HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

January 2014: Vol. 22, No. 1
Pages 1-12

IN THIS ISSUE

Financial Disclosure:
Executive Editor **Russ Underwood**, Associate Managing Editor **Jill Drachenberg**, and Editor **Mary Booth Thomas**, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Nurse Planner **Toni Cesta**, PhD, RN, FAAN, Consulting Editor of *Hospital Case Management*, is a consultant with Case Management Concepts LLC.

AHC Media

If the face is familiar, the patient may be overusing healthcare

Develop strategies to help patients avoid unnecessary visits

You may refer to them as "frequent flyers," "familiar faces," or "super utilizers," but whatever term you use, when members of this group of patients show up in the emergency department, you may think,"Oh, no. Here we go again."

Hospitals are inundated by patients who frequent the emergency department when they have a sore throat, a fever, or another minor complaint; those who come to the emergency department looking for a prescription for narcotics; and those who have complex or chronic conditions, don't follow their treatment plan, and end up back in the hospital.

A report by the Agency for Healthcare Research and Quality concluded that the cost of care for the top 1% of healthcare users accounted for 21.4% of the total spent on healthcare in the U.S. in 2010. The tab for these super utilizers, on average, was $87,570, according to the report. *(The report is online at http://meps.ahrq.gov/mepsweb/data_files/publications/st421/stat421.shtml.)*

Every hospital has patients it sees over and over, often for preventable conditions or problems that could be treated in a lower level of care. According to the Agency for Healthcare Research and Quality, the top 1% of healthcare users account for 21.4% of healthcare expenditures. In this issue of *Hospital Case Management*, we'll show you what case managers are doing to help patients avoid unnecessary hospital visits and to seek treatment in an appropriate level of care. You'll learn how one hospital's "red carpet treatment" has cut hospital visits among super utilizers, how embedded case managers target high utilizers, and how dealing with social issues helps keep patients out of the hospital. We'll describe a communitywide approach to mental health transitions and a program to help emergency department patients navigate the health system. It's all in this issue of *Hospital Case Management.*

"As we experience changes in the payment structure, all health systems are looking at who their frequent utilizers are, why they are coming to the hospital, and what we can do to get these patients connected to routine medical care so they will stay out of the emergency department and avoid readmissions," says **Jason Hyde**, LMSW, M.Ed, assistant vice president for community case management at Lutheran HealthCare in Brooklyn, NY.

Much of the care that frequent utilizers receive appears to be avoidable, says **Brent Williams**, MD, MPH, associate professor of internal medicine and medical director for the University of Michigan Complex Care Management program.

"These patients are in the emergency department and hospital because of a complex set of social, medical, and sometimes psychiatric needs, as well as lack of insurance. These patients are using a lot of resources, but with the right support and care coordination, they could use less," he says.

Not all patients who consume a lot of resources fall into the super-utilizer category, Williams points out.

"When we looked at our own high utilizers and the reasons they were readmitted, we found that about a third were readmitted for unavoidable medical issues, such as catastrophic illnesses, organ transplants, or chemotherapy," Williams says.

Many super utilizers don't have their own physician or don't have the resources to pay for a primary care provider or their medication, so they end up going to the emergency department and often being readmitted, says **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago.

Other frequent users are non-adherent because they don't understand their treatment plan or don't want to follow it and end up in the emergency department again and again when their chronic conditions get out of control, she says. Some frequent utilizers have psychiatric issues that

EXECUTIVE SUMMARY

Patients who use the healthcare system excessively, and often for avoidable issues, create a burden for hospitals and consume a significant portion of healthcare expenditures.

- Many frequent users have complex medical and psychosocial needs, are uninsured, or have behavioral health issues.
- Case managers should identify patients who are potential frequent utilizers and make sure they are connected with a primary care provider.
- Take the time to find out barriers to care and call in a social worker to help line up community resources.

Hospital Case Management™ (ISSN# 1087-0652) is published monthly by AHC Media LLC, One Atlanta Plaza, 950 East Paces Ferry Road NE, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Website: www.ahcmedia.com. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Case Management™, P.O. Box 550669, Atlanta, GA 30355.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: customerservice@ahcmedia.com. Web site: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

The target audience for Hospital Case Management™ is hospital-based case managers. This activity is valid 24 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Mary Booth Thomas**, (marybootht@aol.com).
Associate Managing Editor: **Jill Drachenberg**
Executive Editor: **Russ Underwood** (404) 262-5521 (russ.underwood@ahcmedia.com).
Production Editor: **Kristen Ramsey**
Editorial Director: **Lee Landenberger**

AHC Media

Editorial Questions
For questions or comments, call Russ Underwood at (404) 262-5521.

make them difficult to deal with, or they come to the emergency department over and over seeking pain medication, Sallee says.

"Whatever the reason, when patients frequently visit the emergency department and/or are hospitalized when another setting would meet their needs, it creates a burden for hospitals, especially since insurers began penalizing hospitals financially for readmission. But we also know that receiving primary care in the emergency department and being readmitted to the hospital is not the right thing for patients," she says.

Often, overuse of the emergency department is a system problem as well as a patient issue, says **Donna Zazworsky**, RN, MS, CCM, FAAN, vice president, Community Health and Continuum Care for Carondelet Health Network in Tucson, AZ.

"If a patient lives on one side of town and the only place he can get care is across town, it's unlikely that the patient will see a primary care provider even if someone coordinates transportation. If there's not a primary care provider in a convenient location, patients are going to use the emergency department," she says.

A significant portion of super utilizers have mental health issues as well as medical problems, Hyde points out. "There is a huge need to coordinate physical health and mental health services for all patients, but particularly among high utilizers," he says.

If they are depressed or psychotic, they may not get their prescriptions filled or take their medication regularly, Hyde says. "Mental health issues have a huge impact on a patient's ability to access physical health services and to adhere to their treatment plan," he says.

Traditionally, mental health providers and physical health providers have operated in silos because of privacy issues, Williams says. "But we are recognizing that chronic medical conditions affect many people treated by mental health providers. The average person with severe mental illness has a life expectancy 20 years shorter than their counterparts without mental health issues. They are dying from complications of diabetes and coronary artery disease, not mental health conditions," he says.

Helping patients connect with a primary care provider should be a priority for hospital-based case managers whether they are in the emergency department or the acute care unit, Zazworsky says.

Case managers should identify patients who have the potential to be readmitted or return to the emergency department before they become a frequent utilizer and develop a discharge plan that helps them stay out of the hospital, Sallee says.

Hospitals need to have case managers in the emergency department to develop a care plan that may help frequent utilizers seek care in a more appropriate venue, Sallee says. "We don't give people an alternative to thinking of the hospital when it comes to seeking healthcare. For some people, it is simply easier to go to the emergency department. Patients who do not have a payer source may wait to see a provider until their condition is so serious they need to be admitted," Sallee says.

Few hospitals have case managers on duty 24-7, and even if they do, case managers are so busy that they don't take the time to sit down and talk to patients to find out what really is going on with them, says **Peggy Rossi**, BSN, MPA, CCM, a retired hospital case management director who now is a consultant for the Center for Case Management.

When patients are hospitalized or visit the emergency department, case managers should spend time with them and drill down to find out the reasons they are in the hospital. In addition to looking at their healthcare problems, it is important to find out their financial status, support system, and psychosocial needs, Rossi says.

"Case managers usually don't talk to patients about whether they can afford their medication or the cost of a primary care visit. Case managers should determine if patients need to be referred to assistance programs and explore other options to avoid another emergency department visit or hospitalization," she says.

If patients are insured or receiving Medicare or Medicaid benefits, talk to the case managers at their plan to find out what medications they are taking, whether they are seeking care or drugs in other facilities, and collaborate with them on a plan of care, Rossi suggests.

"We've got to communicate across the continuum to ensure that patients get the best possible care at the right time and in the right setting," she says.

Sallee suggests a social work consultation for patients who are frequently readmitted or visit the emergency department with regularity. "There may be a lot of underlying issues, like problems getting medication or behavioral health problems that cause them to come back over and over. It's better to identify their issues and try to fix them rather than treating them every time they come in

and sending them back to the same situation that brought them to the hospital," she says.

Social workers can help patients access community resources and transition patients with behavioral health issues to a provider, she says.

Hospitals have to do whatever it takes to break the cycle of frequent utilizers, Sallee says.

"When people get better healthcare in an appropriate setting, they have a better experience and achieve better outcomes, which in turn reduces unnecessary expenditures," Hyde adds. ■

Super-utilizers get Red Carpet treatment

High-cost patients get support

Through a partnership with two health plans, MetroHealth Medical Center's Red Carpet Care program provides one-on-one support and care coordination for patients whose average healthcare costs have been running $60,000 to $70,000 a year.

"The program rolls out the red carpet for a segment of the population that has been mostly ignored. The people in the program have multiple medical problems, and many have behavioral health issues. Some are narcotic-seeking, but others don't know better than to use the emergency department for primary care or simply do not have the wherewithal to plan ahead when they have health issues," says **Alice Petrulis**, MD, FACP, medical director, care management for MetroHealth Medical Center in Cleveland.

The health system received the grant for the program from the Robert Wood Johnson Foundation through Better Health Cleveland and partnered with a Medicaid managed care plan and a commercial plan to create the Red Carpet Care program. The health plans provided a list of super-utilizers, based on hospital and emergency department costs. Patients with cancer, who were on dialysis, had suffered significant trauma, or were pregnant were eliminated.

The 136 remaining patients were assigned to nurse practitioners, located at two MetroHealth primary care sites for care coordination. The health system chose nurse practitioners to take on the care coordination role because they can write prescriptions and can see patients in the event of an emergency when the physician is not available, Petrulis says. The health plans pay for the nurse practitioners' salaries and share the savings with the health system.

Patients in the program are treated for their medical problems by their primary care provider. The nurse practitioners develop a close relationship with the patients and work to eliminate barriers to care and ensure that the physicians, the health plans, and any other practitioners treating the patients are aware of what their counterparts are doing.

When patients are identified for the program, the nurse practitioners call them, explain the program, and enroll them. They set up an appointment for the patients to come into the office and complete a comprehensive health risk assessment that includes their socioeconomic needs.

"Many of the patients in the program have more socioeconomic needs than medical needs. When patients don't have a place to live or their electricity has been turned off, they aren't concerned with healthy behaviors. Our nurse practitioners get to know the patients and establish trust so they can find out about their needs," Petrulis says.

The nurses create a care plan for each patient and enter it into the medical record with the patient's name in red to alert the emergency department staff that the patient is in the Red Carpet Care program.

"The plan may be as simple as stating that the patient has recurrent abdominal pain and should be referred to the primary care provider or nurse practitioner for treatment," she says.

The nurse practitioners work to overcome barriers to care, such as lack of transportation, inability

EXECUTIVE SUMMARY

MetroHealth Medical Center in Cleveland has partnered with two health plans to provide intensive care coordination for high-cost patients with multiple medical problems and, often, behavioral health issues.

- Nurse practitioners at two primary care sites provide one-on-one care coordination for super-utilizers.
- They assess the patients' needs, help coordinate community resources, and prepare a treatment plan that is flagged when patients visit the emergency department.
- The nurse practitioners meet with health plan representatives monthly and brainstorm on ways to meet patients' needs.

to pay for their medication, or psychosocial issues. The health system has partnered with community agencies that can provide resources such as housing assistance, help with filling out forms for assistance programs such as Social Security and medication assistance, and help with transportation and utilities.

The care coordinators refer many patients to behavioral health management programs at the health plans. When they feel it's needed, the nurse practitioners go to the patients' homes to assess the living situation and review their medication.

"The key to the success of the program is one-on-one interaction between the case managers and the patients," Petrulis says.

The nurse practitioners call the patients at least once a week, and the patients can call the nurse practitioners as often as they want. The nurse practitioners use smartphones with a caller ID patients can recognize. "Many patients don't answer the phone when the caller ID says 'private,' and that is what happens when the call comes from the hospital," Petrulis says.

One health plan donated cellular phones for patients who don't have telephones so the patients could call their case manager whenever they needed help. "The patients did not abuse the privilege. The nurse practitioners receive a few phone calls in the evenings, primarily from patients who work and can't call during the day," she says.

The program hasn't been in effect long enough to have a full year of data, but patients in the program have had fewer emergency department visits and hospitalizations, Petrulis says. There has been only one instance of a patient in the program being readmitted to the hospital within 30 days after discharge.

The nurse practitioners collaborate with the case managers at each health plan to make sure they don't duplicate their efforts. They meet with health plan representatives every week to collaborate on the care plan.

Petrulis, the nurse practitioners, and representatives from both plans meet regularly to talk about problems with patients and brainstorm on solutions. The nurse practitioners and Petrulis choose the cases to review and alert the patients' payers, but when the team meets, the patients are identified only by initials to respect their privacy. In addition to suggesting community resources for the patients, the team members often volunteer to do whatever it takes to make sure the needs of patients are met, she says.

For instance, one patient kept all his possessions in a wheeled cart, which was stolen. A member of the team had an extra one and donated it. When one patient was moving and had no one to help her, the medical director from one of the plans recruited his son and friends to move her.

Before starting the program, the Red Carpet team conducted a focus group with 18 super-utilizers to find out what they wanted from the healthcare system. The patients said they wanted a relationship with a primary care physician who really cares about them and a medical team that listens to their concerns. Some patients said they couldn't find a physician who speaks their language or that they couldn't afford their medication. "They didn't really want to go to the emergency department every time, but the healthcare system wasn't meeting their needs," she says. ■

CMs coordinate care for frequent utilizers

Targeted patients have multiple needs

At the University of Michigan Health System, a team of specialized case managers coordinates services for patients who frequently visit the emergency department or are hospitalized, helping them get the resources they need to stay away from the hospital.

A small internal analysis showed that six months after receiving interventions from the complex care management team, hospitalizations for the 50 patients in the study dropped by 10% and emergency department use decreased by 8%, says **Brent Williams**, MD, MPH, associate professor of internal medicine and medical director for the University of Michigan Complex Care Management program.

The Complex Care team reviews discharge records each month to identify patients who are in the emergency department or hospital whose needs fall into at least three of six domains — complex medical needs, behavioral health issues including problems coping and substance abuse, psychiatric disorders, lack of physical resources such as housing or utilities, inability to afford medication, and lack of social support.

Patients who meet the criteria are assigned to a complex case manager. The program has

seven complex care managers, who are masters-prepared nurses and social workers and are assisted by three patient care associates.

When patients are referred to the program, a complex case manager contacts them, performs a comprehensive assessment of their medical and psychosocial needs, and barriers to care. Based on the findings of the assessment and input from the practitioners who treat the patient, the case manager develops a plan to coordinate inpatient and outpatient treatment and whatever psychosocial services the patient may need.

Working with the emergency department team, primary care providers and specialists develop an individual treatment plan that can be used when each patient comes into the emergency department. "Rather than reacting to what the patient presents with, the emergency department team can mobilize a pre-existing coordinated treatment plan," he says.

For instance, many patients in the complex care program come to the emergency department because of pain. Before the program started, the emergency department physician would give them a prescription for pain medication and the patient would return as soon as the medication ran out. "Now, with complex care management, there is a plan in place and the emergency department staff gives patients the message that they need to go to their primary care physician for pain management," he says.

The complex care management program emphasizes communication across the continuum of care and with community organizations that can provide assistance. For instance, the team meets monthly with the emergency department team and collaborates on mobilizing resources for frequent utilizers. When patients continue to use the emergency department for non-emergent care, the complex case managers work with the patients' primary care physicians and the patients themselves to find a solution.

Coordinating services

The complex case managers follow patients until they are stable and seek care in the appropriate setting, sometimes for a year or more. They accompany patients to their primary care and specialist visits and see them in the hospital, following up by telephone between visits. The case managers recently began visiting patients in their homes. "These patients have a large number of issues that are best understood and addressed when the case managers visit the homes and can see the conditions for themselves," Williams says.

Many patients in the program need mental health care as well as medical care. The complex case managers can coordinate between the two services to make sure that mental health practitioners are aware of the patient's physical issues and that people providing medical care are aware of the patient's mental health problems, he adds.

The key to the program's success is that the case managers are able to coordinate services both inside and outside of the healthcare arena, Williams says. "The complex case managers provide a coordinated connection to social services and medical services. They know how to get an electronic benefits transfer card for people whose income is so low they may have to choose between buying food or medicine. They help patients access Medicaid-funded transportation and provide connections to a supportive housing group," he says.

The health system is still gathering data from the program but has received accolades from patients and their family members.

"We've gotten great reviews from patients who participate in confidential phone surveys. There have been no negative comments, and when we ask what we could do better, they suggest that their complex case manager move in next door or stop taking vacations," he says. ■

EXECUTIVE SUMMARY

At the University of Michigan Health System, complex case managers coordinate inpatient and outpatient treatment and psychosocial services for patients who frequently visit the emergency department or are hospitalized.

- Patients in the program have complex medical needs, behavioral health issues, and/or lack of physical resources or social support.
- Complex case managers complete a comprehensive assessment of patient needs and work with practitioners to develop a treatment plan that the emergency department can use when patients present for treatment.
- Case managers follow the patients until they are stable, sometimes for a year or longer.

Community collaborates on services for mentally ill

Coalition works on smooth transitions

In Raleigh, NC, hospitals, law enforcement, the mental health system, and organizations that serve the mentally ill are collaborating to provide care and smooth transitions between levels of care for people with mental health and substance abuse issues.

North Carolina has a shortage of psychiatric hospital beds and a critical shortage of psychiatrists in many areas of the state, says **Pat Kramer**, Ed.S, CCM, CSW, NCC, director of case management at Duke Raleigh Hospital, a 186-bed community hospital.

"In 2010, there were 60% fewer beds in state psychiatric hospitals than in 2001, when mental health care reform began in North Carolina. This means that there were many patients on the waiting list for a psychiatric hospital bed, and they were waiting in emergency departments like ours," she says.

From January to June 2010, 86% of all patients who were waiting for a bed in a state psychiatric hospital waited in a hospital emergency room or crisis unit for an average of 2.6 days, according to a report by the Wake County chapter of the National Alliance for Mental Illness.

"The lack of psychiatric beds is a problem all over the United States. This means patients with mental health and substance abuse issues are staying in the acute care hospital longer. We're measuring the time patients stay in the emergency department in days, not hours," Kramer says.

Patients with mental health and substance abuse issues are over-consumers of emergency department services, Kramer points out. "A lot of the patients we see in our emergency department over and over have a mental health issue, and many times, they have medical issues as well," she says.

Improving access to care

In 2007, when the state psychiatric hospital in Wake County announced plans to close, three acute care hospitals — none of which has a psychiatric unit — partnered with a local private psychiatric hospital, a mental health center, and Wake County Human Services and formed the Wake County Crisis Cooperative to respond to the crisis in treatment options for the mentally ill.

Since then, the coalition has grown to 16 members, including representatives from the Durham/Wake County Managed Care Organization, which manages Medicaid behavioral health services, the Wake County sheriff's office, the Raleigh police department, Wake County Magistrate's Court, Wake County Emergency Medical Services' Advance Practice Paramedics, the state psychiatric hospital for the region, the Wake County chapter of the National Alliance for Mental Illness, a disability specialist from the SSI/SSDI Outreach, Access and Recovery (SOAR) program, and a large community agency serving the uninsured.

Participants met regularly and brainstormed ways to improve access to care for the mentally ill. For instance, the partnership standardized the mental illness and substance abuse assessment tool so the patient's condition and needs would be clear across all entities.

"Some facilities are still using their own assessment tool, but the tool we developed has raised awareness of what the psychiatric hospitals need to know about the patients. Education about the tool and the criteria has reduced frustration among the case managers, the nursing staff, and the providers," she says.

Another achievement was developing and getting state approval for standardized transfer guidelines for medical clearance for mental health and substance abuse patients being transferred to

EXECUTIVE SUMMARY

Faced with the closing of the state psychiatric hospital in their community, hospitals, law enforcement, mental health providers, and community agencies in Raleigh, NC, began collaborating on improving care and transitions for the mentally ill.

- The coalition created a standardized assessment tool and standardized transfer guidelines for mentally ill patients, along with other process improvements.
- As a result, Duke Raleigh Hospital is transferring more patients to mental health facilities direct from the emergency department rather than keeping them in an inpatient bed waiting for an opening.
- Hospital case managers get behavioral health patients a follow-up appointment with a mental health provider before they leave the hospital.

state-operated mental health facilities. In the past, each facility had its own guidelines, requirements for laboratory values, and definitions of medical stability.

With the standardized transfer guidelines, the case managers aren't being told different things when they call different hospitals trying to place patients. "This was a tremendous achievement because it reduces frustration with facility-specific guidelines and saves time for our case managers because everybody is now on the same page," she says.

Defining high acuity

The group created a definition of a high-acuity patient to assist psychiatric facilities in prioritizing admissions. "Patients who are homicidal or suicidal don't need to be waiting in an emergency department. Now patients who meet the definition of high acuity are moved up on waiting lists, and the hospitals understand that these patients are taking priority over patients they are trying to place," Kramer says.

The organization created a uniform process for involuntary commitment. Wake County Crisis Cooperative partnered with a private entity to provide mobile crisis services in the community. As a result of the meetings, a psychiatric hospital contracted with an acute care hospital for internal medicine consultations so it could take patients with higher medical acuity. The organization developed a rotation schedule for acute care hospitals when the crisis center goes on diversion.

Since the initiative began, Duke Raleigh Hospital has increased its psychiatric coverage in the emergency department. More patients are being transferred straight from the emergency department to an inpatient psychiatric facility, rather than spending time in an inpatient bed, she says. "There are fewer psychiatric beds available, but it's still easier to get patients out because of the standardized transfer guidelines and assessment," Kramer adds. But at the same time, difficult-to-place patients, particularly elderly psychiatric patients, are staying longer in the hospital before they are transferred, she says.

The Wake County Crisis Cooperative continues to meet monthly. "The whole community has joined together to improve treatment and transitions of people with mental illness," Kramer says. ■

Case managers coordinate discharge

Patients leave ED with follow-up appointment

At Duke Raleigh Hospital, case managers in the emergency department lead interdisciplinary behavioral health rounds each day on all patients with psychiatric signs and symptoms.

During the rounds, the emergency department physicians and nurses discuss patients' mental health issues and medical comorbidities. Psychiatrists who cover the emergency department participate whenever possible.

"The behavioral health rounds help the staff as well as the patients. The team can develop treatment plans for the behavioral issues that reduce acting out and help the staff identify triggers that may set the patients off," says **Pat Kramer**, Ed.S, CCM, CSW, NCC, director of case management at the hospital.

Case managers cover the emergency department 12 hours a day, seven days a week. Two are licensed clinical social workers, and one is a registered nurse. They assess all patients in the emergency department and create discharge plans for those who need it.

When patients with acute mental health needs are treated in the emergency department, case managers develop a treatment plan and set up an appointment with a mental health clinic or private psychiatry practice before the patients are discharged. "We don't just refer patients with acute needs to resources in the community that can help them meet their needs; we make sure they have a follow-up provider before they leave," Kramer says. If patients don't have acute needs, the case managers help them identify a provider. They educate patients with insurance on how to access their mental health benefits.

If the case managers think patients are going to need extra support to manage in the community, they set up an appointment with a provider who can see them immediately and call on the area's Mobile Crisis Team or the Durham/Wake County Managed Care Organization, which manages Medicaid Behavioral Health Services, to send trained staff to the emergency department to escort patients to their appointment. The case managers have a close working relationship with the managed care organization for Medicaid mental health services and often collaborate on support for patients.

The case management staff developed a suicidal patient hand-off tool that the nurses use during shift change and when patients are moved from one unit to another, such as going from the emergency department to a unit on the floor or from the ICU to the nursing unit. For instance, the tool reminds the nurse to remove linens and plastic bags from the room.

"The hospital doesn't have any dedicated psychiatric beds, so we are placing patients on a nursing unit. The hand-off tool reminds the nurses of the steps they need to take to secure the room and ensure patient safety," she says. ■

ED navigators help patients find a PCP

Helping patients navigate healthcare system

When patients show up in the emergency department for non-emergent issues, **Renee Perez**, community health outreach coordinator/ emergency department navigator for Carondelet Health Network in Tucson, AZ, coordinates a follow-up appointment with a primary care provider.

Patients who use the emergency department for primary care tend to fall into one of three categories: patients who are uninsured and don't have a primary care provider, those who are insured but don't have a primary care provider, and those who have a primary care provider but can't get in to see him or her, Perez says.

"The patients get the care they need in the emergency department, then I coordinate the follow-up appointment with a primary care provider. Some patients need follow up the next day; others can wait longer. I try to get all the patients who are referred to me set up in a medical home if they don't already have one," Perez says.

If patients have a primary care provider but can't get an appointment, Perez contacts the provider office and asks them to work the patient in. If patients still can't get an appointment, she refers them to walk-in clinics for treatment while they wait for a slot at their regular physician office.

Perez gets between 50 and 100 referrals a month from emergency department physicians and case managers. Whenever possible, she meets with the patients while they are still in the emergency department. Otherwise, she contacts them by telephone and helps them get established with a primary care provider in a convenient location.

After she refers people to a clinic, Perez calls the primary care clinic to find out if the patient went to his or her appointment and documents it in the medical record.

Many people who frequently use the emergency department are uninsured, says **Donna Zazworsky**, RN, MS, CCM, FAAN, vice president, Community Health and Continuum Care for Carondelet Health Network. "The role of our navigators is to help patients learn to navigate the healthcare systems and to identify community resources," Zazworsky says.

The navigators are not clinicians and are from the varying cultures that represent the people they serve, making it easier to establish rapport with the patients. They assess the patients for psychosocial needs and can help them sign up for Medicaid, food stamps, energy assistance programs, Social Security disability, or other assistance programs.

If they are uninsured, Perez helps them find a medical home at a federally qualified health center. "Most of these patients do not realize that there are other resources out there where they can receive care at a reduced rate or for no cost," she says.

Perez educates patients on seeking care in an appropriate setting. "I tell them I can get them set up at a low-cost clinic where the fee depends on the family size and family income. I explain why it's better to have your own primary care doctor than to come to the emergency department when it's not an emergency."

If patients continue to come to the emergency department for primary care, Perez meets with them again and arranges another appointment in a medical home.

"There are people that keep coming back for

EXECUTIVE SUMMARY

Carondelet Health Network in Tucson, AZ, places community health outreach workers in the emergency department to help patients who use the ED for non-emergent conditions find a primary care provider.

- Navigators coordinate primary care appointments and get patients set up in a medical home.
- If patients have a primary care provider but can't get an appointment, the navigators try to get them in or direct them to a walk-in clinic.
- Navigators assess patients for psychosocial needs and can help them access community resources and sign up for benefits.

primary care issues. They tell me they forgot the appointment or they didn't have the money. I keep working with them in hopes that they eventually understand," she says. ■

Embedded CMs work with high-risk patients

Initiative targets diagnoses, utilization

A pilot project at Lutheran HealthCare in Brooklyn, NY, has embedded care managers in six of the health system's family health centers to help patients who are frequent utilizers learn to manage their conditions, adopt healthy behaviors, and stay out of the hospital.

"We started this program using a two-year grant. The idea is to test the model and see the outcomes and to expand support to more patients depending on the kind of impact we have," says **Jason Hyde**, LMSW, M.Ed, assistant vice president for community case management at Lutheran HealthCare.

The initiative targets patients with 11 diagnoses: asthma, chronic obstructive pulmonary disease, diabetes, heart failure, hypertension, obesity, alcohol abuse and dependency, drug abuse and dependency, and mental illness. Eligible patients have at least one of the diagnoses and a combination of two or more visits to the hospital or the emergency department in a six-month period.

The majority of patients who are appropriate for the high-risk interventions are identified through a risk assessment based on information in the health system's electronic health record. In addition, the care managers work closely with the inpatient case managers in the hospital to identify high-risk patients who need follow-up support. Each family health center holds pre-visit planning meetings when the treatment team can alert care managers to patients who don't show up as high-risk but whom their providers believe need extra attention. "Our software is very good, but it's not perfect. The providers know the patients better than anyone and can suggest patients to target," he says.

The 12 care managers, who have bachelor's degrees and have gone through extensive training, call all patients treated by the health center, regardless of risk, within 25 hours of when they are discharged from the hospital. "We know that the period of time right after the discharge is risky for everyone," Hyde says.

The care managers ask how the patients are feeling, if they have questions or concerns, make sure they have their medication and that the patient has a follow-up appointment with the clinic. "Our goal is to make sure these patients are reconnected to primary care during the vulnerable time following discharge. We try to get high-risk patients into the clinic within 48 hours of discharge and make sure all others see the primary care provider within seven days of discharge," he says.

During the post-discharge phone calls, the care managers administer a 15-question care transition survey that asks patients about their experiences in the hospital and assesses their return to the community. Questions include whether patients were involved in their care plan, if they understand their care plan, and if they are following it at home. "We are looking for trends and areas where there are opportunities to improve and provide feedback to the inpatient team," he says.

The care managers receive lists each day of patients who are coming in for an appointment the next day and access the electronic medical record to see what gaps in care or other problems they may be having. For instance, patients with diabetes may have hemoglobin A1c levels that are too high, they may be overdue for an A1c test, or they may not have seen an ophthalmologist or had a diabetic food exam. The case managers contact at-risk patients for pre-visit planning and talk to them about gaps in care and other problems. "If a patient has had an appointment scheduled with a specialist but didn't go, the care manager may find out that it's a transportation issue and may need to set up transportation," he says. They ask the patients about their conditions, the support they are receiv-

EXECUTIVE SUMMARY

Care managers embedded in primary care clinics work with patients with high-risk diagnoses and multiple visits to the emergency department or hospital.

- Patients are identified though risk assessments, suggestions from inpatient case management, and requests from primary care clinicians.
- Care managers call patients before their clinic visits, look for gaps in care and find out patients' questions and concerns, sharing the information with the treating clinicians.
- Care managers follow patients for four weeks after their visit, helping them meet their health care goals and follow their treatment plan.

ing, and any questions and concerns and share those with the patient's provider.

Early each morning, the care team at the health center holds a huddle to discuss the patients scheduled for that day and their challenges. The team includes physicians, nurses, medical assistants, receptionists, and the care managers. Based on input from the team at the huddle and information in the electronic medical record, the care managers choose four or five patients to see in person while they are at the clinic.

When they see the patients, the care managers conduct a self-management assessment and develop a brief care plan with input from the patients. They go over the patients' diagnosis, find out their health concerns and answer any questions they have. They share the information with the provider. Using motivational interviewing techniques, they collaborate with the patients to set two or three healthcare goals to work on and identify the support they have at home to help address any barriers to meeting the goals.

In addition, the care management team has developed a document called "My Self-Care Plan," which is completed during the self-assessment sessions and identifies the goals the patients have set, includes questions and concerns they want to share with their provider, and has a place where they can write the providers' answers.

The care managers follow the patients for an additional four weeks after the care planning session. They contact them by telephone to find out if they are meeting their goals or if they need additional support. If the patients report not feeling well or have a lot of questions, the case managers connect them to the nurse or physician in the clinic.

"We want patients to learn to reach out to providers if they aren't feeling well so the providers can intervene before their condition gets to the point that they end up in the hospital," he says.

When they're not seeing patients, the care managers make outreach calls to patients who were discharged from the hospital and make pre-visit phone calls to the high-risk patients coming in the next day. The care managers typically have a caseload of about 50 patients in one stage or another at any one time.

In addition to the 12 care managers, the health system has embedded a nurse case manager and a social worker case manager at the busiest clinic, which treats a large portion of the highest-risk patients, many of whom have behavioral health disorders in addition to physical problems.

The care managers are assisted by five community health workers who live in the communities they serve. The community health workers offer hands-on support for the care managers in a variety of ways. For instance, if a high-risk patient misses an appointment and doesn't answer the telephone, the community health worker goes to the patient's home to find out what's going on. If a patient can't get to the clinic because of lack of transportation, the care manager may ask a community health worker to go to the patient's home and give the patient a transit card for the bus or subway. Community health workers help patients get connected to services, such as housing support, free legal services, and public benefits. They escort patients with drug or alcohol problems to residential treatment programs and help with the intake.

"The community health workers undergo intensive training and supervision so they can interact with patients effectively and engage them in getting the treatment they need and managing their own health. They live in the community and are able to identify with the problems the patients face and quickly build rapport," Hyde says. ■

CNE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

- identify the particular clinical, administrative or regulatory issues related to the profession of case management
- describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
- discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

COMING IN FUTURE MONTHS

■ Strategies from your peers on reducing readmissions.

■ Case management in Accountable Care Organizations.

■ Teaming with community agencies on transitions in care.

■ Discharge planning for hard-to-place patients.

CNE QUESTIONS

1. According to a report from the Agency for Healthcare Research and Quality, the top 1% of healthcare users accounted for 21.4% of the total spent on healthcare in this country in 2010.
   A. True
   B. False

2. How often do the nurse practitioner care coordinators at MetroHealth Medical Center in Cleveland contact patients in the Red Carpet program?
   A. 48 hours after discharge from the hospital.
   B. At least once a week.
   C. Every two weeks.
   D. At least once a month.

3. At Duke Raleigh Hospital, what hours do case managers cover the emergency department?
   A. Eight hours a day Monday through Friday.
   B. Eight hours a day, seven days a week.
   C. 12 hours a day, Monday through Friday.
   D. 12 hours a day, seven days a week.

4. At Lutheran HealthCare in Brooklyn, how long do case managers follow high-risk patients after their clinic visit?
   A. Five weeks.
   B. Four weeks.
   C. Six weeks.
   D. 72 hours.

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. ■

Dear *Hospital Case Management* Subscriber:

This issue begins a new continuing education semester.

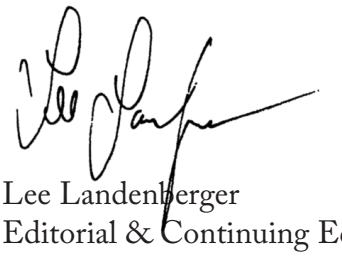
Here is how you earn credits:

1. Read and study the activity, using the provided references for further research.
2. Log on to cmecity.com to take a post-test. Tests can be taken for each issue or collectively at semester's end. First-time users must register on the site using the 8-digit subscriber number printed on your mailing label, invoice or renewal notice.
3. Pass the post-test with a score of 100%; you will be allowed to answer the questions as many times as needed to pass.
4. After completing the last test of the semester, complete and submit an evaluation form.
5. Once the evaluation is received, a credit letter is e-mailed to you instantly.

If you have any questions about the process, please call us at (800) 688-2421, or outside the U.S. at (404) 262-5476. Our fax is (800) 284-3291 or outside the U.S. at (404) 262-5560. We are also available at customerservice@ahcmedia.com.

Thank you for your trust.

Sincerely,



Lee Landenberger
Editorial & Continuing Education Director