not real. Some are just perceived," says Kelly, noting that it is not uncommon for a busy nurse or case manager to say that there are no beds available without thoroughly checking whether that is really the case.

Beginning in 2014, accredited hospitals will need to measure and set goals for mitigating and managing the boarding of patients who come through the ED. Further, TJC is recommending that patients be boarded for no longer than four hours, based on safety and quality.

Source

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Patient flow gets new look, standards

Report puts more emphasis on psych patients

Patient flow and boarding have been recognized for some time as problems that hospitals need to address. But whatever is being done isn't enough, and The Joint Commission (TJC) released a report in December outlining new standards in the Leadership section, some of which came into effect on January 1, and some of which will take effect in another year. The hope is that the new elements will help facilities take a more holistic approach and view the problem — and its potential solutions — in a more systemic manner. *(The entire report is available at http://www.jointcommission.org/assets/1/18/R3_Report_Issue_4.pdf.)*

Newly in effect are standards that require measurement and goal-setting of data such as the number of patient beds available, the throughput and safety of places where patients receive care and services, how efficient non-clinical services are (like housekeeping and transport), and patient access to services like case management and social work.

Coming into effect in January 2014 are standards that deal with the measurement and abatement of boarding patients from the emergency department, with a recommendation that the goal for time spent boarding not exceed four hours while taking into account the specific needs of the local community and resources available to the hospital. Leadership must review the goals and take action if they are not met, the new standards state. Teams involved in such review should include members of the medical staff, the hospital board, facility executives and senior management, and nursing.

Further, the new standards put special emphasis on dealing with the needs of patients experiencing psychiatric and behavioral health emergencies, to ensure they are not boarded for extended periods of time and that when they are, their care and safety and the safety of others in the facility are appropriately considered. If the hospital doesn't typically deal with this type of patient, the standards require plans to ensure quality care and a safe environment when they do present. Further, the hospital leadership is encouraged to coordinate with the wider community to ensure that the needs of this special patient group are met.

Shine the light

That The Joint Commission is putting further emphasis on the topic is great, says **Mary Baum**, MPH, RN, chief healthcare officer of Connexall, a Toronto-based company that makes software designed to help hospitals improve patient flow. "It is a tough problem to break apart because healthcare is so complex, with interdependent parts, and patients and staff that have the freedom to act unpredictably," she says. The four-hour goal for boarding is particularly welcome, she adds. "For most patients, that four-hour window won't be hard to meet. But for some patients — mental health patients particularly — it's going to be very, very difficult."

There are fewer beds for behavioral patients — 11% fewer than just a couple of years ago, says Baum. These patients are often too incoherent to help providers figure out what is wrong with them. Some are brought to an emergency room because law enforcement doesn't know what else to do with them. She mentions a large hospital system on the West Coast that Connexall worked with recently. "They never divert for trauma, but they do for mental health often. They don't have hallway space for any more patients. They need a security guard for each one. These are usually patients who don't need an inpatient bed, but need some kind of treatment." The average time for a mental health patient in the system was 17 hours. And the staff were trying desperately to move the patients through the system, Baum says. "But what can they do? Create new beds? Build a new wing? Those are long-term things."

The new standards are great, Baum says, but no single entity can solve the problem of mental health patients boarding in the ED by itself. It's the language that calls on leadership to work in the wider community to serve the needs of this patient population that she hopes will energize action. "Acuity levels and volumes are up; there are fewer beds. One in ten suicides is seen in the ED within 60 days of the suicide. There is a tangled web of homeless people with drug and alcohol issues, who are uninsured and often present with grave comorbidities."

What worries Baum is the emphasis on how other industries deal with workflow and how to apply those lessons to healthcare. While noting there are certainly lessons to learn and ideas to implement from others, "we aren't Toyota," she says. "Patients move in erratic ways, they come from a variety of places, and we don't know their acuity level before we see them." How can you put a flow system together for that kind of environment? "It has to be a systemwide thing. And these standards might help by shining a light on it. But every ED out there is already looking at throughput and growing volume. They do it, too, with limited dollars because so much of the available funding is going to technology 'solutions' like electronic records. But

those things don't change throughput or connectivity or how we work together in meaningful ways that solve this problem."

Four hours is a goal, but not something that hospitals will be surveyed against, says **Lynne Bergero**, MHSA, project director at TJC's Department of Standards and Survey Methods, Division of Healthcare Quality Evaluation. "Hospitals will set their own goals, based on their own reality," says Bergero.

It's particularly important for care to be delivered and dispositions made for mental health patients in a timely manner, Bergero says, since just being in an unfamiliar, noisy, and hectic environment can lead to a deterioration in that group's mental condition. "But if a hospital can't meet that four-hour goal as a practical matter, they can set their own goal. The surveyor will ask how they came to make that number and how they ensure safe and timely care for patients."

For the elements related to working within the community to address the problems of psychiatric and behavioral health patients, Bergero recommends using the American Hospital Association's resources related to finding community solutions to caring for them, such as a report from a year ago that not only outlines the issues, but examines some success stories from around the country (http://www.aha.org/research/reports/tw/12jantw-behavhealth.pdf).

The hope is that hospitals will start to think strategically about the continuum of care and the elements in it that affect how patients move through the hospital and the wider healthcare system, Bergero says. "This isn't going to get easier and the pie won't get any bigger, so don't act like you are in a silo."

Steps to take now

Baum reiterates that the new standards are a good thing, but don't expect them to have a huge impact right away. And don't be discouraged if it takes more time to get this right than you'd like, she says, because there are steps a facility can take to set goals that are meaningful, achievable, and will benefit both the hospital and the wider community.

"Think about how you work together across functions," she says. "Look at your wider community for novel ways to address the needs, particularly of the mental health patients. The ED is just the door they access for care. Most don't need hospitalization, and with proper treatment have the same risk of harming themselves or others as the rest of the population." Involve police, social workers, EMTs, and community services for at-risk populations in your discussions. Hospitals can't do it alone, Baum says, and there isn't really best practice out there for what can work with this patient subset. "Best practice is not a security guard on each person. Putting them in hallways isn't best practice."

For more general throughput issues, Baum recommends taking time to go see what really happens in the ED, versus what your workflow charts say should be happening. "Patients don't come in neat rows. This isn't a linear problem that Lean and Six Sigma can solve. Reality is messier," she says.

One option is to hire experts to do ethnographic studies on what really happens in your ER. It's time-consuming, and it's not cheap, Baum notes, but the results of such current state analyses can be eye-opening and provide ideas for simple fixes that will lead to meaningful improvements. Among the things that an expert can determine, says Baum, are how transitions are made, what happens when you send a nurse with a patient for imaging or other tests, and how moving that nurse with the patient impacts the care other patients or new admits get. "How does having a pharmacist in the ED impact flow? What's the mean bed turnover time? Does admissions staff know how many patients are waiting for beds? Where are the bottlenecks and barriers to flow?"

It's all doable over time, but you have to prioritize, Baum says. "Map your reality with a huge degree of honesty, ideally with an objective person doing the mapping. Put teams together, including people from the community to find the root causes of the issues you face for all kinds of patients that lead to throughput problems. Then figure it out. It's not going to all be about the ED."

Most people who work in the ED know that already. But Baum thinks it's great that others are getting this message from TJC, too.

RESOURCE

For more information on this topic, contact:

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COMING IN FUTURE MONTHS

- All about the focus on wellness
- Why hospice shouldn't be a last resort
- Case management throughout the continuum
- Using technology for efficiency, effectiveness

CNE QUESTIONS

1. According to Tammy Lenski, EdD, chief executive officer of Tammy Lenski, LLC, when you encounter grumpy or combative patients you should:
   A. Leave the room immediately.
   B. Try to convince them that you have their best interests in mind.
   C. Snap back at them and let them know you are annoyed by their behavior.
   D. Take time to understand the person and why they are acting that way.

2. John Banja, PhD, professor of rehabilitation medicine, medical ethicist at Emory University's Center for Ethics, says when case managers document their encounters with difficult or combative patients, they should include subjective details such as "The client is unreasonable."
   A. True
   B. False

3. According to Robert Flores, MD, medical director, population health for Cigna Medical Group, what is the most crucial time for patients after discharge?
   A. 24 to 72 hours.
   B. 5 to 7 days.
   C. Two weeks.
   D. 30 days.

4. What is the average caseload for nurses in the Hospital Sisters Health Systems Medical Group's nurse navigator program?
   A. 15 to 20.
   B. 50 to 75.
   C. 120 or less.
   D. About 100.

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. ■