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

**August 2014:** Vol. 25, No. 8
Pages 85-96

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**Financial disclosure:**
Editor **Mary Booth Thomas**, Associate Managing Editor **Jill Drachenberg**, Executive Editor **Russ Underwood**, and Nurse Planner **Margaret Leonard** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

# Meet the challenge of managing care for dual eligibles

*Communication between providers is the key to success*

Individuals who are eligible for both Medicare and Medicaid are among the most challenging patients for whom case managers coordinate care.

Dually eligible beneficiaries represent only about 14% of the total Medicaid population, but they consume about 36% of the resources, says **Martin Samples**, senior vice president of marketing and product management for HealthX, a technology company that provides cloud-based solutions for healthcare payers.

"Providing care for the 9.6 million dual eligibles in this country costs over $300 billion a year. Even though there is a significant amount of money spent on healthcare, the care these individuals receive is often inadequate or poorly coordinated," he says.

Dual eligibles typically require care from multiple physicians, specialists, and home and community service providers who may not communicate or coordinate care with each other. Not only is it costly to provide fragmented care, when dual eligibles have poor outcomes it can impact a health plan's HEDIS (Healthcare Effectiveness Data and Information Set) scores and Medicare Advantage Star ratings, Samples points out.

Beneficiaries who are eligible for both Medicare and Medicaid have complex and long-term medical and social services needs and often have

EXECUTIVE SUMMARY
Individuals who are dually eligible for Medicare and Medicaid have complex medical and social service needs, and many also have behavioral health issues, making coordination of care a challenge.
• Coordinating both the social needs and medical issues is critical.
• Communication among providers is essential to eliminate fragmented care and poor outcomes.
• Educating members about the need for preventive care and screenings improves their health as well as health plans' quality scores.

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behavioral health issues as well, says **Pamme Taylor**, vice president for advocacy and community-based programs for WellCare Health Plans, based in Tampa, FL.

"The individuals in the program have critical needs, and the best place to meet their needs is not always in the hospital setting. Home or a community-based setting may be the best environment for them, but often the system is not set up to support them in the home as effectively as possible. Being able to coordinate the social issues as well as the medical issues is really critical," she says. *(For a look at how WellCare coordinates care for dual eligible members, see article on page 88.)*

People who are eligible for both Medicare and Medicaid are challenged by low socioeconomic status as well as healthcare issues, points out **Jeri Peters**, RN, BSN, vice president and chief nursing officer for UCare. In addition to physical and mental health issues, many dual eligible members need help with housing, meals, transportation, and support in the community, she adds.

UCare, with headquarters in Minneapolis, provides coverage for dual eligibles through two different programs, based on the individual's age. Members who are over age 65 are covered by the Minnesota Department of Human Services' Minnesota Senior Health Options program. UCare manages both the Medicaid and Medicare benefits for this population. Through UCare Connect, UCare manages the Medicaid benefits for members ages 18 to 64 who have been certified as disabled and meet certain financial guidelines, Peters says. *(For details on both programs, see page 90.)*

The problem of coordinating care for dual eligible patients is complicated by the fact that Medicare is a federal government program and Medicaid is run by the states and the benefits are not always aligned, Taylor says.

Boston-based Network Health is participating in the Massachusetts Medicare-Medicaid demonstration project, which integrates Medicare and Medicaid benefits for people who are dually eligible for both programs. *(For details, see related article on page 87.)*

One of the keys to providing high-quality care to dual eligibles is establishing lines of communication among all of the providers and organizations providing services, Samples says. "The technology used by the entire team needs to be integrated to allow all providers to see what the others are doing. Collaboration is a huge part of it. When providers do not collaborate, the care is fragmented and the results are poor," he says.

Samples recommends better care coordination for dual eligibles through education about gaps in care, wellness, and preventive procedures such as mammograms and other kinds of screenings.

Not only does this improve their health, it can help insurers improve their quality scores, he adds. He suggests a holistic communication strategy engaging member, payer, and provider in strategies to close those gaps in care.

"In a rapidly changing healthcare environment, it is critical for health plans to stay ahead of the curve. When you achieve better care coordination

Case Management Advisor™ (ISSN# 1053-5500), is published monthly by AHC Media LLC, One Atlanta Plaza, 950 East Paces Ferry Road NE, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Website: www.ahcmedia.com. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

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

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: U.S.A., **Print:** 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $419. Add $19.99 for shipping & handling. **Online only, single user:** 1 year with free Nursing Contact Hours or CMCC clock hours, $369. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Back issues, when available, are $75 each.(GST registration number R128870672.)


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This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.
This activity is valid 24 months from the date of publication.
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and communication among care managers, primary care physicians and specialists, and community-based providers, you drive better outcomes for the dual eligible population, improve performance on quality measures, and save healthcare resources by improving operational efficiencies," he says. ■

# Team effort keeps members independent

*Project integrates Medicare, Medicaid benefits*

A demonstration project that integrates Medicare and Medicaid benefits for Massachusetts residents who qualify for both programs is helping participants get all the services they need to remain independent, says **Helene S. Forte**, RN, MS, PHM, vice president for care management for Network Health.

The Commonwealth of Massachusetts selected Medford, MA-based Network Health, a division of Tufts Health Plan, as one of three managed health plans participating in the Massachusetts One Care demonstration project to administer the services. Network Health provides health care coverage to Massachusetts residents with disabilities and low or moderate incomes.

The members in the One Care demonstration project are ages 21 to 64, are enrolled in Medicaid, and have a disabling condition that makes them eligible for Medicare, Forte says. People in the program have significant chronic physical and mental health issues. Some struggle with substance abuse, are homeless, and have major social needs.

"These members receive fragmented care. A lot of time, they see multiple providers with no one to look at them holistically and make sure the services are coordinated. They have trouble navigating the healthcare system, and often they don't realize some of the benefits they are eligible for," Forte says.

The purpose of the demonstration program is to coordinate all of the services and resources the individuals need and help them be as independent as possible, she says.

When participants are identified for the program, the state notifies them of their eligibility and sends them a packet explaining the One Care program. When members enroll, Network Health sends them information specific to their plan, called Network Health Unify. Then the Network Health outreach staff calls the individuals, explains the program, determines if they have immediate needs, and schedules an assessment by a clinician. The assessment may be at the member's home, a community center, or a provider office — wherever the person feels most comfortable, Forte says.

A care manager, either an RN, a licensed mental health professional, or a social worker, is assigned to the member based on the initial information Network Health has received about the member. If the member's needs appear to be mostly medical, an RN case manager conducts the assessment. If they primarily have behavioral health issues, a mental health professional or social worker is assigned, she says.

After the assessment is completed, a multidisciplinary team meets to develop a plan to coordinate the care and meet the member's needs. Services are tailored to meet each individual's needs.

The Network Health members of the team include the RN care manager, the behavioral health care manager, the social work care manager, the community outreach staff, the medical director, and pharmacist.

If the member is already receiving other services, representatives from those organizations are included on the team. For instance, the Visiting Nurse Agency case manager would attend if the member is receiving home health services. If the member is receiving Long Term Services and Support (LTSS), the person who oversees the coordination of services would attend. The member and family members or caregivers are also part of the team. Some of the team members attend in person, but most attend by conference call, Forte says.

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EXECUTIVE SUMMARY

Network Health is participating in a demonstration project that integrates Medicare and Medicaid benefits for individuals ages 21 to 64.

- Care managers conduct an extensive face-to-face assessment in the home, a community center, or provider office.
- A multidisciplinary team takes the information from the assessment and develops an individual plan to coordinate care and meet the member's needs.
- A community advisory council, made up of members in the program, meets quarterly to give the health plan feedback.

The care manager shares the information from the assessment, including the members' needs and challenges. Using that information, the team works with the member and family members to develop a plan of care and goals for the member, she says.

"The team pulls all the pieces together by identifying all the members' needs and setting in motion ways for the member to access all the components of care. The care manager follows up with all the disciplines involved and works with the members on an ongoing basis to make sure all the needs and goals are being met," Forte says. The care managers follow up with the members as frequently as necessary until they become more self-sufficient, then taper off but continue to follow them.

After the care plan is in place, the team members continue to meet as needed to monitor progress and make changes in the plan when necessary. "These members have very complex needs, and we expect that things will change. We may need to pull the team together periodically when the members' care needs escalate or there is another change," Forte says.

To keep everyone on the same page, Network Health has set up a centralized record system with information on all enrollees. The member controls which team members can have access to sensitive information. The interdisciplinary team can access the records and add documentation and all providers have access to the information so they know what services and supports the member is receiving, Forte says.

Often during their meetings, the multidisciplinary team can uncover problems that have frustrated the members and work to solve them so the members will have what they need to become more independent, Forte says.

A case in point is a 58-year-old woman with medical and behavioral health issues. Her physical disability impacted her mobility and her ability for self-care. She had been unsuccessful in getting her physician to understand her need for a motorized wheelchair to help her become more independent. "She had been seeing the same primary care provider for 18 years but didn't feel like he was hearing her," Forte says.

The care manager listened to her concerns and gave her tips on communicating with her providers, she says. When the multidisciplinary team discussed the case, they made sure the woman's physician was present.

As a result of the meeting, the Network Health and Long-Term Services and Support team worked with Easter Seals to get the woman the equipment she needed, Forte says.

"The member told us that this was the first time she felt like her physician had listened to her. The new equipment made her more independent and she was feeling less stress. By partnering with the member, we were able to help her deal with her issues and become more involved in caring for herself," Forte says.

Network Health has developed a community advisory council, comprised of members in the program, which meets quarterly to share their experiences. Council members give the health plan input on what parts of the program are working well and have identified areas of improvement. "We've had three meetings, all of which were very interactive. They have given the care managers a lot of accolades and given us good information. It's working very well," says **Kathleen Connolly**, vice president of sales, marketing and products, and executive director of the Network Health Unify plan. "As confirmed by the members themselves, the goal of One Care to provide seamless care management program for our members seems to be on track," she says. ■

# Meetings help CMs meet members' needs

*Building trust helps the care plan succeed*

When individuals who are eligible for both Medicare and Medicaid are enrolled in WellCare Health Plans' special needs programs for dual eligible beneficiaries, a case manager meets with them in their home or other care setting and conducts a thorough assessment of the individual's needs, says **Pamme Taylor**, vice president for advocacy and community-based programs for the Tampa, FL-based managed care organization.

"Meeting these individuals in person is essential in establishing rapport and building a relationship. The individuals need to trust us before they reveal the details of their life circumstances, which are so critical to know in developing a plan of care," she says.

WellCare's special needs plans for dual eligibles differ slightly depending on the Medicaid rules in

the state in which they are administered, but in all instances, the case managers work closely with the members and all of their healthcare providers to make sure all of the members' medical, behavioral health, and social needs are met, she says.

The case managers WellCare assigns to work with the dual eligible population must be detail-oriented and able to ask probing questions, but at the same time, they should understand human nature and be caring and sympathetic, she says. "The people who are dually enrolled have so many health issues and so many barriers to care. We have to spend a lot of time identifying all the nuances," Taylor says.

Over time, the clients get to know the case managers and bond with them, often revealing information and problems they never would tell their healthcare provider. "We don't act like representatives of an insurance plan. That doesn't build a level of trust. We treat them as if they are our family and that their health and well-being is important to us," she says.

WellCare's health risk assessment involves far more than just asking a set of questions, Taylor says. The case managers, usually nurses and social workers, look at the individual's living environment, social support system, and physical condition and get all the information needed to develop a plan that makes the most sense for them.

"We look at everything — the circumstances at home, the person's support network, the physical, mental, and social services that they need. We make sure they live in a safe environment and can dress, groom, and feed themselves. We determine if they have a social support system, if they have access to transportation, if they need help with home maintenance or lawn care, and on and on," she says.

The case managers also assess the needs of the caregivers. "We may not be able to provide actual care for the caregiver, but we do give support to help them assist the patients with their activities of daily living," she says.

The care manager takes the information gathered during the assessment and works with WellCare's interdisciplinary team to develop and implement a care strategy. The team includes social workers, nurses, a medical director, and a behavioral health coordinator. The team involves family members and/or the primary caregiver for the individual and drills down to determine what is happening in the patient's life and what kind of support is available in the home.

"Our interdisciplinary care team cannot provide treatment for the patients. That is provided by their physician office and other members of our network. Our team devises a care plan based on what we see in the home but they also work closely with the clinicians to make sure the individuals get everything they need," she says.

The WellCare team regularly holds grand rounds on each patient to make sure all the bases are covered.

"We have a view of the entire care continuum, something the individual providers don't have. The behavioral health clinics have a piece. The primary care providers have a piece. We bring it all together," she says.

The case managers visit patients in their homes at intervals determined by patient needs and follow up by telephone between visits.

When the nurses visit the homes or follow up with patients on the telephone, they often uncover new symptoms or life circumstances and alert the primary care provider or behavioral health professional. For instance, Taylor says, one patient with a comorbid diagnosis of depression was hospitalized for a medical condition. When the case manager called to confirm that the patient had transportation to her follow-up appointment, she learned that the family's dog had died. She alerted the patient's physician, who arranged counseling and ensured that the medication regimen was stable to help the patient during the grieving process.

The case manager who performs the assessment has the primary relationship with the individual in most cases but sometimes may not have the clinical expertise to be the lead on the case, Taylor says. For instance, if a patient is severely depressed as

EXECUTIVE SUMMARY

WellCare Health Plans' case managers meet face to face with dual eligible members and conduct an assessment that looks at the individual's living environment and social support system, as well as medical and behavioral health issues.

- An interdisciplinary team that includes the member and caregivers develops and implements a care strategy.
- The team members work closely with providers to ensure that all components of the plan are met.
- WellCare has created a social safety net database of social service organizations and other community resources organized by ZIP code to assist case managers in meeting the members' needs.

well as having a medical condition, a behavioral health clinician may take the lead until the depression is resolved while the nurse coordinates the clinical part of the treatment plan.

The case managers have access to a social safety net database with detailed information on all the available social service organizations and other resources in the community. The database is organized by ZIP code so the case managers can locate organizations that are convenient to the members.

WellCare hired teams of researchers to create the database and piloted the process in Kentucky, starting with 2,500 organizations. Now, three years later, the database includes 6,700 organizations that represent about 300,000 services.

"We also created an electronic health record just for social services. Every time we connect a member to the social program, we track who the member is, what services they need, what organization they are referred to, and whether the person actually received the services. We are working to automate the process so the case manager can send referrals directly to the organizations," Taylor says. ■

## CMs help multiple providers communicate

*Coordination varies by member needs*

UCare members who are eligible for both Medicare and Medicaid are enrolled in one of two different programs, depending on their age.

Members who are dual eligible and over age 65 are covered by the Minnesota Department of Human Services' Minnesota Senior Health Options program. UCare care coordinators manage the integration of both the Medicaid and Medicare benefits for this senior population.

Individuals ages 18 to 64 who have been certified as disabled and meet certain financial requirements may enroll in UCare Connect, a special needs program that offers healthcare coverage for adults with disabilities who qualify for Medicaid. About half of the members in UCare's plan also qualify for Medicare.

UCare manages the Medicaid benefits for the younger UCare Connect members and helps those members eligible for Medicare access those benefits, says **Jeri Peters**, RN, BSN, UCare's vice president and chief nursing officer.

The care coordinators are the hub for communication among the multiple providers who treat dual eligible members. "They ensure that everyone on the interdisciplinary team who is treating the member is aware of the comprehensive plan of care, including interventions and services other providers have developed and the medications they have prescribed. This helps eliminate duplication of services and keeps all the providers on the same track," Peters says.

Many of the dual eligible members have behavioral health issues along with physical issues and chronic conditions. A large percentage of them also need assistance with housing, meals, transportation, and support in the community.

Generally, UCare care coordinators live in the same community as the members they work with and are familiar with the resources that are available within the members' communities, Peters says.

"We believe care coordination is best done at the local level and contract with local entities, such as counties, local agencies and care systems in areas throughout Minnesota where we do not have our own case management staff. Regardless of whether they are our own employees or delegates working on our behalf, the care coordinators follow all of UCare's procedures for elderly and disabled members," Peters says.

UCare has different care models for the dual eligible populations, based on several factors including population analysis, demographics, and

EXECUTIVE SUMMARY
UCare's care coordinators are the hub for communication among providers treating the Minneapolis health plan's dual eligible members enrolled in one of two care plans depending on their age.
• Most care coordinators live in the same community as the members with whom they work so they are familiar with the resources in that community.
• Members who are over 65 are assigned a case manager who conducts a face-to-face assessment of medical, behavioral health, and social needs and follows up with them at regular intervals.
• Younger members, who are part of UCare's special needs program for adults with disabilities who qualify for Medicaid, tend to be more independent and many prefer to manage their own care.

contractual obligations with payers and regulators. UCare assigns a care manager to members who are 65 and older. Within 10 days after enrollment, a care coordinator contacts them and sets up an appointment to visit them in their home and perform a health risk assessment that includes an assessment of their medical, behavioral health, and social needs.

A care coordinator conducts a face-to-face health risk assessment and identifies gaps in care and services that the individual needs, Peters says. The members often need medical and behavioral healthcare services and have multiple social needs.

The care coordinators develop an individualized care plan that addresses gaps in care and social needs, and work with the members to set mutual goals and identify services and interventions for meeting them. Then they work with the member to establish goals and strategies for meeting them. If members do not have a primary care provider, the coordinators help them identify one and can assist them in scheduling appointments.

"The care coordinators look at the full range of services — medical, behavioral, and long-term services — to fill each individual's needs and facilitates access to the services through the interdisciplinary care team. The primary care provider is always part of the team. Other clinicians and providers join the team as members need services," she says.

During the home visit, the care coordinators ask the members to show them all the medications they take, along with vitamins and supplements, Peters says. They review the medication and make a list of everything the members are taking and forward it to a UCare pharmacist for review. If there are duplications or other concerns with the medication, the pharmacist contacts the prescriber, she says.

The care coordinators at UCare help members get connected to nutritional programs like food stamps, food banks, or local farmers markets. They arrange transportation to medical appointments, day treatment programs, and in some cases, social activities such as senior day treatment. They help them find affordable housing that is safe and sanitary. They can help seniors find someone to perform repairs, help with housekeeping, and prepare food, Peters says.

The care coordinators stay in touch with the senior members regularly for a minimum of six months, contacting them as frequently as needed and tapering off the visits as the members become more self-sufficient, she says. They conduct a full reassessment and review the plan of care each year.

The care coordinators fax a copy of each member's plan to the primary care provider and communicate with the entire disciplinary team as needed, Peters says.

UCare care coordinators offer all disabled members a face-to-face assessment and about 50% to 60% take advantage of the offer. Dual eligible members under age 65 are eager to self-manage their conditions and maintain independence, Peters points out.

"Many are doing a good job of self-managing and they don't need our assistance. Our care coordinators educate the members on the need for preventive care screenings and identify gaps in services the younger dual eligible members need. The care coordinators always offer to facilitate access to services and help make appointments while remaining sensitive to the fact that many members prefer to make arrangements themselves," she says. ■

# Patient flow scorecards show complexity

*Approach relies on multidisciplinary team*

A common refrain of ED administrators is that when it comes to patient flow, there is only so much they can do to eliminate wait times when the upper floors cannot quickly accommodate admissions from the ED. Further, numerous studies have shown that capacity problems of this nature can impact care quality and patient satisfaction scores.

Recognizing that such problems are difficult to resolve without fully appreciating the interdependence of multiple departments, and the many different factors that ultimately impact the flow of patients through the hospital, investigators at Children's Hospital of Philadelphia (CHOP) developed a five-domain patient flow scorecard, designed to capture the complexity that is inherent in the patient flow process and to highlight specific areas where ripe opportunities for improvement exist.

While the approach is being continually refined, leaders of the effort note that it has helped them home in on the specific reasons for hold-ups so resources can be focused in the most effective way while also giving hospital administrators and staff a larger, holistic view of the patient flow process.

## Establish a multidisciplinary team

The new approach was initiated in the summer of 2009 after hospital administrators identified patient flow improvement as a priority, explains **Evan Fieldston**, MD, MBA, MSHP, medical director of care model innovation and an attending physician in the Division of General Pediatrics at CHOP, and the lead author of a research paper on the project.[1]

"I have been involved for many years in our patient flow quality improvement activities and thought that we needed better systems of measurement," says Fieldston. "While the ED in many places is a large microsystem, it is also in a concentrated place with concentrated staff. For our hospital, we have 500 beds [with 9,000] people distributed in over 21 physical locations, each with their own dynamics and operational flows."

Among the problems administrators encountered when measuring performance was that individual measures, such as the time between arrival in the ED and admission to an inpatient floor, did not adequately reflect the complexity of the patient flow process. Further, administrators were concerned that trying to improve one isolated measure could adversely impact another, simply moving the problem rather than making the overall process better.

Consequently, researchers sat down with a multidisciplinary team to develop a patient flow scorecard that captured data from five domains, including:

- ED and ED-to-inpatient transition;
- bed management;
- discharge process;
- room turnover and environmental services department activities; and
- scheduling and utilization.

Within these domains are several more component measures that are assigned one to four points. For instance, there are eight individual component measures within the "ED and ED-to-inpatient transition" domain. These include various time intervals, such as "arrival to physician evaluation," with the goal of 80% of patients seeing a physician within 60 minutes; "ED physician evaluation to decision to admit," with the goal of 80% occurring within 240 minutes; and "decision to admit to MD report complete," with the goal of 80% occurring in 120 minutes. Each of these components receives four points on the patient flow scorecard, with five other component measures in the ED domain receiving fewer points.

For example, three points are aligned with "RN report to patient floor," with the goal of 80% occurring within 60 minutes; two points are aligned with "ED length-of-stay (LOS) for non-admitted patients," with the goal of 80% of patients having an LOS less than 300 minutes; and one point is aligned with a "leave without being seen (LWBS) rate," with the goal of less than 3%.

Also included in the ED domain are "ED admission rate" and "ED volume" adjusting measures, each of which is aligned with one point. These enable administrators to adjust the scoring based on the severity of patients visiting the ED and high volumes.

While the number and type of components differ within each domain, the total number of points associated with each domain is the same at 20 points, adding up to a maximum patient flow composite score of 100 points.

## Tie entry points to workflows

When selecting metrics to be included on the patient flow card, developers looked not just for overall relevance to patient flow, but also for items that were automated, explains Fieldston. "We wanted something that would be relatively easy to use, so [all the measures] come from any number of the variety of electronic systems in the hospital," he says.

While there was not much disagreement about which time intervals were important in the emergency setting, coming up with the best metrics to use was still challenging, according to **Nicholas Tsarouhas**, MD, medical director of the emergency transport team and associate medical director of the ED at CHOP, and a co-author of the research. Tsarouhas notes that the ED at CHOP sees nearly 90,000 patients a year, so it is a very busy department.

"You need a starting point and an ending point, and then you need the users to be compulsive about entering those time points," he says. "So the challenge [revolved around] potentially disrupting someone's workflow and making them go to a computer to hit a button."

To make such entries or time stamping as easy and efficient as possible, developers endeavored to tie the key time entries to parts of the ED workflow that made it practical for someone to be at the computer when the entries needed to be made. For example, the nurses were instructed to always

note in the computer whenever a patient is leaving the ED to go to an upper floor, but the challenge was getting the staff to do this consistently. "Sometimes [these types of entries] are made before the patient leaves; sometimes the nurses forget and they wait until they take the patient upstairs and they come back down and do the time stamp when they return," says Tsarouhas. "So even though the job is actually done, when you time stamp it is very important."

Another challenge with the patient flow cards was trying to make sure that hospital staff fully appreciated the results. "As much as there is a problem with single measures not giving you a holistic picture of what is happening, a multicomponent patient flow scorecard also has its complexities in the ability of people to understand it," says Fieldston. "Getting used to it, and getting people to understand the overall flow as well as how the various pieces connect together, is a communications and a culture issue."

To help with understanding, developers used color descriptors. For example, when staff met or exceeded a particular component goal, the results were in the "green" category. Results that were 10 percentage points below the goal fell into the "yellow" category, and performances below this level were in the "red" category. Domain and overall composite scores were likewise color-coded, with performances of 16 or above on the 20-point domain scale or 80 and above on the overall composite score presented in green, scores between 70% and 79% in yellow, and scores below that level in red.

Fieldston notes that the patient flow team also communicated directly with the teams and subteams for the particular domains, sending out scores or sub-scores with explanations about what was happening with respect to the different parts of the patient flow process.

## Engage frontline staff on metrics

Even with the added level of complexity, developers say the approach has helped the hospital better home in on the specific areas that need improvement. "All of our metrics are broken down into sub-metrics, and the sub-metrics let us look at the areas that need focus," says Tsarouhas.

For example, from the scorecard results, administrators were able to discern that the bed-cleaning process was not commencing quickly after patients left beds, delaying the availability of the beds to new patients. "Examining our metrics enabled us to see that there was a lot of down time when the rooms were empty and nobody knew that someone should start cleaning," says Tsarouhas. "That was an example of where we tried to close that gap."

In response to those metrics, the improvement team decided to link the process of removing a patient from the ED tracking board with a notification to environmental services that the bed needed to be cleaned. "What we realized is if you tie workflows together, that makes the data better because … when you tie one operation to the next, you get more efficiency," says Tsarouhas.

Also in response to these data, environmental services reorganized their workforce, and the changes produced improvement. "In that way, rather than just looking at one global number [showing] how long patients spend in the ED or what time they get discharged, which doesn't really cause other members of the team to connect to the process and the improvement work, we were able to provide all of the key stakeholders in the patient flow progression with information that they could respond to," says Fieldston.

The metrics utilized in the patient flow cards are continually refined, and developers are always looking for new and better ways to present the information in the most concise and meaningful way, explains Fieldston. His advice to others interested in employing a similar approach is to engage frontline staff on what is important to patient flow and what metrics to follow.

"We have identified some important time stamps in patient progression, but by no means are these the only steps in the process, and our values may be different than what other places have," says Fieldston. "I also think that pairing the [patient flow card] approach with things like process mapping and value stream mapping, so that organizations can understand the key steps in their patient flow processes and identify where there are opportunities for improvement, are crucial steps in patient flow improvement."

Tsarouhas observes that the overall focus on patient flow was well received in the ED. "We always feel that it is so important to our optimal functioning that we move patients out efficiently so that we can bring other patients in," he says. "The scorecard itself is just an objective way for us to measure some of our processes to hopefully provide objective data to help drive improvement work."

However, Tsarouhas adds that a multidisciplinary group needs to drive the improvement process. "It doesn't work if there are just doctors or nurses or administrators," he says. "The success of our programs has really been predicated on every one of our meetings including doctors, nurses, nurse practitioners, people from environmental services, people from bed management, and people from administration who are all in the same room, and all committed to the work."

Further, for any improvement to work, there needs to be high-level executive support, says Tsarouhas. To win this support, you have to present good data, he says. "If you can give data to the executives and they can see where the areas for improvement are, that makes it easier for them to support the work."

REFERENCE
1. Fieldston E, Zaoutis L, Agosto P, Guo A, et al. Measuring patient flow in a children's hospital using a scorecard with composite measurement. *Journal of Hospital Medicine*, 2014 April 18. [Epub ahead of print] ■

# Patient sitters effective in reducing falls

*Study explores the benefits*

Patient sitters are a somewhat controversial strategy for reducing patient falls, with many administrators arguing that the cost of paying someone to sit in a room and watch a patient all day cannot be justified. A recent study, however, suggests that patient sitters can be cost effective and significantly reduce falls.

The cost savings achieved in decreasing rates of falls with harm, both in terms of money saved and decreased severity of injury, might justify the costs associated with implementing and maintaining a sitter program, says lead author **Michelle Feil**, MSN, RN, senior patient safety analyst with the Pennsylvania Patient Safety Authority in Harrisburg. Feil and her co-author both have risk management backgrounds.

They analyzed data from 75 hospitals participating in the Hospital and Health System Association of Pennsylvania Hospital Engagement Network Falls Reduction and Prevention Collaboration.[1] (The full study is available online at http://tinyurl.com/lyfw9tn.)

Their analysis revealed a statistically significant correlation between low rates of falls with harm and the use of sitter programs. A statistically significant correlation also was identified between low rates of falls with harm and three specific sitter program design elements: defining criteria for sitter qualifications, providing a training program for sitters, and establishing a pool of sitters.

Analysis of falls suggests that the use of sitters might be associated with a higher percentage of assisted falls and a lower rate of falls with harm, Feil explains. "The key is to have a pool of sitters and a process in place to make sure you are utilizing sitters appropriately," Feil says. "There has been research in the past that suggested sitters did not effectively reduce falls, but what they did not account for was who was in the role and whether they had specialized training. It takes time, money, and effort to implement these programs and to do it correctly."

Patient sitters also are sometimes called patient safety assistants, companions, and one-to-one or constant observers. In any case, they are staff members or volunteers assigned to provide direct observation of patients at risk to harm themselves or others.

One-on-one observation and assistance might seem like a surefire, if expensive, way to prevent falls. But Feil says research into the clinical effectiveness of sitter programs has produced inconsistent results. The cost-effectiveness of these programs is always in question, she says.

Feil's research, however, found a statistically significant correlation between lower rates of falls with harm and the use of sitter programs, as well as specific sitter program design elements. The study also identified specific sitter program design elements that should be used to structure sitter programs.

The data came from a state survey that was designed to evaluate the current structure and content of hospital falls prevention programs compared with evidence-based, best practice guidelines. Hospitals were asked to report the level of implementation (no implementation, partial implementation, or full implementation) for individual falls prevention practices and falls prevention program elements across 17 categories of falls prevention practices.

The use of patient sitters was the third lowest scoring category of practices. Forty-eight of the

75 hospitals surveyed reported having sitter programs, of which 21 reported full implementation of six specific design elements of sitter programs.

"I think if cost were not an issue, more hospitals would have sitter programs, but cost is clearly an issue," Feil says. "But we can see that though it takes money to find these sitters, train them, and to pay them for their hours, a hospital also can suffer huge costs if there is a fall because a patient needed constant observation and you weren't able to provide it."

REFERENCE
1. Feil M, Wallace SC. The use of patient sitters to reduce falls: best practices. *Pa Patient Saf Advis* 2014; 11(1):8-14. ■

# Readmitted patients more likely to die

Patients released from one hospital and readmitted to another within 30 days are more likely to die within the next month than those readmitted to the same hospital, according to a study from Canada.

Researchers analyzed data from about 200,000 patients who were readmitted to 21 hospitals in the Toronto area. About 20% were readmitted to a different hospital than the one they recently left. The study was published May 1 in the *Canadian Medical Association Journal*.

The death rates after 30 days were 19% for those readmitted to the same hospital and 22% for those readmitted to a different hospital. Patients readmitted to a different hospital tended to be older and to have more health problems, but the increased risk of death remained after the researchers accounted for these factors, according to the study led by John Staples, MD, a physician with the Institute for Clinical Evaluative Sciences in Toronto.

While the study found an association between higher death rates for patients and readmission to a different hospital within a month after discharge, it did not prove a cause-and-effect relationship.

"One interpretation of these findings is that alternative-hospital readmission can compromise patient safety," Staples said in announcing the results. "Yet it's also possible that these findings reflect the greater burden of illness among alternative-hospital patients, particularly if that burden of illness wasn't fully captured in the databases we used." ■

## 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

- Home-based care gains in popularity
- How your peers are reducing readmissions
- Having the palliative care conversation
- Helping members choose the right level of care

# CNE QUESTIONS

1. According to Martin Samples, senior vice president of marketing and product management for HealthX, a technology company that provides cloud-based solutions for healthcare payers, how much does it cost to provide care for dual eligible beneficiaries each year?
A. More than $300 billion
B. More than $30 billion
C. More than $3 billion
D. More than $9.6 billion

2. What is the clinical background of Network Health care managers who work with dual eligible beneficiaries?
A. RN case manager
B. Licensed behavioral health professional
C. Social worker
D. All of the above

3. WellCare's interdisciplinary care team cannot provide treatment for the patients, but devises a care plan and works closely with clinicians to make sure the individuals get everything they need.
A. True
B. False

4. How long do UCare care coordinators follow senior dual eligible members?
A. 30 days
B. Three months or longer
C. A minimum of six months
D. As long as the members needs it



# 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 to the right or log on to www.cmecity.com to take a post-test. 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. Complete and submit and evaluation form.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■