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Organizations look beyond cookie-cutter case management initiatives

An individual approach improves results

When it comes to case management, there's no such thing as one-size-fits-all. What works for one person may not work at all for another. And, often, what works for one group of people doesn't work so well for another group.

"Population management is a term often used to identify what might be effective when we are working with individuals who have the same diagnosis, such as heart failure or diabetes. But even within these defined population groups, there are unique differences among the individuals with that diagnosis. The true art of case management is in the creation of individualized programs to meet the very unique needs of the individual," says **Catherine Mullahy**, RN, BS, CRRN, CCM, president of Mullahy and Associates, LLC, a Huntington, NY-based case management consulting firm.

She points out that the case managers routinely use evidence-based guidelines to promote improved outcomes, but that's often not enough.

"The real contributions that case managers can make go way beyond a standardized connect-the-dots approach to managing care. Educational, cultural, or religious differences cannot be viewed as barriers, but rather

EXECUTIVE SUMMARY
Recognizing that case management programs should be tailored to the special populations being served, health plans are creating specialty programs to meet the needs of their members.
• Pediatric case managers at UPMC *for You* collaborate with caseworkers to ensure that children in foster care receive well-child visits and dental check-ups and other healthcare services they need.
• CareSource's substance abuse program provides case management for members who are receiving multiple prescriptions for narcotics from multiple providers.
• Native American members in Molina Healthcare's Medicaid managed care plan may apply for a stipend to cover traditional healing.

AHC Media

as opportunities to truly understand a patient population and then individualize the approach that we will use to help them maximize their health," she says.

Case managers need to acquire an understanding of the cultural beliefs of people with whom they interact, take into consideration their behavioral health needs as well as medical needs, and recognize the challenges that patients face in their everyday lives in order to effectively manage their care, Mullahy says.

Health plans and providers have recognized the value of fitting their programs to the specific needs of the populations they serve. They are going beyond the typical case management programs and are creating specialty case management initiatives designed to improve the health of specific patient populations that might not benefit from traditional case management.

For instance, pediatric case managers at UPMC *for You* work with caseworkers from each county's Department of Children, Youth and Families to see that children in foster care receive well-child visits to a pediatrician or family practitioner, are up on their immunizations, and have dental check-ups.

"We believe this is a population that needs a lot of help with healthcare, and we are committing the resources to see that they get it," says **Laura Fennimore**, RN, DNP, a clinical director who oversees pediatrics for UPMC Health Plan. UPMC *for You* is the Pittsburgh-based health plan's Medicaid managed care plan. *(For details, see article on page 63.)*

The challenges that children in foster care experience early in life have an impact on their overall health as they go into adolescence and adulthood, Fennimore says. "When you take into consideration the long-term impact on the health of the individual and the cost of caring for people over the course of a lifetime, making sure these children get the healthcare services they need is well worth the effort and expense," she says.

When CareSource looked at ways to help their members who were abusing controlled substances overcome their addictions, the Dayton, OH-based Medicaid managed care plan decided to have RN case managers work with the members and support them as they struggled to give up drugs. "We tried other approaches in the past, but we didn't have the positive outcomes that we have in this program," says **James Gartner**, RPh, MBA, vice president of pharmacy and medication management for CareSource.

The case managers work closely with the members who enroll in the program for 18 months and collaborate with the physicians who are prescribing medications for the member.

"Our program is unique because nurse case managers hold the hands of our members as much as needed and help them get into a better situation. We are a member-centric health plan, and this is just one of the programs we have developed to help our members," Gartner says. *(For details on the program, see page 64.)*

Molina Healthcare's Traditional Medicine

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Benefit allows its Native American members to use traditional healing to complement Western medicine. Members in Centennial Care, Molina's Medicaid managed care plan, can apply for a stipend of up to $200 to pay for the cost of traditional care, such as herbal treatments or sweat lodge ceremonies. *(For details, see related article on page 66.)* ■

Coordinating care for foster children

CMs collaborate with caseworkers

When children in foster care are covered by UPMC *for You*, a pediatric case manager collaborates with a designated caseworker from each county's Department of Children, Youth and Families to ensure that the children have access to all the care, preventive, and behavioral health services they need.

In the first year of the program, the proportion of children in foster care receiving annual well-child visits in Allegheny County, PA, increased from 53% to 78.5%, and the percentage of children with annual dental check-ups grew from 60% to 75%.

"Our goal is to ensure that all of the children covered by UPMC *for You* have access to the Early Screening, Diagnosis and Treatment component of Medicaid designed to improve the health of low-income children. Foster children often have major unmet needs and are behind on immunizations and well-child visits and many times, their medical and dental records are scattered among several providers," says **Laura Fennimore**, RN, DNP, a clinical director who oversees pediatrics for UPMC Health Plan. UPMC *for You* is the Pittsburgh-based health plan's Medicaid managed care plan.

The state of Pennsylvania sends UPMC *for You* a list of children placed in foster care or juvenile protection every two weeks. The health plan's pediatric case managers access claims data to find out if the children on the list are up on their immunizations and have had a well-child visit or seen a dentist. "We use our electronic health record to identify children with gaps in care and focus on those we are most concerned about who have missed an important piece of all aspects of preventive care," she says.

The health plan's pediatric case management team gets in touch with each child's Department of Children, Youth, and Families caseworker and works with him or her to make sure the child has had preventive services. "We don't work directly with foster parents, but collaborate with the caseworkers to ensure that the children covered by our health plan get the care they need," she says. In some instances, if the foster parents or the birth parents agree, the UMPC *for You* pediatric case managers work directly with them.

Using health plan claims data, UPMC *for You* case managers prepare an abbreviated medical record showing children's hospitalizations and emergency department visits as well as where the gaps in preventive care are occurring. "We share it with the caseworker, who can use the information to encourage foster families to take the children for well-care visits with their pediatrician, to the dentist, and to keep them up on their immunizations," she says.

UMPC *for You* case managers provide monthly updates to the case workers on interventions foster children receive, including hospitalizations and emergency department visits for physical health and behavioral health issues. "This is another way to make sure the case worker is aware of any issues going on with the children," she says.

Children who are enrolled in Medicaid frequently have gaps in care, partially because of poverty and all the social issues that come with poverty, Fennimore says. Foster children are especially challenging because they may move from one family to another and often the caseworker is the one who has the most complete history and there still may be missing pieces, she adds.

EXECUTIVE SUMMARY

Pediatric case managers from UPMC *for You* collaborate with caseworkers to ensure that children in foster care get the care, preventive, and behavioral health services they need.

- Children typically have gaps in care, and their medical and dental records are scattered among several providers.
- Case managers access claims data, identify any unmet needs, and alert the caseworker.
- As part of a pilot program in Allegheny County, health plan representatives meet with Department of Children, Youth and Families caseworkers to collaborate on improving the process.

Often, foster families have trouble navigating the healthcare system or issues with transportation. "We can't work with them directly, but we work through their caseworker to help overcome the barriers to care," she says.

"The pediatric case management team can help the caseworker obtain a complete medical history and can help them connect the child with providers," she says. For instance, if children are placed in foster homes that are across town from their previous homes, the case manager can help the caseworker find a pediatrician or a pediatric dentist who accepts members covered by the plan in a location that is convenient for the foster family.

The health plan has developed a Foster Pilot Work Group with Allegheny County's foster care system to look at ways to improve the process. A pediatric social worker and a behavioral health case manager meet regularly with the staff from the Allegheny County Department of Human Services and discuss ways to work together to coordinate services and ensure that foster children have access to the healthcare they need.

"The work group members discuss ways to engage foster families in preventive care services and barriers they encounter, such as difficulty in scheduling appointments or transportation problems," she says. The pediatric case managers can help families access funding for transportation, or if the foster children are disabled, line up door-to-door transportation.

The circumstances that lead to children being in foster care often lead to serious behavioral health concerns, and many foster children have behavioral health issues as well as medical needs.

In Allegheny County, behavioral health benefits are provided by Community Care Behavioral Health, which is part of the UPMC organization. Case managers from the behavioral health organization also work with the case worker to make sure children are seen by a behavioral health professional within seven days of discharge after a stay in a psychiatric hospital.

The UPMC *for You* case managers coordinate physical health services with the behavioral health case managers and make sure that the Children, Youth and Families caseworkers have the full picture, she says.

Caseworkers have expressed their appreciation for the program, Fennimore says. "They welcome the health plan care managers as a valuable resource in helping them meet the children's needs," she says. ■

Program helps cut drug dependency

CMs support members, work with MDs

A substance abuse case management program developed by CareSource is helping its members with substance abuse problems kick the habit.

CareSource launched CARE4U about six years ago to help members who were abusing controlled substances reduce their overall dependency on drugs. "Instead of just telling our members they can't have the medications, we wanted to help them get off the drugs," says **James Gartner**, RPh, MBA, vice president of pharmacy and medical management for the Dayton, OH-based Medicaid managed care company.

CARE4U has helped 15% of the people who completed the 18-month program abstain from narcotics completely. An additional 25% of participants who completed the program have reduced their overall dependence and receive only an average supply of two weeks' worth of narcotics in a quarter. The program received a Pinnacle Award for Best Practices from the Ohio Association of Health Plans in 2013.

Members eligible for the program are using 12 or more controlled substances in a quarter and are getting prescriptions from four or more providers and filling them at four or more pharmacies. Most of the members in the program are addicted to pain medications. Many have behavioral health issues, as well, Gartner says.

"In a lot of cases, the members have surgery or are injured and are prescribed pain medication. They start abusing the medication and become

EXECUTIVE SUMMARY

Rather than just cutting off the supply of controlled substances, CareSource case managers work with members with substance abuse problems and help them reduce their dependency.

- Members eligible for the program use 12 or more controlled substances in a quarter, get prescriptions from four or more providers and fill them at four or more pharmacies.
- Case managers work with eligible members for 18 months.
- Case managers provide information to all prescribing physicians, alerting them that the member is receiving prescriptions from multiple providers.

addicted. Then they start seeking prescriptions for medication from multiple providers. In most cases, the patients no longer need the drugs for the reasons for which they were originally prescribed," he says.

The program is staffed by a team of five RN case managers, most of whom have experience in working with people with addictions. The health plan uses RN case managers because of the knowledge they have about medication and their abilities to work with members, Gartner says.

The nurses work with the members, educating them and supporting them in their efforts to overcome their addiction. In addition, they collaborate with the prescribing physicians, alerting them that their patients are getting multiple prescriptions and keeping them informed on the patients' progress.

The health plan mines claims data quarterly to identify members for the program. In addition, members are referred by physicians and through the health plan's prior authorization reviews.

When members are identified as being eligible for the program, a nurse case manager calls them, explains the program, and encourages the member to be enrolled. The health plan also sends members a letter explaining the program.

"We chose not to use technicians to make the outreach calls because if we get the member on the phone, we want to get them engaged right away. The nurses can start working with the members immediately after they agree to enroll," Gartner says.

The nurses start the conversation by letting the member know they are aware that he or she is getting multiple prescriptions from multiple providers and offering to help. "It's not always an easy conversation. Some members resent that we are interfering with their drug-seeking behavior," he says.

They ask the patients about their specific situation, what their pain is like, and why they think they need multiple prescriptions for controlled substances. They find out if the patients understand the purpose of their medication and the long-term dangers of taking large doses of medicines. "They dig down to find out the type of the pain the members are having, how the medication is working for them, and discuss other opportunities for relief. The conversations are tailored to the individual," he says. For instance, the case managers find out if the members have been referred for physical therapy and encourage them to go. They ask if members have an exercise program that can help with their pain or if their doctors have suggested other ways of dealing with pain, such as losing weight.

The case managers ask the members to identify one physician that they want to see for pain management. "We encourage them to use one doctor and one pharmacy. If they continue to use more than one physician, we may lock them into a pharmacy," he says. When that happens, when the member goes to another pharmacy, the CareSource system will advise the pharmacist that the prescription is not covered.

Members are enrolled in the program for 18 months. The case managers contact the members monthly and follow up on their progress, encouraging them to stay off the drugs and educating them on the dangers of overutilization of medication. They communicate any pertinent information to the patient's physician.

One key to the success of the program is the collaboration between the case managers and the physicians who are prescribing the medications, he says. "When members enroll, the nurses contact the prescribing physicians to let them know what is going on and get them engaged in the program. No doctor wants to be involved in facilitating addiction, and they are eager to work with us to help the members," Gartner says.

Most of the time, the doctors are not aware that their patients are getting prescriptions for controlled substances from other providers and are unaware of the amount of medication they are taking, Gartner says. "We let the physicians know that we aren't trying to control what they do but we are monitoring our members' drug use to make sure it's appropriate. We don't want to practice medicine, but we do advise the doctors when members are getting excessive amounts of medications and work with them to try to help the members overcome their addiction," he says.

When the doctors become aware that their patients are seeing multiple doctors and taking multiple medications, they talk with the member about the need for him or her to get off the medication, and the case managers reinforce what the doctors say during their monthly calls, he says.

"It's a challenge. People who are addicted to controlled substances are not going to change overnight. It's often difficult to get in touch with them because this is a transient population. The case managers make attempts to reach them every month and keep working at it," he says. ■

Health plan reaches out to Native Americans

Benefit covers the cost of traditional healing

Recognizing that many Native Americans have limited faith in Western medicine, Molina Healthcare created a Traditional Medicine Benefit that gives Native Americans with Molina's Medicaid coverage in New Mexico a stipend to spend on traditional care. The health plan has a similar program in Utah.

Molina wanted to honor Native American culture and traditional healing as a way to stay healthy holistically, says **Shelly Begay**, Native American Affairs manager for Molina in New Mexico. "A number of Native Americans have strong ties to their traditional culture and appreciate having this benefit to help out with the cost of services rendered by traditional healers," she says.

Molina consulted a number of Native American tribal leaders and learned that Native Americans often go to traditional healers for consultation or treatment because they don't feel comfortable going to see a Western doctor and some may not agree to see a doctor without the blessing of their traditional healer. "It was suggested that the health plan provide a benefit that allows Native Americans to tap into traditional healers to complement the use of Western medicine," Begay says. Molina's staff met with tribal leaders and community members in New Mexico and visited reservations in remote rural areas to get ideas on how the program should work.

Native Americans have a lot of economic and environmental challenges when it comes to accessing healthcare, Begay says. "We have 23 established identified tribes in New Mexico and many of their members have poor health outcomes that are made worse because of their social environment."

Molina established the Traditional Medicine Benefit as a complement to its Western medicine benefits. Members may apply for a stipend of up to $200 that they can use for traditional healing treatments such as herbal treatments or a purifying sweat lodge ceremony with a spiritual healer. The health plan implemented a similar benefit in Utah in 2011.

"We encourage our members to use traditional healing in coordination with Western medicine and preventive services. This way they receive holistic healing as well as physical treatment. We have made it clear that in no way do we want to interfere with the role of traditional healers," Begay says.

All members of Centennial Care, New Mexico's Medicaid program, are assigned a care coordinator. The care coordinators review the members' medical history and conduct an assessment of gaps in preventive care and other healthcare needs. Then they contact the members and work with them to obtain the care they need. If the members don't have a primary care provider, the care managers help them find one.

The care coordinators are well versed in social service organizations and health education programs in the community. They can help members identify resources in the community and help them overcome the barriers to obtaining medical care. For instance, many reservations are located an hour or more from the nearest medical facility and the members need help with transportation to see a provider.

"Care coordinators also refer members for the services they need, such as programs to help them stop smoking, and diabetes education programs," she says. They also help members access other benefit programs that provide financial assistance for medication, housing, or utilities.

Some of the care coordinators are Native Americans and live in the communities they serve. The entire team has been through cultural competency training and are familiar with Native American practices and beliefs. "Our staff respects our members' cultural practices and honor them," she says.

The members who receive the Traditional

EXECUTIVE SUMMARY

Molina Healthcare offers Native Americans covered by its Medicaid managed care plan a Traditional Medicine Benefit, which gives them a stipend to spend on traditional healing.

- The health plan developed the benefit as a way to allow members to tap into traditional care to complement the use of Western medicine.
- The health plan care coordinators do not ask questions about how the benefit is used but encourage members to tell their primary care provider about any herbal remedies or traditional treatment.
- Care coordinators help members overcome barriers to receiving medical care and access community resources.

Medicine Benefit stipend are responsible for choosing what services they want and for making arrangements to receive them. "We don't ask intrusive questions about what the benefit is used for, but we do encourage them to tell their primary care providers about any herbal remedies they may be using or other traditional treatment they have received," she says.

One of the goals of the program is to make sure members are aware of all the benefits that Molina offers. "We have an integrated staff from all disciplines that can help connect them with the care and services they need," Begay says.

Many Native Americans continue to receive health care at Indian Health Services, where they can get physical health and behavioral health services and fill their prescriptions at the pharmacy. "Indian Health Services and Tribal Clinics are part of our network, and we encourage our members to continue to utilize services at their local service units. The care coordinators assist members with seeking out services in their communities," Begay says.

New Mexico has a high poverty rate and many individuals could be eligible for Medicaid but have not signed up or don't know how to sign up. "New Mexico has expanded its Medicaid program to cover individuals ages 19 through 64. Many young individuals feel like they don't need insurance. We are educating a lot of people about benefits and encouraging them to enroll in Medicaid," she says.

"The purpose of the program is to make sure our members have better health outcomes and at the same time help individuals take charge of their overall health with the assistance of the care managers. We focus on making sure our members have the right resources and know how to access them," Begay says. ■

New guidelines for geriatric EDs

Recommendations cover many ED strategies

As documented in the CDC's National Hospital Ambulatory Medical Care Survey (NHAMCS), the population of patients being seen in American EDs continues to get older, except in EDs with a mission to serve children. This continues to be a quiet success story for the emergency system, as emergency care and public health efforts to reduce premature death from trauma, burns, and cardiac arrest have allowed the American population to enjoy much longer and healthier lives. Hospitals are increasingly focused on policies and practices that can more effectively meet the care needs of seniors. A number of hospital systems have opened specialized units or sections within their traditional EDS that are devoted to caring for older patients. However, until recently, hospital and ED administrators have had little in the way of guidance on how to proceed in developing a senior-focused ED, and most experts would acknowledge that data regarding outcomes and costs are still very much lacking in this area.

All hospitals except pediatric facilities are serving older populations, and there are already more than 50 EDs set up to cater to the needs of older populations, with more to follow. A cadre of groups, including the American College of Emergency Physicians (ACEP), the American Geriatrics Society (AGS), the Emergency Nurses Association (ENA), and the Society for Academic Emergency Medicine (SAEM), has jointly issued a comprehensive set of Geriatric Emergency Department Guidelines. *(The full guidelines can be accessed at www.acep.org/geriEDguidelines/.)*

While the guidelines provide a template of sorts, delineating what is required in terms of staffing and infrastructure to set up a geriatric ED, the authors stress that the new guidance is not just designed for administrators who are planning to open senior-focused facilities or units.

"The development of the guidelines was intended to really look at an evidence-based approach to not only managing care for seniors, but in developing a system of care for seniors when it comes to their emergency care, emergency management, and emergency partners," explains **Mark Rosenberg**, DO, MBA, FACEP, FACOEP-D, chairman of ACEP's Geriatric Emergency Department Guidelines Task Force, and chairman of Emergency Medicine, Geriatric and Palliative Medicine, St. Joseph's Healthcare System, Paterson, NJ. "So the guidelines involve not only the environment of care, but also transition of care strategies, and the assessment of delirium, dementia, depression, and a host of other screenings that are necessary when you are dealing with an older geriatric patient."

Rosenberg likens the emerging trend toward the creation of geriatric EDs to what happened

with respect to pediatrics a generation ago when hospital systems were building children's hospitals and pediatric EDs. "Now we are starting to see these [specialized] needs for seniors," Rosenberg states.

"The [intent] of the guidelines was to develop a standardization or at least a goal for EDs who want to specialize in better care for seniors."

Health care experts broadly agree that older patients have unique healthcare needs, but rapidly changing demographics and regulatory pressures have clearly pushed hospitals to consider these needs in a more comprehensive way. The new guidelines point out that according to the latest census figures, there were more than 40 million Americans older than the age of 65 in 2010, and that the population aged 85 and older is growing at a rate that is nearly three times faster than the rate of the general population.

The NHAMCS data also clearly show that older adults have a high demand for emergency care, notes **Timothy Platts-Mills**, MD, a co-author of the new guidelines and an assistant professor of emergency medicine at the University of North Carolina at Chapel Hill. "Older adults have a very high rate of acute, severe illness and injury … and additionally they have a lot of requirements for after-hours care," explains Platts-Mills, noting that he is speaking as a researcher and clinician rather than on behalf of the other guideline authors or of the sponsoring organizations. "Are there ways we can do this better? I think even though the evidence is not overwhelming for this, the answer is definitely yes. There are better and less better ways to do this."

To be sure, there are some documented benefits to senior-focused care. For instance, Rosenberg points out that patients who receive services in senior-focused EDs are more satisfied with their care. "We also know statistically that patient admissions go down, and this is measurable and quantifiable," says Rosenberg. "At my institution, we went from 54% to 46% of our seniors who would be admitted [from the ED]. And we know that we have seen a decrease in returns to the ED for the same complaint. Practically, that is because of improved patient transition-of-care strategies."

Even though more cost and outcomes data are needed, an increasing number of older adults are seeking emergency care, and more geriatric EDs are being developed. "This is all moving forward so we thought that at least having some expert consensus around what it is to have a geriatric ED, and what that should look like, was important even if the evidence isn't there yet to support every suggestion we made," says Platts-Mills.

'It takes a village'

Through structure and organization, the guidelines emphasize three main areas: staffing, follow-up and transitions of care, and education, says Platts-Mills. "These areas are where there is a lot of [potential] for administrators to improve the quality of care for older adults," he says.

Of particular importance is the way organizations use these three areas to identify and address the priorities of care for the older patient, says Platts-Mills. "Older patients vary a lot in terms of what their priorities are. Some are very high functioning and are sick and want maximal care, and some are not high functioning and they are sick and they may not actually want maximal care," he says. "Then some older patients aren't too sick, and they are able to go back to the community, but they may have a lot of disabilities, and so the potential for a well-run ED to help older adults return home or return to a nursing home safely is large. I think there is a lot of potential added value."

For instance, if an older patient presents to the ED because he fell in a nursing home, the care decisions made by a provider can vary greatly, says Platts-Mills. "You can spend a lot of money very quickly by doing tests in the ED, and I think emergency physicians realize this," he says. "But it requires extra time and support to have conversations with the people in the nursing home who saw what happened, with the family members to get a better understanding of what the preferences are, and then coordinating things at home to make sure that yes, there is a neighbor who can check on the patient and yes, there are home health people who can come by the following day, and yes, the primary care physician can see the patient within 48 hours."

All of this extra work takes time and energy, and EDs can only accomplish these tasks with the proper staffing and organization, but such resources can add tremendous value both to the patient and to the healthcare system, says Platts-Mills. "If you have a geriatric ED or the components of a geriatric ED — meaning a social worker, connections to a primary care system that

can take care of the patient, and resources in the community — then you can really make a big difference," he says. "Yes, it is complicated. It sort of takes a village to take care of older adults, so part of the role of the ED is being at the center of the village or one of the hubs of the village, and being connected to the other parts of the village."

Further, clinician education is central to providing effective care to the older patient, says Platts-Mills. "Medications are a common contributing factor to all sorts of adverse events, including falls," he says. "Also, [education about] looking for more subtle symptoms or presentations in the setting of trauma or acute coronary syndrome; signs and symptoms in older patients sometimes will not be as obvious."

Effectively caring for a geriatric patient requires added training in many different areas, adds Platts-Mills. "Some of this involves developing a comfort level in communicating with older adults and their families, treating their pain, and addressing their symptoms without having a fear of legal concerns or something else," he says.

Aim for a protocol-driven care system

Rosenberg reiterates that it is not reasonable or financially feasible for all hospitals to establish separate geriatric EDs or units. However, they can still rely on the guidelines to improve the care they provide to older adults. In fact, he notes that many of the changes that the guidelines recommend are not just good for seniors; they're better for all patients. For instance, with respect to environmental factors, non-slip, non-glare floors, dimmable lighting, thicker mattresses, and soothing paint colors make sense for all patients, he says.

All types of hospitals and EDs are planning to improve the delivery of services to older patient populations. Rosenberg recalls the administrators of a 6,000-visits-a-year ED wanted to create a senior-friendly ED — even though they only had about a half-dozen beds to work with. "I said let's make the whole ED more senior friendly," he says. "Let's look at the lighting and those types of things, but also for the 65-and-older population, let's come up with policies, protocols, and care strategies that will be uniquely beneficial for that age group, and that's what we did."

In his own setting, Rosenberg says there have been many improvements in care for senior patients, but one particularly obvious stride is that clinicians are doing a much better job of diagnosing cases of delirium — one of the conditions commonly misdiagnosed in the senior population. "It is hard to imagine how many cases we would have missed under the old model of care, but we are now doing delirium screening on everybody and we are picking up more cases," he says.

Similarly, by performing nutritional assessments on patients, clinicians are picking up more cases of malnutrition, a condition that puts seniors at risk for revisits to the ED, says Rosenberg. "It is not just painted walls, soundproofing, and thicker mattresses. It is a whole protocol-driven care system that is unique for the needs of seniors," he says.

However, Rosenberg acknowledges that the guidelines offer so many recommendations that it may be difficult for administrators to discern where to begin their senior-focused improvement efforts. Consequently, he is working with ACEP's geriatrics section to put together a work group to prioritize the recommended steps and practices. This way, if an administrator is planning to open up a geriatric ED, he or she will be able to focus on the most important things first, explains Rosenberg.

"Some things are very, very easy. The cost of creating a geriatric ED should not be unobtainable within the budgetary constraints that hospitals are going through," says Rosenberg. "You don't have to add big expense to get better care, better patient satisfaction … better management of patients whether they need admission or don't need admission, and better transitions of care. Much of this can be done by just coordinating [existing] resources."

If the Affordable Care Act helps to link more seniors with primary care providers, that should help EDs better focus their efforts on behalf of senior patients as well, says Platts-Mills. "Then, hopefully, there will be somebody who has a clear sense of what the patient's priorities are and what sorts of problems they face," he says.

However, Platts-Mills hastens to add that emergency providers should not worry that they will somehow be displaced by PCPs. "There is a common misconception that primary care, once it is set up properly, will make the need for emergency care go away, and that is not supported by any of the data that we have," he says. "Emergency care and primary care are not substitutes. Primary care increases the recognition that patients have medical problems and one of the

ways that we treat medical problems is through emergency care." ■

Geriatric medicine offers a roadmap to follow

Tenets can apply to complex patients

While an increasing number of hospital systems are creating senior-friendly EDs, one new study suggests that many of the tenets of geriatric medicine are also applicable to the care of patients with complex health problems, especially with respect to care transitions.[1]

"The main lesson that comes out of geriatrics is the whole idea of taking a holistic approach," explains **Alicia Arbaje**, MD, MPH, the director of transitional care research at Johns Hopkins Bayview Medical Center, and an assistant professor of medicine at Johns Hopkins School of Medicine in Baltimore. "[With these complex patients] it is not just about a particular disease. It is about how all those diseases interact with each other that makes a patient end up back in the ED."

Arbaje notes that while it is easier to focus on a particular disease, complex patients require providers to consider a bigger picture. "Focusing on disease-specific interventions such as a heart failure clinic or some sort of bridge clinic that is focused on a particular disease is not going to be as helpful to someone who has multiple chronic conditions," she says.

A second lesson from geriatrics is the notion that providers should not just consider the patient, but also their immediate home community and the health system in the region that cares for the patient. "Especially for frail, older people and others with complex needs, there is often a whole team of people who are trying to help," says Arbaje. "So spouses, children, the primary care practitioner [PCP], specialty physicians, social workers, and case managers also need to be included in interventions to help reduce readmissions."

It is not enough to just notify a PCP that a complex patient has been to the hospital or the ED, says Arbaje. "As doctors, we often say that as long we keep our patients safe, we have done our job. Our jurisdiction, so to speak, is the patient and maybe their family, but it is really much broader than that," she explains. Consequently, she stresses that it is important to facilitate an exchange of information to all the different receivers of the patient.

Too frequently, home health agencies are left out of the loop, says Arbaje. "They are often the ones who help manage these complex patients out in their homes and their communities … but often times they don't really get involved until after the fact," she says. "They may not know what changes have been made, and they are often relying on the patients themselves for this kind of information, and we can't let the patient be the only person providing this information."

As is the case with many geriatric patients, complex patients often have cognitive and/or functional impairments from whatever diseases they have. "Maybe it is diabetes and they can't walk very well, maybe it is arthritis, or maybe they are a dialysis patient and they have some cognitive issues around dialysis or functional impairments," notes Arbaje. "They can't move, they can't think, and they can't manage their healthcare. And that is a big driver of what is making people end up back in the ED, or making families frustrated that they can't handle the patient anymore and therefore the ED is the next place to send them."

Arbaje laments the fact that many of the interventions that have been developed to reduce readmissions and improve transitions of care stem from research on patients who don't have a very high level of cognitive or functional impairment. "[Interventions] really need to incorporate the fact that many of these patients may not be able to implement a discharge plan that an ED has so carefully put together," she says.

Consequently, Arbaje states that it is important to involve people who can assess the level of cognitive or functional impairment and identify community resources to address these deficits. This could involve referrals to physical or occupational therapists, for example. "In some cases, the solution may be as simple as giving the discharge instructions to someone who isn't cognitively impaired or functionally impaired, or making sure that the instructions are clear enough to be understood by the patient," she says. "There needs to be follow-up because we know that cognitive and functional impairment can get better over time."

Providers should keep in mind that there is only so much a patient or family can take on at one

particular moment. Therefore, spreading the information out to others who can take it and then also having a time frame to follow up when people may be better able to receive the information may make sense in some cases, says Arbaje.

Having ED-based care coordinators who can take on some of these responsibilities is one potential solution. "This can be a case manager or a social worker, but the key is there needs to be those resources for them to coordinate to," says Arbaje. "And there needs to be a sense of accountability around that."

To achieve this accountability, hospitals and EDs may need to work with outside resources to devise new solutions. For example, Arbaje notes that in recent years there has been a big push to make sure that PCPs are notified whenever they have patients who are being discharged from the hospital or the ED so that they can follow up. "That is very good, but the reality is that most PCP offices are not able to handle this information as it is coming in," says Arbaje. "There is usually not a workflow to pick that up. It is just not part of the culture. So you can push the information out, but there is usually not someone who can receive it."

One way to rectify the problem would be to have PCP offices establish a mechanism to receive that information and have someone call those patients, says Arbaje. "Maybe there could be a partnership between the PCP offices and the ED to have certain slots available for people who have just been seen in the ED," she explains. "There isn't one clear answer because people are still trying to figure this [problem] out."

With the emergence of accountable care organizations, more health care systems are experimenting with ways to get different parts of the health system to work more closely together to improve patient outcomes. With financial incentives behind such changes, more solutions should emerge, notes Arbaje. "The health systems that are going to be the most successful are going to be the ones that figure this out, embrace it, coordinate care, and establish a model that works for them."

REFERENCE

1. Arbaje A, Kansagara D, Salanitro A, et al. Regardless of age: Incorporating principles from geriatric medicine to improve care transitions for patients with complex needs. *Journal of General Internal Medicine* 2014 Feb. 21. [Epub ahead of print] ■

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's 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

- Tips on dealing with dual eligible patients
- Why the elderly need specialized care
- How your peers are preventing readmissions
- Ways that navigators improve patient care

CNE QUESTIONS

1. According to Catherine Mullahy, RN, BS, CRRN, CCM, president of Mullahy and Associates, LLC, case managers shouldn't view educational, cultural, or religious differences as barriers, but as opportunities to truly understand a patient population and individualize the approach used to help them maximize their health.
A. True
B. False

2. Why are foster children a challenging population to manage?
A. They have a lot of issues associated with poverty.
B. They often move from family to family and their medical records are scattered among multiple providers.
C. Foster families often have problems with transportation to physicians and dentists.
D. All of the above

3. How long do case managers in CareSource's CARE4U substance abuse program follow participants?
A. 1 year
B. 18 months
C. Six months
D. As long as needed

4. When Molina Healthcare's Native American members receive the Traditional Medicine Benefit, which gives them a stipend to spend on traditional healing, the care coordinators find out what services they accessed and notify their Western medicine provider.
A. True
B. False

CNE OBJECTIVES

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

CNE INSTRUCTIONS

Nurses participate in this continuing education program and earn credit for this activity by following these instructions.
1. Read and study the activity, using the provided references for further research.
2. Scan the QR code below or 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. ■