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

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Professional case management doesn't always happen

True story demonstrates gaps in transitions

When **Marcia Diane Ward's** mother was treated in the emergency department, admitted to a nursing unit, and then transferred to a skilled nursing facility, Ward, RN, CCM, PMP, a case management consultant based in Columbus, OH, was chagrined to observe that the coordination between levels of care wasn't any smoother than it was when she first became a case manager.

"Getting back into the clinical environment gave me a memory trip. I remember that back in 1993, I wrote about the lack of transitions as patients move between levels of care and what we need to do as a profession to correct the problem. I've been in the healthcare business a long time, and I still see little progress when patients are handed off from one facility or level of care to another," she says.

Ward agreed to tell her personal experience in hopes that it will be a wake-up call for case managers overseeing patients through the network of healthcare management and delivery.

"I saw gaps in care throughout the continuum. Case managers are supposed to be advocates for patients, but that doesn't always happen today, in part because they are overwhelmed by often working 12-hour shifts, are assigned tasks that are not part of the Case Management Standards of Practice, and are inundated with paperwork and continuous data entry," she says.

EXECUTIVE SUMMARY
In today's fragmented healthcare world, case managers are so inundated with tasks that care coordination and transition management often suffer, as this case study illustrates.
• Take time to get to know your patients and always advocate on their behalf.
• Push back when you're asked to take on duties that aren't part of the Case Management Standards of Practice.
• Pick up the telephone and talk to the case managers at the next level of care rather than relying on e-mails and faxes.

When case managers try to do utilization review, discharge planning, care coordination, and transition planning along with copying, faxing, and other clerical tasks, they can't get it all done and things fall through the cracks, adds **BK Kizziar**, RNC, CCM, CLCP, a case management consultant based in Southlake, TX.

"The case management role is first and foremost being an advocate for patients, but often that's not the path we are directed to take," she adds.

When her mother was hospitalized, Ward felt fortunate that she had the skills to make sure her mother got the care she needed and ensure that all providers were aware of her medical history. "But not everybody has healthcare experience, and it's very consequential for patients and their families when clinicians don't talk to each other and don't look at the whole picture," she says.

Ward tells of consistently reminding clinicians of basic needs of her mother's that were not being . "The healthcare industry needs to address the holistic treatment needs of the individual," she says.

Medical specialists tend to concentrate on one aspect of the patient's condition, Ward says. "If you are admitted to the hospital by a physician who is concentrating only on his or her specialty, your care may be jeopardized unless there is a case manager who recognizes it." She recommends that as patient advocates, case managers make sure the patient's other problems, such as incontinence or refusal to eat, are addressed. Otherwise, the problems may never be treated.

"My mother was hospitalized with heart problems and for insertion of a pacemaker and saw a specialist referred by her cardiologist. But nobody was treating her pulmonary edema until I pointed it out and asked for a pulmonary consultation," she says.

Ward addressed her mother's gaps in care with the nursing manager on the floor and asked for a generalist to assess the problems not being treated by the cardiologist. "If the cardiologist as the primary admitting physician can't prescribe a stool softener or a sedative, a generalist must be called in as an adjunct to the specialist," she says.

Ward reports giving the list of her mother's medication to the nursing staff and discovering that there was an information gap between nursing and the pharmacy. "Every day, I had to review the medication she was taking and point out that some of her regular medication was missing. In my mother's situation, the hospital's case management process was a weak link. As a nurse, I was very aggressive in advocating for my mother's care. Most families wouldn't be able to do that," she says.

The skilled nursing facility where Ward's mother was transferred had an employee who was called a case manager, but he stayed in the office all day. "His role seemed directed toward administrative functions," she says.

When Ward's mother was transferred to the skilled nursing facility, the discharge notes didn't come with her. "I had to run those down and the skilled nursing facility asked me to drive to the cardiologist's office and pick them up. There was no information on the pacemaker, so I called the cardiac laboratory at the hospital to get details. It turns out that the physician thought the discharge planner would take care of it

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and vice versa," she says.

Case managers bear a sizeable responsibility to ensure that patients are safe in the next place they go, whether it's back home, to an assisted living center, or to a skilled nursing facility, and to make sure that the hand-off to the next level of care goes smoothly, adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm.

"Case managers should never treat the hand-off like a hot potato. They should continue to be accountable for what they did to get patients ready for the transition and to make sure that providers at the next level of care have all the information they need," she says. "Case managers need to continue to assert themselves in their patients' care and continue to position the value of case management for achieving the optimum outcome for their patients," she adds.

Based on her experiences, Ward believes that a case manager should be assigned to every patient in every setting and should make daily rounds. Case managers should never be afraid to step up and ask physicians about discharge orders or make sure the pharmacist is overseeing the medications, she says. "Case managers can ask the right questions and immediately pull all the disparate pieces together. They are the safety net within the healthcare delivery system that coordinates all the pieces and that make sure nothing falls between the cracks in the continuum of care," Ward says. ■

Be an advocate for your patients

Don't get saddled with extra duties

Whenever there's something new that has to be done, there's a tendency for administrators in many settings to assign the task to case management, often with the comment that "they're already in the patient record."

And that often means that many case managers are so overworked and inundated with tasks that don't require their level of skill that they don't have time to do true case management, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm.

"The largest number of case managers are nurses, and nurses have so many skills that they are called on to do more and more. And unfortunately, nurses, whether it's their educational background, a cultural phenomenon, or because they are women, accept all the extra jobs they are given and never say 'no,' even though they don't have time to take on new jobs," she says.

Case managers often are asked to perform tasks that don't require clinical expertise such as faxing, copying, and filing. "When they're spending their time on paperwork and clerical tasks, case managers can't spend time with patients and they aren't going to get good results," says **BK Kizziar**, RNC, CCM, CLCP, a case management consultant based in Southlake, TX.

Many patients in the hospital are in crisis and cannot speak for themselves, adds **Marcia Diane Ward**, RN, CCM, PMP, a case management consultant based in Columbus, OH.

"They need somebody who knows the healthcare system to advocate for them. That's what case managers must be doing, but they can't do their job properly if they have too much on their plates. We need to get back to basics of case management and make sure people who are acting as case managers have been educated and trained to understand the collaborative role of case management," she says.

Standards of practice

Case managers have standards of practice that they should follow, and they don't include being responsible for finance-oriented tasks such as utilization review, clerical tasks, or handling paperwork required by payers, Mullahy says. "Hospital case managers can't walk in to a patient room with a Hospital Issued Notice of Non-Coverage (HINN) and tell patients their stay may not be covered by their insurance and then say that they are there to help," Mullahy says.

Case managers in the hospital setting can have a huge impact on readmission, lengths of stay, and transitions, but not if they are doing other things, Mullahy says.

Case managers in the insurance industry shouldn't be treated as the claims police, Mullahy adds. "Ensuring cost-effective treatment does not mean simply finding the cheapest scenario. It means being a coordinator, a facilitator, an educator, and an advocate for patients," she says.

Now that hospital readmissions have become the focal point due to reimbursement penalties, case

managers are being targeted as the ones responsible for preventing readmissions, Kizziar points out.

"That's a role they should be taking, but we all need to keep in mind that a successful outcome is not just getting patients out the door. It's providing the information clinicians or caregivers at the next level of care need to meet patient needs, and following up to make sure the services are in place," she says.

And that gets back to the case manager job description and eliminating all the tasks that don't fall within the Case Management Standards of Practice, Kizziar says.

Case managers need to take the time to get to know their patients, their culture, their level of understanding, their financial situation, their support system, and their emotional status in order to develop a workable discharge plan, Kizziar says.

"You can't find these things out by just reading the chart or doing a short assessment. And case managers can't determine what a patient's needs will be at the next level of care or the best way to engage a patient in following a treatment plan if they're spending their time on other tasks that are not specific to their job description and practice standards of case management," Kizziar says.

Case managers are needed throughout the continuum to coordinate care, make sure nothing falls through the cracks, and hand patients off to their counterparts in other levels of care, Mullahy says. "If it's not possible for one case manager to follow a patient through all settings, there should at least be one point person at every level of care who can take off where their counterpart left off," she says.

Case managers are going to have to be the agents for change and push back when new tasks are dumped on them, Mullahy says.

"We have only ourselves to blame if we are overworked if we don't educate people on the role of case managers and push back when we are given tasks that are not part of the case management role and function," she says.

Mullahy advises case managers to look for champions in their organization who can speak up for case managers and the roles they should play in healthcare. "One person may not be able to change an organization's outlook, but a team of people can," she says.

Instead of just asking for more staff, develop a pilot project that demonstrates the outcomes when complex patients have "real" case management, Mullahy says. ■

A phone call is worth a thousand documents

Talk to the next level of care

The problems of the world could be solved if people just talked to each other, **BK Kizziar**, RNC, CCM, CLCP, a case management consultant based in Southlake, TX, asserts. And that statement definitely applies to case managers as they hand off patients to clinicians at the next level of care, she adds.

"It may be easier to e-mail a document or send a text message, but nothing beats taking the time to pick up the telephone and talking to the provider who is taking over the care of a patient," she says.

Case managers in all settings need to communicate across levels of care to make sure that everyone has the whole picture of the patient, Kizziar says.

"Case managers may say they don't have time for the phone calls, but lack of communication with the next level of care is going to come back to haunt us with readmissions and poor outcomes. In addition, that is not the attitude that a patient advocate would take," she says.

Telephone communication gives the receiving case manager a chance to ask questions and gives the case manager who knows the patient a chance to share information that doesn't get into the patient record. "There may be nuances about the patient's health and family situation that a case manager wouldn't feel comfortable in writing down but that will help the staff at the next level of care meet the patient's needs," she says.

"Nobody has the whole picture of the patient. We all need to be communicating with each other and doing so in the most effective way," she says.

When patients are discharged from the hospital or another facility, case managers typically take care of the paperwork, then move on to the next case, Kizziar says. "Rarely have I seen hospital case managers call the next responsible party and give them a discharge report. Standards of Practice require us to give pertinent information to the next person handling the case, and we have failed miserably. We are so dependent on electronic transmissions and material copied and stuck in an envelope that it never occurs to us to communicate verbally, and that's where patients fall through the cracks," she says.

People in healthcare tend to operate in silos, adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM,

president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm. "They work with a patient during one episode but don't hand the patient off to the next level of care. High-cost, complex patients don't stop being that way because you can't see them. You have to talk to the case managers at the next level of care," she says.

In addition to providing details on medical treatment and medication, case managers should give their counterparts at the next level of care information about the patient's family/caregiver situation, what happened during the hospitalization, and the patient's challenges. "Otherwise, it's just a discontinuation of services and not a real transition," she says.

Kizziar advises health plan case managers to reach out to their counterparts at hospitals, physician practices, and other settings to find out exactly what is going on with the patient and collaborate on planning the care. "You can't get a clear picture just by reading a document. Often if case managers speak to someone about the patient's situation, it can change their perception of the case," she says.

"I saw that when I worked on the insurance side. The documentation might lead me down one path, but if I called and talked to the case manager who had been working the patient, sometimes I would be more inclined to go in another direction," she says. ■

CM interventions prevent readmissions, ED visits

Nurses meet with at-risk patients

Group Health Cooperative's program that provides case management for patients with complex conditions and/or psychosocial issues has decreased preventable admissions, readmissions and emergency department visits, particularly among the Medicaid population, says **Barbara Wood**, BSN, MBA, executive director of case management for the Seattle-based non-profit health system.

Group Health Cooperative is an integrative healthcare system that includes a health plan, 25 clinics, six specialty clinics, seven behavioral health clinics, and a small hospital.

The organization established the Emergency Department and Hospital Inpatient Improvement project in 2009 with a goal of improving care transitions. Since then, the organization has reviewed the process, looking for ways to make improvements and further reduce admissions, readmissions, and emergency department visits, Wood says.

Group Health Cooperative partners with hospitals throughout the state of Washington to coordinate patient care and ensure smooth transitions. The organization has embedded hospitalists and nurse case managers, called case management liaison nurses, to manage care for patients covered by its health plan in the six highest-volume hospitals and provides telephonic care coordination for patients in other hospitals.

"We contract with community hospitals to provide care for all of the patients in our health plan. As part of our contract with the high-volume facilities, our hospitalists treat the patients covered by our health plan and our case management liaison nurses are responsible for utilization management, discharge planning, and transition management for those patients," Wood says.

A team of clinicians, including Group Health hospitalists, analyzed why patients were readmitted or visited the emergency department after discharge and developed a standardized tool that rates patient acuity to help determine who is at risk, she says.

"We now are using a combination of patient diagnoses, their conditions, and psychosocial situations to determine who is at risk," Wood says. For instance, someone with diabetes wouldn't necessarily be at risk, but if the patient is unstable or frail or has no support system at home, that would stratify him as high risk. "Patients on certain drugs, such as warfarin, are also high risk," she says.

After research, the team determined that high-acuity patients should have a follow-up visit with a primary care physician within seven days of discharge and that patients who are low or medium risk should see their physician within 14 days. "When we

EXECUTIVE SUMMARY
Group Health Cooperative's case managers target patients with complex medical conditions and/or psychosocial issues who have been hospitalized and work with them on managing their health with a goal of avoiding admissions, readmissions, and emergency department visits.
• At-risk patients are identified using a combination of patient diagnoses, their conditions, and psychosocial situations to determine who is at risk.
• Hospitalists and case managers embedded in high-volume hospitals provide care and care coordination for patients covered by the health plan.
• Case managers call patients after discharge and refer those with long-term needs to the health plan's case managers for follow up.

looked at our records, we realized that many patients were waiting much longer than 14 days to see their physician after a hospital stay. We want to get them in as quickly as possible, particularly if they are at high risk," she says.

If patients are high risk, the nurse or an administrative assistant makes the appointment while they are still in the hospital. "Our goal is to get the appointment made, no matter who does it. Typically the nurse explains the need for the follow-up appointment to the patient and family and the administrative assistant makes the appointment," Wood says.

Every morning, the embedded case management liaison nurses get a census of Group Health patients in the hospital and review their medical records. Early in the day, the Group Health hospitalists and case management liaison nurses meet to review all the patients and determine which patients are high, medium, or low acuity. They also discuss potential discharge needs, and any psychosocial issues the patients may have that could affect the discharge. "As the patient gets closer to discharge, the team starts talking about what the patient wants and what the clinicians think is reasonable and formulating a discharge plan," she says.

On an ideal day, the case management liaison nurse sees all of the Group Health patients in person, Wood says. If that's not possible, they visit the high-acuity patients, discuss their condition and treatment plan, and what is likely to happen next during their course of treatment. In some cases, they talk with the patients about their benefits and what their plan will cover. For instance, if a patient is going to be discharged to a skilled nursing facility, the nurse will let the patient and family know how many benefit days are left in the benefit period.

The nurses and physicians make sure the patient and family members understand why the patient is in the hospital and educate them about the disease and what they will need to do to manage at home after discharge. They discuss their medications, how and when to take them, and the importance of following their medication regimen and treatment plan. They also educate the patient on what signs and symptoms indicate they should call the doctor. In addition to verbal teaching, they give the patients and family members the same information in written form.

The nurses see patients with moderate acuity at least once while they are in the hospital and stress the importance of making a follow-up visit with their primary care physician.

The program's goal is for all patients covered by Group Health insurance, regardless of acuity, to receive a follow-up call within 24 to 48 hours after discharge.

The case management liaison nurses call the patients that have been discharged from the hospital in which they are embedded. Patients who are treated in Group Health clinics are called by complex care managers who are embedded in Group Health's clinics. Other health plan case managers call the other patients.

All of the case managers, regardless of where they are located, use the same tools, the same language, and the same documentation.

During the calls, the nurses conduct an assessment to make sure the patients understand their chronic disease and its potential impact on their lives, if they are following their plan of care, and if they have questions and concerns. If the patients didn't leave the hospital with a follow-up appointment, the nurse finds whether they have made an appointment. If the patient hasn't made an appointment and plans to see a provider in a Group Health clinic, the nurse sets up the appointment while the patient is on the phone.

"The nurses check on the patients' conditions, support systems, and assess the transition to determine if patients need extra follow-up," she says. They look for any barriers that may interfere with the patient following the treatment plan or receiving follow-up care. For instance, if patients are not taking medication because of financial issues or need transportation assistance, the nurses call in a social worker for assistance. They also call in the social worker if they determine that patients need resources such as meal deliveries or household help.

"Sometimes, patients just need a lot of education on their conditions and the importance of following the treatment plan. If they are not absorbing their plan of care or are resistant to treatment, the nurses will bring them into case management and work with them. It's much better to help them get control of their health in the beginning, rather than waiting until they are higher-acuity patients," she says.

If patients don't have a plan of care or aren't adherent, the case manager may refer them to complex case management, where the nurses will follow them for 90 to 120 days and give them the tools to be successful with their plan of care, she says.

"Patients may not be successful because of lack of knowledge. The nurses talk about why it's important to have a plan of care, the importance of following it, and what patients should do if they don't feel well.

The organization has a home health residential care program in the Puget Sound area that provides

in-home services to patients who are homebound or need a lot of support. In addition, Group Health contracts with an organization that provides support for at-risk patients from nurse practitioners throughout the state.

"Now we are working on strategies to make sure patients who are hospitalized meet medical necessity criteria and finding alternatives to social admissions," she says.

For instance, Group Health's on-site hospitalists consult with the emergency department staff at their hospital to evaluate patients' symptoms and medical history to determine if they meet hospital admission criteria. ■

ED care managers offer outpatient care options

Focus is on admission vs. discharge decisions

The debate raging over whether it is wrong or right for lawmakers to be looking at ways to limit ED utilization may be missing the more important discussion, according to **Timothy Peterson**, MD, an assistant professor of emergency medicine and medical director for the population health office at the University of Michigan Health System in Ann Arbor. He argues that while the ED is clearly a high-value place for people to receive care, policymakers and emergency providers themselves should be thinking more about the downstream impact that ED physicians have. "We make very expensive decisions for patients. And that admissions vs. discharge decision is one of the most expensive decisions that ED physicians are responsible for," states Peterson.

What's needed, according to Peterson, is programming and resources so that ED physicians will feel comfortable sending some patients who they now tend to hospitalize home, knowing they will receive the kind of care they need in an outpatient setting. It's a care model that Peterson and colleagues are planning to have in place within the next six to nine months at the University of Michigan Health System. The process is beginning with the deployment of specially trained nurse care managers throughout the hospital and the ED setting.

First, focus on observation

The ED-based care managers will be tasked with at least assessing every patient who comes through the door, but the degree of intervention is going to vary, explains Peterson. "There are going to be those cases where a patient is clearly going to need to be in the hospital, and their degree of assessment is only going to be to help transition that patient up into the hospital and to set expectations for the admission, length-of-stay, and those sorts of things," he says. "The majority of that work will be handed off to an inpatient care manager."

Similarly, for those patients who are clearly going to be headed home, the intervention by care managers is going to be minimal because these patients will already have discharge plans in place that their physicians are comfortable with, says Peterson.

Where the care managers will have most impact is on those patients who are on the margin. Physicians may be inclined to admit them, observes Peterson, but it will be up to the care managers to help to create outpatient plans that would be equally efficacious and safe for the patients outside of the hospital. "That is where most of their work will be, but we think the absolute number of these patients will be relatively small," he says. "If we can put a resource in place to help physicians feel more comfortable with an outpatient treatment program, where it is appropriate, I think we can have an impact on our readmission rate."

To make such a program work, there has to be what Peterson refers to as a toolbox of alternatives that care managers and physicians can tap into. Already in development is a visiting nurse program from the ED, where patients can get assessment in the home and services delivered to the home, with someone coordinating all of this care with an ED referral, he explains.

"We are also working with some of our skilled nursing facility partners to develop similar programming to help prevent ED admissions," says Peterson. "Fully developing this toolbox is probably going to take another five to seven months. We have to understand what the need is, we have to find partners, and then build those programs out."

Peterson fully anticipates that it will take time for the physicians to become comfortable working with the care managers on cases. "A little bit of tension is going to be natural because we're going to be taking physicians who are accustomed to a current mode of practice and asking them to think about the difficulty and adjust to a different operation," he says. "We expect some people to have some degree of reservation, but our goal is to put together the clinical programming needed in order

for physicians to feel comfortable with alternative treatment plans."

To ease this transition and allow time for the development of effective outpatient treatment options, the care managers will first focus on what Peterson sees as the most straightforward cases: patients who are currently on observation stays. "These patients are defined by payers as folks who don't need to be in the hospital in the first place," he says. "We think this is the group most amenable to being transitioned out of the hospital and back to home, and receiving the medical care they need in that setting."

Over time, Peterson intends to grow the program to the point where patients with slightly riskier or complicated cases can be safely and comfortably treated at home, but further development of the program will depend on several factors. "On the one hand we have to actually turn on the programming and get the care managers doing the work and assessing the patients, and on the other hand we have to develop that toolbox that we believe people are going to need to be able to tap into," he says. "I don't believe for a second that ED physicians are admitting people to the hospital for no good reason. They feel there is a lack in the outpatient environment that can't be met in any other way except by putting the patient in the hospital."

Own the discharge vs. admission decision

Rather than viewing the ED as a high-cost center, policymakers and hospital administrators should, instead, look at how they can better leverage the ED to improve care and potentially reduce readmissions, according to **Keith Kocher**, MD, assistant professor of emergency medicine in the Department of Emergency Medicine at the University of Michigan Health System. Kocher recently completed a study on hospital and ED utilization among a sampling of 2.4 million Medicare patients who underwent six common surgical procedures over a three-year period. He and his research colleagues found that nearly one in five of these patients had an ED visit within one month of their hospital stay, and more than half of these patients ended up back in the hospital.[1]

The findings suggest that health care teams need to find better ways to keep surgery patients from experiencing emergencies after they leave the hospital. However, Kocher notes that the data also illustrate the role that EDs can potentially play in preventing readmissions. "You have a huge opportunity to address a lot of the needs that might have caused a patient to feel like they needed to seek out unscheduled care," he says. "You won't be able to prevent all readmissions, certainly, and I think it would be unfair to expect that, but you certainly have the opportunity to really try to coordinate some potential alternative plans to readmission."

It is not a matter of putting further pressure on EDs to fix these problems, emphasizes Kocher. "That is not going to get you anywhere meaningful because a lot of these problems are not just clinical," he says. "You are talking about trying to navigate a potentially complex web of social and family concerns."

Improvements at this stage require a system-level perspective and approach to the problem, adds Kocher. "There are certainly going to be lessons that are generalizable and universal, but probably everyone is going to have to struggle with the details of a solution that works in their own environment," he says. "There is not one solution."

Kocher is happy to see care managers being deployed in the ED at the University of Michigan Health System, but he expects a fair amount of trial and error as the intervention is fine-tuned. "I think there is going to be a lot of experimenting going on as far as how to enlist their help. Ideally, you want the care managers to be proactive so it is not the emergency provider who has to constantly generate a discussion or figure out alternatives," he says. "I think it is going to take some time to figure out how best to integrate them into the management of patients, and particularly into the flow of the ED, which is chaotic and time-dependent."

At the same time, emergency physicians need to fully engage in the process, adds Peterson. "If you are thinking about where health care reform is headed on a federal or even a commercial level, we as emergency physicians need to think about owning that admission versus discharge decision," he says. "The more we can do to begin to shape what that looks like for our patients, I think the more successful we can be. That is really what we are focused on here with this type of program."

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Program seeks to stop asthma readmissions

Program utilizes community paramedicine

As health care reform continues to unfold and performance-based payment models make more headway, emergency providers are pushing the boundaries beyond what the market has traditionally expected from this field of expertise. The latest example of this is taking place in Indianapolis, where emergency medicine faculty at Indiana University School of Medicine (IUSOM) hope to improve the way asthma is managed in children through the use of a community paramedicine program.

Under the program, dubbed Treat the Streets: Pre-Hospital Pediatric Asthma Intervention Model to Improve Child Health Outcomes, children who have either visited the ED or been admitted to the hospital for asthma will receive home visits by specially trained paramedics who will be empowered to assess for potential triggers in the environment and make any needed referrals for social services or medical follow-up. The idea is to improve outcomes and reduce recidivism among this highly vulnerable population.

There is plenty of room for improvement. Statistics show that nearly 30% of children who have been hospitalized for asthma require readmission to the hospital not long after discharge, and as many as 25% of children who have been treated in the ED for asthma will return to the ED within 30 days for another asthma-related visit. Further, experts say that asthma is one of the leading causes for ED visits among children.

While Treat the Streets is narrowly focused on a single county in Indiana, and it specifically targets asthma-related admissions or ED visits to Riley Hospital for Children in Indianapolis, developers hope to create a model than can effectively be deployed to improve outcomes and cut costs in many other communities across the country.

Consider the home environment

Elizabeth Weinstein, MD, FAAEM, FACEP, FAAP, assistant professor of clinical pediatrics and emergency medicine at IUSOM and deputy medical director of pediatrics at Indianapolis EMS, observes that emergency medicine providers have a vested interested in how the healthcare infrastructure cares for children with asthma. "We are the place where people go when they are having an acute event, so we catch a lot of these kids as they enter the system," she says. "More importantly, we are situated at a place where we can intervene in ways which may prevent them from having relapses or a failure to complete the course of therapy that they need to get better."

Weinstein, who is a co-investigator for Treat the Streets, explains that the approach is based, in part, on years of research on how to make a difference with the pediatric asthma population. "There have been a lot of different interventions to try and reduce the [recidivism] rate, and the ones that seem to have the most impact are those that get into the home and into the environment of the family, and work with the families through the barriers that they have," she explains.

Weinstein emphasizes that it is not just a matter of telling children to take their medicine. Many families struggle to pay for the medicine or to even pick up the medicine regularly at the pharmacy. Learning how to administer the medicine correctly is likewise a challenge in asthma care. "There is also the issue of reducing a child's exposure to triggers, which may include smoking or cockroaches or mold in the home," she says.

Establish a curriculum

Leveraging paramedics or pre-hospital providers in a more proactive community health role is not unique; the approach was developed in Minnesota and has been used in the Western mountain states, explains **Andrew Stevens**, MD, the principal investigator for Treat the Streets, an assistant professor of emergency medicine, and medical director of paramedic sciences at IUSOM. But he believes this is the first time the approach has been used in an urban setting to address pediatric asthma. "We took what has been a movement in the last five years to use paramedics in a different way, and came up with a novel program that really applied to us here in Indianapolis," he says.

In fact, another community health program that uses paramedics to help prevent readmissions among adult patients with congestive heart failure (CHF) is already ongoing in Indianapolis, so the new program has a ready source of seasoned paramedics who are accustomed to this type of role, says Stevens. Further, since a paramedic training curriculum is already in place for the CHF program, developers have a vehicle they can use to train paramedics for the asthma program.

"What we are doing is adding to the curriculum that we already have for [the CHF] program," says Stevens. While paramedics are already equipped with the training to monitor and treat asthma so that it does not become life threatening, the new content includes aspects of pediatric social work, pediatric public health, pediatric environmental care, and the basics of medicine in pediatric respiratory disease related to asthma. "We have broken [the information] down into a month and a half of a fully enveloped, hands-on curriculum that tries to be all encompassing from all of those different disciplines. It is basically an advanced practice curriculum for [the paramedics]," he adds.

To handle the demands of both the CHF and the asthma programs, three paramedics have been tapped to serve as full-time community medicine paramedics. "The expectation is that this will become part of their career experience, and that it will allow them to do this job while also still functioning as street-level paramedics," says Stevens.

Establish comprehensive home visits

When Treat the Streets debuts, first as a three-month pilot in January of 2014 with full implementation of the program to follow in the spring, any visit by a child to the ED or the hospital for an acute asthma exacerbation will be a trigger for a follow-up home visit by one of the community medicine paramedics. At least initially, the prompt for these visits will be manual, explains Weinstein. "We have people working on this everywhere. We have several people situated with EMS, and several people at Riley Hospital — both in the ED and within the division of pulmonology," she says. "Their social workers are on board, and their nurses are on board, so by the time we launch this out into the community, there will be a streamlined process for manual triggering [of the home visits] as soon as kids are admitted."

The home visits will be put on the calendar before patients leave the hospital, and discharge planners will endeavor to schedule the visits within a few days of the hospital visit. "The intention is that this will be a one-time home visit, that the visit will be comprehensive, and that it will enable the EMS provider to initiate stop-gap measures so that if a child is starting to get sick, he or she can make sure the appropriate medicines are started and that the acute care needs are met," says Weinstein. "But [the intention] is also to identify ongoing issues, and then activate appropriate referrals for continued management and care, so public health nursing might be one thing that is triggered by that home visit."

As part of their training, the paramedics will be equipped with resources that they can tap into for specific problems or issues. For example, if paramedics find that there is a cockroach infestation in the home, they will have a specific number they can call to arrange for removal of that infestation, explains Stevens. Similarly, paramedics can take steps to link families with a primary care provider or a high-risk asthma clinic for follow-up. "They can make decisions, and they have the ability to do any necessary medical interventions or basic pharmacology," he says.

Monitor utilization, qualitative factors

Information gathered during the home visits will go toward the construction of an asthma registry that will provide better insight into the barriers that prevent families from achieving more effective asthma control, says Stevens. In addition, he stresses that investigators will be keeping a close eye on 30-day, 90-day, and one-year readmission metrics. While utilization statistics are most important, investigators will also monitor qualitative measures related to parental and family satisfaction with the intervention, and provider approval as well.

Treat the Streets is being funded with an $899,700 grant that IUSOM's Emergency Medicine Division of Out of Hospital Care received from the U.S. Department of Health and Human Services in Washington, DC. However, Stevens is hopeful that the program will be sustained over the long term with payment reforms that move away from fee-for-service models.

"I feel that with these kinds of programs, hospitals are starting to buy into [the concept] of accountable care organizations and [payment models based on] episodes-of-care," says Stevens.

With the risks posed by bounce-back admissions, programs like Treat the Streets may be viewed as a way to reduce utilization or to identify ongoing risk factors, he says.

Perhaps boosting the program's chances for success is the fact that participating groups are already pretty well integrated, says Stevens. "We have a unique partnership in that the EMS system is part of the city/county government, which is also very intertwined with the [Indiana University] School of Medicine, IU Health, and the county health system."

Sources

• Andrew Stevens, MD, Assistant Professor, Emergency Medicine, and Medical Director, Paramedic Sciences, Indiana School of Medicine, Indianapolis, IN. E-mail: steveand@iu.edu.
• Elizabeth Weinstein, FAAEM, FACEP, FAAP, Assistant Professor, Clinical Pediatrics and Emergency Medicine, Indiana School of Medicine, and Deputy Medical Director, Pediatrics, Indianapolis EMS, Indianapolis, IN. E-mail: elweinst@iu.edu. ■

Incident reports don't tell whole story

Several studies have shown that hospitalized patients still have unacceptably high rates of harm and injury due in part to limited access for quality staff to obtain primary care data from electronic medical records. As a result, hospital incident reports do not capture most harm that occurs in hospitals, according to a study published in the *Journal for Healthcare Quality*.

The study showed that using administrative data, such as discharge abstracts, can gauge the quality of care and identify opportunities for improvement. The purpose of the study was to develop a new global measure of harm, called "whole patient measure of safety," that uses administrative claims data to measure the incidence of 14 "highly undesirable events" (HUEs).

The goal is to determine the probability for a patient to complete a hospital stay without any HUEs and the central measurement question is, "What proportion of hospitalized patients experience at least one HUE during their episode of care?" Data from 6.5 million discharge abstracts in 161 hospitals from July 1, 2008, to June 30, 2010, were studied.

Results of the analysis showed that the percent of hospitalizations with at least one HUE varied greatly among hospitals (13.32% to 1.99%) with a mean of 7.74%. Hospital-acquired infections (HAIs) were the most common HUE across all facilities, and blood incompatibility was the least common. HAIs usually result in readmission within 72 hours, and half of the HAIs identified occurred with other HUEs.

The study concluded that the new whole patient measure of safety provides a global assessment of what happens to hospitalized patients as they move through the care system. It assesses the entire care process and can augment patient assessment metrics for specific diseases and procedures. The measures can be used to help hospitals interested in understanding where the most egregious safety deficiencies exist by examining patients with multiple HUEs.

Also, since hospital-acquired conditions are not being reimbursed by payers, administrative data can be a valuable resource to help gauge potential liability and risk and identify opportunities for improvement.

An abstract of the study is available online at http://tinyurl.com/ohot46g. ■

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com/. *Case Management Advisor's* executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute. ■

COMING IN FUTURE MONTHS

- Strategies for managing the care of dual eligibles
- Case management for the physically handicapped
- Opportunities in accountable care organizations
- How your peers are preventing readmissions

CNE QUESTIONS

1. Based on her experiences when her mother was hospitalized and transferred to a skilled nursing facility, Marcia Diane Ward, RN, CCM, PMP, tells of observing gaps in care throughout the continuum. What does she think is the reason the gaps occur?
   A. Case managers are overwhelmed by often working 12-hour shifts.
   B. Case managers are assigned tasks that are not part of the Case Management Standards of Practice.
   C. Case managers are inundated with paperwork and continuous data entry.
   D. All of the above

2. According to Catherine M. Mullahy, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, ensuring cost-effective treatment does not mean simply finding the cheapest scenario. It means being a coordinator, a facilitator, an educator, and an advocate for patients.
   A. True
   B. False

3. According to BK Kizziar, RNC, CCM, CLCP, case managers need to talk to each other across levels of care rather than just emailing or faxing information. What is the advantage of verbal communication?
   A. It takes less time than writing things down.
   B. You can be sure the right person gets the information.
   C. It gives you a chance to share information that doesn't get in the written record.
   D. All of the above

4. Group Health Cooperative has determined that high-acuity patients should have a follow-up visit with their physician within what period of time after discharge?
   A. 24 to 48 hours
   B. Three days
   C. Seven days
   D. 14 days

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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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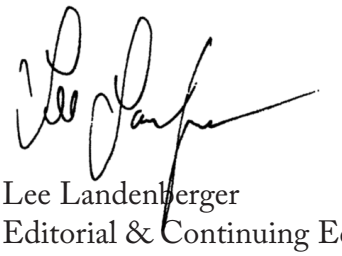

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