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Covering Case Management Across The Entire Care Continuum

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Technology can bring case management into the 21st century

New tools can increase efficiency, effectiveness

If you're not using technology in your case management practice, you're doing yourself, your organization, and your patients a disservice, experts say.

"There's no question about it. Case managers are behind their peers and are not performing at an optimal level if they don't use technology," says **Marcia Diane Ward**, RN, CCM, PMP, a case management consultant based in Columbus, OH. It's time to put down the pen and paper and start using laptop computers, tablets, and even smartphones as you assess patients, develop care plans, and create reports to show your progress, she adds.

"No matter what kind of case management someone does, technology can make their job easier. As healthcare continues to evolve, technology is going to be essential for case managers to do their jobs," she says.

Technology in healthcare has taken a giant leap forward in recent years and now it is mandated for accountable care initiatives, Medicare demonstration projects, and reimbursement, points out **Teri Treiger**, RN-BC, MA, CHCQM-CM/TOC, CCM, a case management consultant

EXECUTIVE SUMMARY
It's time for case managers to join the 21st century and start using technology to input assessments, create care plans, track progress, and write reports.
• As case managers are recognized for the value they add, they need to have access to real-time data in order to meet the demands of today's healthcare environment.
• When your organization purchases new technology, make sure the designers understand the case management process and what you need the technology to do.
• Remember that technology is a tool, and it doesn't replace critical thinking or human relationships.
• Leverage the technology your patients are already using to help them stay healthy and follow their care plans.

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based in Holbrook, MA.

"Technology is no longer a choice for organizations. How they proceed to purchase and implement it is definitely a choice, but healthcare organizations still have to go down that path to survive," she says.

Using technology in healthcare, particularly in case management practice, is important because it improves quality of care and outcomes, helps case managers better engage patients and provide patient-centered care, and helps prove the value of case management, says **Mary Beth Newman**, MSN, RN-BC, CCP, CCM, case management director for CareSource, a Dayton, OH-based insurer.

"It's clear that technology can help case managers in so many ways. It improves communication, leading to better coordination of care. It helps case managers identify and eliminate gaps in care, and helps with patient engagement," she says.

Case managers are becoming major players in the healthcare environment and they need technology to leverage their position, Ward says. "Case management promotes a balance between quality care and cost-effective outcomes. Case managers need access to information in real time in order to do their job successfully," she says.

In the past, the technology focus in many organizations was getting the physician orders written and transmitted to the laboratory, pharmacy, and other areas. "Historically, technology has not been specific to case management, but now there are several systems out there that have tools designed specifically for case management and disease management," Treiger says.

Case management software helps case managers in every setting capture all their interventions, document care processes, promote comprehensive assessments, and produce reports that track everything from at-risk patients to outcomes for specific interventions, whether they work with clients face-to-face, by telephone, or a combination of both, Ward says.

Good case management software helps case managers provide greater continuity of care, saves money, and provides a repository of data that can be used for research and analysis, Ward adds. "With just a few keystrokes, case managers can use software to aggregate patient data and write reports that show the results of interventions. With paper records, it could take days," Ward says.

One of the big advances in case management software is assessment in an electronic form, Treiger says. "Case managers still need to do the face-to-face interview and may still use paper if they don't feel comfortable typing the patient's responses into the computer," she says.

But when they complete the interview and use the case management software, they will capture all the information they collected from the patient and family members in a uniform way, she says. "Now, instead of having to sort through thousands of pages of documents, case managers can easily access the information and find out what they need to develop a plan," she says.

Most case management software produces a guide to a case management plan based on the information the case manager inputs, she says. For instance, if a

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patient is worried about losing his utilities and is on home dialysis, an associated problem is on the top of a to-do list while education about a diabetic diet would be lower on the list.

If transportation to physician visits is an issue, the software may suggest that the case manager check to see if the patient has transportation benefits, or make phone calls to the family, or check to see if the patient has a supportive social group.

The data also can be used to measure the intensity of the intervention needed and identify which patients are taking the most time and which case managers are coordinating care for those patients. "You can track not only the depth of patient complexity but the intensity of the interventions. Capturing the intensity of the case management effort is a major step forward," Treiger says.

For instance, if the patient has transportation benefits and the case manager can line up rides easily, it might be an intensity of 1, but if a case manager has to call numerous people to arrange transportation, it might be an intensity of 3.

"This is just the tip of the iceberg," Treiger adds. Case management software can be used to record and report case management interventions and outcomes, identify at-risk patients, develop short-term and long-term goals and track patients' progress. "Case management software has the ability to aggregate data and put it into usable information. It's a powerful tool, but it is up to the director of case management and the case managers to harness that power," she says.

Case management directors will find software invaluable when it comes to showing the value of case management and making the case for more staff, Treiger points out.

"It's easy for management to wave off a case management director who requests hiring more staff. Now, instead of just saying 'the case managers are working 10 or 12 hours a day,' and giving anecdotal examples, they can use data to show that the staff is working beyond regular hours and demonstrate the value in what they are doing," Treiger says.

When your organization is purchasing technology, insist that case management has a seat at the table to make sure the software is going to work for them, Ward says.

A lot of times in the past, it's been the organization's management that chose technology without a lot of input from the frontline case managers who had to use it, she adds. "Companies are starting to wise up and involving end users in the decisions about medical management technology," says Ward, who worked as project manager with two large healthcare organizations to help them implement an electronic medical record.

Case managers need to meet with the software designers and educate them on how case management will use the software, she adds. "Often they don't have a realistic idea of what case management entails and what the case managers need the software to do," she says.

No matter how good the software is, it still has to be easy to use and work with the other technology you are using, she adds. "As the clinical informatics people design the way the medical record will look, they need to keep in mind that they are asking people who already have huge workloads to enter information, so it has to be concise and intuitive. If case managers have to go through 10 or 12 layers that connect one system to the next, it can be extremely time-consuming," she says.

Make sure any kind of case management software you consider is compatible with and can be connected to the other technology in your organization. Talk to your technical people to make sure it will work. Develop a good long-term relationship with vendors. You'll be working with them on training, upgrades, and more training, Ward says.

"One of the biggest challenges in implementing new technology is getting the staff trained," she says.

Some case managers are reluctant to try technology, mostly because they have never been trained to use it, Treiger says.

"There are a lot of case managers over the age of 45 who have not worked in an environment that incorporates information technology into their job. When faced with learning technology, their stress level is very high. It's like trying to learn a new language and you know you are intelligent but you have a tool that you don't know how to use and it makes you feel inadequate," she says.

Clinicians may feel overwhelmed by the new hardware and software products on the market, but today's healthcare environment makes it imperative for them to keep up with cutting-edge technology, Ward adds.

Newman suggests working closely with case managers who don't want to use technology and explaining the benefits.

"When people resist technology, we have to help them understand and appreciate how beneficial it is. This means mentoring people and teaching them to use all the technology that can help them become better case managers," she says. ■

Technology can't replace a CM

Use it carefully and keep personal connections

Using technology increases efficiency and effectiveness and helps case managers do their jobs, but it also can be a double-edged sword if case managers are so concerned with the electronic side of care coordination that they forget about the personal side, warns **Mary Beth Newman**, MSN, RN-BC, CCP, CCM, case management director for CareSource, a Dayton, OH-based insurer.

"I've seen case managers write on blogs that their organization is so focused on getting information into the electronic health record that they can't be attentive to their patients. There has to be a balance," she says.

Case managers shouldn't get so carried away with technology that they forget about communicating with the patient, Newman says. "Despite the benefits of technology, case managers still have to make that human connection if they are going to be effective," she says.

Case managers at CareSource use mobile telephone applications to document their visits with Medicaid beneficiaries in the health insurer's community-based model of care coordination. "All of our case managers have smartphones with a case management application that helps remind them of the purpose of the visit, has a place for notes, and a place for the member to sign. It's all downloaded into our medical management system, including an image of the member's signature," she says.

The application has check boxes that the case managers use as they assess the member and work on the treatment plan. After the visit, they can go back and fill in more information on the client, using what they entered into the mobile application as a guide.

"It helps the case manager doing the home visit focus on the person, rather than focusing on the laptop. Then they can fully document after the visit is over," she says.

Technology is just a tool, and every organization should have guidelines in place for using technology. "It's a disservice all around if technology is used irresponsibly," says **Teri Treiger**, RN-BC, MA, CHCQM-CM/TOC, CCM, a case management consultant based in Holbrook, MA.

Case management software will never replace the critical thinking and knowledge needed to synthesize an achievable plan of care that helps move a patient from a high level of complexity to someone better able to manage him- or herself, she adds.

A guide, not a substitute

"Software will not do the work or write the report. Case managers need to understand technology and use it appropriately. If you put a hammer in someone's hand and they try to saw wood with it, that's not an effective use of a tool. It's the same with case management software. Someone can't just check off boxes in a software program and come up with a workable plan. It takes analysis of the individual situation and critical thinking to do that," she says.

Case management software is a guide, not a substitute, and should never be considered a replacement for a highly trained, professional case manager, Treiger says. She expresses concern that with the current emphasis on care coordination, organizations are creating numerous new positions across the continuum that purport to be case management but are not. "In some settings, unlicensed and uncertified people with no clinical background are calling themselves case managers and assuming pseudo-case management roles with the aid of software. It's fine to use non-clinical staff to support professional case managers, but they can never truly replace case management because they don't have the requisite education and knowledge, the critical skills to take the information from the software and develop a case management plan," she says.

"If it's so easy to replace the clinical piece of case management, it probably wasn't authentic case management in the first place," Treiger says.

Technology can make life easier and make people more efficient case managers if they use the technology appropriately, she adds. "If someone is not already a good case manager, technology isn't going to make them better," she says. ■

Use technology to connect with patients

New applications help communication

When you have patients who are joined at the hip with their smartphones or electronic tablets, it doesn't make any sense to use any other technology to engage them and communicate with them, says **Teri Treiger**, RN-C, MA, CCM, CCP, a case management consultant based in Holbrook, MA.

"There are new health-related applications coming on the market for mobile devices all the time. Case managers need to be mindful of the new applications and the technology their patients use, whether it's a smartphone, a tablet, or a computer," she says.

Text messages (appropriately protecting confidentiality) are a good way to send reminders to patients about appointments or to remind them of tests and procedures they need, she says. Many consumers of all ages routinely send and receive text messages on their mobile phones. Even older patients are familiar with text messages, in part because it's the best way to communicate with their children and grandchildren, Treiger points out.

Leverage the technology people are already using to help them improve their health, suggests **Mary Beth Newman**, MSN, RN-BC, CCP, CCM, case management director for CareSource, a Dayton, OH-based insurer.

As patient advocates, case managers should familiarize themselves with mobile applications that can help patients do everything from keeping track of their exercise and diet, to reviewing their personal health records, to monitoring their diabetes or asthma, Newman says.

"There also are a lot of sophisticated applications available such as one that includes a device geared to children that fits on an asthma inhaler. When a child uses the inhaler, the device wirelessly sends the time and day to the application. It helps with monitoring and encourages self care," she says.

Several technology firms have developed medication boxes and bottles embedded with Bluetooth technology that can remind patients to take their medication and generate an automated phone call to a case manager or physician office if the patient doesn't open the box or bottle, Treiger says.

"Patients, caregivers or their case managers can load the boxes for a week or a shorter period of time and set the reminder alarm. The box will beep or flash when it's time to take the medication. At this point, the technology can't track whether the patient actually put the pill in his mouth and swallowed it, but it can be a big help in supporting adherence," she says. The technology cost is minimal compared to the cost of a hospitalization, she points out.

Web-based services that offer audio and video are an effective way to communicate with patients, particularly those who live in a remote area, Treiger says. "Case managers can learn a lot by seeing a video feed as they talk to their clients. They can see if they are disoriented or are having labored breathing. It helps create rapport and makes people feel less isolated," she says.

These services create the best of both worlds from the perspective of the patient and the organization, she points out. Contacting patients by video can create the same kind of rapport as face-to-face meetings, while allowing case managers to work more efficiently by eliminating driving time. "It opens up a whole new world of possibilities for personalized contact. For elderly or shut-in patients, a video visit may be the highlight of their week," she says.

When patients with heart failure are released from the hospital, it's very common for them to take remote monitoring tools with them that transmit information such as daily weight to the physician office, or an online portal that may be accessed by the case managers, Newman points out. "This promotes communication between the patient, the case manager, and physician. It's an exciting way that technology can be used to promote good health," she says. ■

Care coordination helps seniors stay independent

Team develops a person-centered plan

Since Medica care coordinators began working with dual eligible seniors to help them live safely at home, the proportion of Medica members in the program who live on their own in the community has increased from 39.4% to 71%.

The program, offered through the Minnesota Senior Health Options program, combines health

programs and social support systems into one program.

Members who enroll in Minnesota Senior Health Options are assigned a care coordinator who is either an RN or licensed social worker. The care coordinator contacts the member and sets up a time to go to the member's home and completes a 25-page comprehensive health risk assessment. The assessment looks at the person's living situation and activities of daily living, and includes a complete healthcare screening.

"We develop a person-centered plan of care and take into consideration what the member wants to do, what they no longer can do because of changes in their health, and what services we need to put in place to help the person live in their home environment as long as possible," says **Julie Faulhaber**, MBA, vice president and general manager of state public programs for the Minnetonka, MN-based health insurer.

The program serves a wide range of members, says **Kristy Wilfahrt**, RN, director of dual eligible and care system products for Medica. "Some are pretty healthy seniors and others need more help. Sometimes the family is able to assist them and sometimes they are not. Some are so frail and have so many needs that they require a nursing home for a permanent residence," she adds.

After the plan of care is developed, the care coordinators follow up with the members' primary care providers and provide a summary of the assessment along with a copy of the plan.

The care coordinator conducts a home visit at least annually or more often if the member has a change in condition.

The care coordinators may go to physician appointments with seniors to assist the senior, explain the care plan and medications, and answer questions. They also help seniors access services to help them remain as independent as possible, such as home care, adult day care, transportation assistance, home-delivered meals, and line up people to mow the lawn or shovel snow. They may arrange for a podiatrist or a therapist to visit them in their homes. They work with the Medica customer service team to arrange transportation for activities that are beyond the normal medical benefits, such as rides to church or adult day care services.

"We look at the community for assistance to our members. For instance, there may be a neighbor or a member of the parish who can drive members to church," Wilfahrt says.

The care coordinators live in the communities they serve and are familiar with services in their community that the seniors can access, she says. For instance, the care coordinator may know the pastor of the church the member attends and can find out if there are members who can assist the senior. They connect with local civic organizations, such as the Lions Club and American Legion, which may offer assistance in obtaining equipment for people who need them. The care coordinators follow up regularly by telephone and at least once a quarter in person. Any time the members go to the hospital or emergency department, are discharged from a skilled nursing facility, or have a change in health status, the care coordinators reassess them to determine if the plan of care should be modified. "We are notified about 90% of the time a member in the program accesses the healthcare system," Faulhaber says.

Often, the care coordinators can help members with transitions of care as they move from one facility to another. "Navigating the healthcare system can be difficult, especially when people are stressed. The care coordinator can be a resource for patients and family members whenever they need assistance," Faulhaber says.

Care coordinators are supported by a highly licensed clinical social worker and a registered nurse, called clinical liaisons, who can help identify resources and other solutions if a member has unique needs. "They are another pair of eyes and ears in support of the care coordinators. They not only support our members, they support the care coordinators as well," she says.

The program provides services to seniors in both urban and rural areas throughout Minnesota. The care coordinators may be employed by Medica or community agencies or care systems with which the insurer contracts.

Medica arranges continuing education sessions

EXECUTIVE SUMMARY

Medica's program for dual eligible seniors offered through the Minnesota Senior Health Options programs combines medical care coordination and psycho-social support to help seniors live independently in the community.

- Care coordinators visit seniors at home and complete a comprehensive health risk assessment.
- They help seniors access services ranging from snow shoveling to home-delivered meals to adult day care.
- Care coordinators assess seniors in person at least once a year or whenever there is a change in health status.

twice a year which care coordinators may attend in person or by conference call. In addition, the clinical liaisons and operations manager visit each care coordinator entity at least twice a year and provide updates to the program in person.

"There is a huge value in having face-to-face conversations with the care coordinator. We can answer questions and find out what is working and what is not," she says. The care coordinators have access to a website that includes policies and procedures, forms and other tools, helpful hints for working with the elderly, and a database of resources. ■

What does the 2014 IPPS have in store for you?

Two-midnight rule stirs controversy

Have you read the final rule for the Centers for Medicare & Medicaid Services (CMS) 2014 Inpatient Prospective Payment System (IPPS) yet? Even if the thought of plowing through 2,200 pages of *Federal Register* documents makes you queasy, it's something quality managers must do, according to **Deborah K. Hale**, CCS, CCDS, president and CEO of Shawnee, OK-based healthcare consulting firm Administrative Consultant Services.

Within the pages is what Hale calls "a paradigm shift" in rules related to admission that will require providers to think very differently from how they have in the past. "CMS talks about how the decision to admit is a very complex medical judgment that only a doctor can make, but in the next breath, they talk about the need for a case manager to be available for consultation at all times," she says.

The first thing is for you to read and understand the rule, says Hale, and then to open up a line of communication with physicians to help them understand it. "If you are not clear on this stuff, it's like playing a game of telephone when you are a kid: You might think you're giving them the right information, but if you haven't thoroughly understood it, then you can't be sure that what you tell them is correct."

The biggest change relates to the new "two midnight" rule, which requires that a patient stay 24 hours that encompass two midnights to be considered for inpatient care. Hale explains the genesis of the rule. "Medicare has always defined an inpatient as someone who has a severity of illness and plan of care that warrant inpatient status. They took into account not just the existing illness, but also comorbidities." The benchmark for inpatient status versus observation or outpatient care was, up until now, 24 hours. If the care required more than 24 hours, then the patient was an inpatient. If less, then the patient was classified as outpatient, and some of that outpatient group was classified as observation patients.

When the Recovery Audit Contractors (RAC) looked at cases, they denied many where the patient stayed only one day because he or she was not expected to need 24 hours of care and the physician should have known that. Hospitals have appealed many of those decisions and have won some 70% of them, Hale says. Hospitals also got very conservative as a result, putting a lot of patients they would in the past have admitted into observation status.

The rule was designed to help decrease the number of long observation stays, as well as very short inpatient stays, according to Hale.

When the two-midnight rule was unveiled in the proposed IPPS, comments quickly accumulated that it's hard for even a very good physician to estimate a patient's length of stay. But CMS held its ground and stated that doctors have been required to do this for Medicare patients for some time. The back and forth of comment and response is readily evident in the *Federal Register*. If a physician can't estimate the length of stay, then CMS says he or she should continue to treat the patient as an outpatient until there is enough information to determine whether the patient should be admitted. That means that while a patient has to stay two midnights to qualify for inpatient status, a patient could — conceivably — stay longer than two midnights and still be considered an observation or outpatient. However, CMS says the goal is to reduce very long observation stays to near zero.

Hale says many have expressed worries that the change in rules will lead RAC auditors to disallow inpatient payments in an inconsistent way. Some commenters noted that there are other guidelines available for inpatient care from medical societies, healthcare

organizations, and commercial entities like Milliman and McKesson. Can providers use those non-CMS manuals to aid their decision making? The final rule notes that they can be used, but not instead of the CMS manual, rather in conjunction with it. In the end, the auditors will come down on the side of that, not InterQual or Milliman Care Guidelines.

While the tenor of information coming from CMS supports the theory that hospitals and providers will gain financially from this — there won't be any more of the lesser-paying long observation stays; those patients will move to inpatient status, which has higher reimbursement — Hale says it's hard to believe that will pan out. "Observation status has been overused, and CMS rightly wants to reduce it. But I think they have been too conservative. They say the decision to admit will be easier as the second midnight approaches. And it sounds simple. But knowing how they interpret guidelines, and based on what's being said in the forums they have held, they are saying that if you admit before that second midnight, you have to meet medical necessity only. You can't do this because you are waiting for a discharge plan or you have to wait for Monday for a stress test. That's for the convenience of the patient or hospitals, not medical necessity."

The big problem with that is that it leaves some patients in observation for potentially longer times. "I can't help but think this will explode," says Hale. "I have taught seminars with a variety of hospitals, and I always poll the audience and ask if this is better or worse or unchanged. So far, they seem evenly split between good and bad. But it will be months before we know how bad."

Hale notes that CMS says that these cases will, in the beginning, be exempt from RAC and MAC audits. Instead, 10 to 25 records from each hospital will be audited between now and the end of this year. That and the fact that there is litigation pending against these changes make her think there will, inevitably, be changes to the two-midnight rule. "To me, this seems like a showdown," she says. "Everyone expected CMS to back down because their own forums showed they didn't have a lot of answers and said they'd be providing guidance after the rule was put into effect. Everyone is frustrated, and CMS, even though they are unprepared, appears to have dug their heels in."

Your to-do list

As the issue winds through courts and bureaucracy, Hale says there are things to know and do. First, be prepared that the shift in inpatient admissions may affect data. Coders may see that while before, admission indicators kick off with the admission order, now the time and date of admission orders may differ by two days from the time the patient entered the hospital.

Imagine a patient who comes to the ED with dizziness. In observation, that patient falls and breaks a hip. But the patient isn't admitted yet, so that second condition is present on admission. "You might need a mechanism to better find hospital-acquired conditions."

Hale figures that if a physician could have admitted before the second midnight in the past, he would have, so she is unsure how much will change. That said, hospitals often overuse observation status and something had to give. "The battles between RACs and hospitals can drag on for two to three years. The hope is that this will reduce the number of denials and appeals."

IPPS is just one of a number of huge changes in healthcare — ICD-10 coding comes in next year, there are changes in VBP, and huge efforts to reduce mortality and readmission rates. Hale says hospitals are stretched very thin already. Your best bet to say on top of everything is to be as informed as you can. "Read the rule," Hale says. "Really. Read it all. If you don't understand something you have read, ask questions at seminars or of peers or experts," she says. "Then talk to the docs where you are and make sure they understand it."

For the full IPPS rule, complete with comments and responses, see the *Federal Register* at https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-18956.pdf. The explanation of and comments on the two-midnight rule, and responses to those comments begin on page 1,807. The CMS page related to the final rule can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html.

For more information on this topic, contact Deborah K. Hale, CCS, CCDS, President and CEO, Administrative Consultant Service, Shawnee, OK. Telephone: (405) 878-0118. ■

New care model targets high-utilizing patients

Center aims to better match resources, needs

While EDs are designed to respond to acute care needs, they are often inundated by patients with complex medical, social, and behavioral health problems that require comprehensive solutions. Not surprisingly, the results of this mismatch can involve long wait times, inefficient care, and less than satisfactory outcomes. Further, lacking good alternatives, many of these patients return to the ED time and time again, taking up expensive resources that are often not a good fit for their needs.

However, with new payment reforms on the horizon, some health care systems have taken steps to short-circuit such patterns of utilization and redirect these complex patients into care pathways that will better meet their needs. For example, Hennepin County Medical Center (HCMC) in Minneapolis is winning kudos for its Coordinated Care Center, a clinic located on the hospital campus that is rolling out the welcome mat for those very same high-utilizing patients who are well known to emergency providers and hospital staff.

Administrators say that while the infrastructure is not yet in place to make the model a financial winner, the approach is credited with slashing ED visits by 37% and inpatient care stays by 25% after one year of operation, according to the National Association of Public Hospitals (NAPH), which recently honored HCMC and its Coordinated Care Center (CCC) with the 2013 Gage Award for Improving Public Health. What's more, the model offers a glimpse of what can be accomplished when hospitals and EDs are tightly integrated with the kind of outpatient and community resources that complex patients need to stabilize and make progress.

Troubling utilization patterns are what initially prompted administrators at HCMC to develop the CCC. They found that roughly 7% of the hospital's patients were responsible for 30% of the cost of care, and much of this expense was due to preventable hospital admissions and frequent ED visits. Administrators found that these high-utilizing patients were typically low-income adults with complex medical, social, or behavioral health problems.

Informed by these demographics, the CCC was set up to deliver the kind of comprehensive services that these patients need, explains **Lisa Fink**, RN, CNM, JD, the program practice manager for the CCC. "Our focus is on people who have a diagnosis that is primarily medical, such as CHF [congestive heart failure], COPD [chronic obstructive pulmonary disease], or diabetes," she says. "The way someone is eligible for care here is they have had three hospital admissions, and they are usually associated with lots of ED visits and very few visits to a primary care provider [PCP]. They usually aren't hooked up with a PCP at all."

Such patients are typically flagged by the health system's electronic health record at the point of admission. An RN clinical coordinator from the CCC will visit with a patient while he or she is still in the hospital, review the chart to make sure that the patient is a good candidate, and then invite the patient into the clinic; the patient will then come to the clinic for a discharge visit after he or she leaves the hospital, explains Fink.

Two RN clinical coordinators also keep an eye out for these high-utilizing patients at the point of triage in the ED at HCMC, a level 1 trauma facility that sees about 100,000 patients every year. "They are looking constantly for [new] patients, as well as identifying patients who are well-known to them," says **Kathleen Moore**, RN, MSN, the nurse manager in the ED/urgent care center at HCMC. An emergency physician can also bring an ED-based clinical coordinator in on a case at the back end. Moore adds that the ED-based clinical coordinators are accessible in the hospital until 11 p.m., seven days a week, and they are on call 24/7.

When a patient is a good candidate for the CCC, the ED clinical coordinator will facilitate the transition right away if the patient's primary complaint can be better handled in that setting. "I really feel like we are getting the patients to where they need to be, and that they are also getting additional services that the ED wouldn't necessarily be able to provide," says Moore. "Even if the patients are seen in the ED, the clinical coordinators are able to arrange all the things they will need as far as follow-up, which definitely better serves the patients."

Moore stresses that the ED-based clinical coordinators have made a huge impact in terms

of freeing up emergency providers to take care of patients with acute care needs while also connecting patients with more appropriate sources for the care they will need following the ED visit. "In the past, I don't know that we did the best job we could do as far as [arranging] follow-up," says Moore. "We really were leaving patients with no other alternative than to be utilizing the ED."

Facilitate access, relationship-building

Those patients who meet the criteria to be seen by the CCC get plugged into the kind of multidisciplinary care that they have been lacking, even while heavily consuming inpatient and ED resources. Fink describes the CCC as an ambulatory intensive care unit, with an on-site pharmacist, social worker, psychologist, and chemical health counselor, as well as physicians, nurse practitioners, LPNs and patient navigators — enough personnel to comprise two full care teams.

"When patients come in they are usually here for 90 minutes or so. They will see either a physician or a nurse practitioner, and they also might see the psychologist. Then [the psychologist] might suggest that they also stop in and see the chemical health counselor because he might have some good resources for the patient," says Fink. "It is like a one-stop shop. We even have a dental clinic one morning a week."

The social workers spend a lot of time connecting patients with housing because many of them are either homeless or living on someone's couch when they first come in, notes Fink. "It is such a critical piece to being able to stay healthy," she says.

"The individuals who come to our clinic have been frequent utilizers of the ED, and they certainly continue to use it some, so we have a relationship with the clinical coordinators there," says Fink, noting that if a CCC patient presents to the ED for care, the ED clinical coordinators will be in touch. "One of us will walk over to the ED, and if the patient is stable enough to be seen in the CCC instead of the ED, then we will walk him back over to our clinic and see him here. There is a lot of back and forth communication."

Patients who agree to be seen in the CCC will receive guidance about when to use the CCC for care versus the ED, and they are given broad access. The CCC is open from 8 to 5 during weekdays, and patients can either make appointments or walk right in, says Fink. Further, when patients need to contact the CCC, they are not funneled through the health system's general contact line; they call the CCC directly. "The person who picks up the phone, they probably know," says Fink. "For patients who have historically not trusted the health care system, and have not used it in a way that was most effective, we want to maximize the relationship-building, so we answer our own phones." In some instances, the CCC will also equip patients with phones, adds Fink.

While the CCC is currently not open in the evenings or on weekends, Fink says there will soon be a call system in place so that patients can reach a CCC provider during off hours. Even without the call system, though, Fink stresses that running the CCC requires tremendous flexibility on the part of staff. "It really is an ambulatory ICU. That's what a lot of people refer to it as," she says. "It is pretty intense with all of the comorbidities going on."

Take a broader view of health

The contributions of the two ED-based clinical coordinators have made a significant impact on the ED, says Moore. While not all of the patients they intervene with require or qualify for care in the CCC, the clinical coordinators have been instrumental in matching patients with the specific resources they need. For example, Moore notes that in the past, a patient who was seen and treated for a wound in the ED would have had few options for follow-up other than to return to the ED for needed dressing changes. However, now the ED clinical coordinator steps in to arrange for this type of follow-up in an urgent care setting or another clinic that is accessible to the patient.

"They have been very instrumental [in eliminating] those repeat visits for things that clearly don't have to be looked at again by the ED staff, but definitely need to be done to obtain better patient outcomes," says Moore. "We want to grow our volume, but we want people to be in the right places. We want the people who are acutely ill and definitely in need of emergency services to have that fast response through our front door, so decreasing utilization for non-urgent visits is huge. It helps deliver better outcomes for the acutely ill."

Currently, the CCC cares for about 240 patients, although Fink anticipates that the number will grow significantly. "We know there are a lot more people out there who meet the criteria — heavy utilizers of the ED and inpatient use, and people we feel we could help," she says.

To accommodate growth, Fink acknowledges that the CCC needs more mental health practitioners and access to more community resources such as sober housing and respite care. "A lot of this is really a broader sense of what makes health," she says. "What we mostly need is a new payment model because we don't get paid for what we think makes the most difference, and that is real, on the ground, consuming care coordination. It takes a huge amount of time; it is not just a phone call once a month, but we can't bill for that."

However, Fink notes that HCMC is continuing to support the model with resources. And administrators believe the approach will pay off as payment reforms focus more on the total cost of care. "This is absolutely in line with where we are heading, but we are not there yet," she says. "This is quite a leap of faith. It is really about saying that this is the right thing to do."

SOURCES

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CMS hints at more telemed payment

The Centers for Medicare & Medicaid Services (CMS) is considering paying primary care physicians for chronic care management services without an in-person visit, and also for telehealth services. Keep a close tab on how this proposal fares as you work to avoid fraud and abuse issues with telemedicine.

CMS proposed the improved payment in the Medicare Physician Fee Schedule for 2014 and suggested a change that would start in 2015. Under the CMS proposal, patients would need to have an annual, in-person wellness visit and consent to a doctor's management plan for a year.

To make telehealth reimbursement possible, the proposal redefines the definition of "rural" to avoid disruption of services if an area's geographic designation is changed. CMS said in the proposal that it is looking for evidence that "the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury" or that it improves patient functioning.

CMS would reimburse for telehealth only if it is provided by one of eight kinds of healthcare professionals. Additionally, only certain kinds of codes are eligible, mostly involving screening and mental healthcare. ■

COMING IN FUTURE MONTHS

- What should case managers really be doing?
- How your peers prevent readmissions
- What accountable care organizations could mean to you
- Career opportunities in primary care

CNE QUESTIONS

1. According to Marcia Diane Ward, RN, CCM, PMP, a case management consultant, what is one of the biggest challenges in implementing new technology?
A. Getting the staff trained
B. Making sure it is compatible with other software
C. Ensuring that it will do what you need it to do
D. Having a good relationship with the vendor

2. Teri Treiger, RN-C, MA, CCM, CCP, a case management consultant, cautions that case management software is a guide, not a substitute and should never be considered a replacement for a highly trained, professional case manager.
A. True
B. False

3. According to Mary Beth Newman, MSN, RN-BC, CCP, CCM, case management director for CareSource, what health-related things are patients doing with their smartphones?
A. Keeping track of their exercise and diet
B. Reviewing their personal health records
C. Monitoring their diabetes or asthma
D. All of the above

4. How often do Medica's care coordinators visit seniors in their homes?
A. At least once a month
B. At least once every six months
C. At least once a year
D. Weekly

CNE OBJECTIVES

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

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

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