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Covering Case Management Across The Entire Care Continuum

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'The world is our oyster,' says CMSA Lifetime Achievement winner

Case management now is in the spotlight

When **Margaret Leonard**, MS, RN-BC, FNP, talks about case management and the impact case managers can have on patients and the healthcare system, her voice resonates with the passion she feels for her profession.

"The world is our oyster right now. Administrators, physicians, health plan officials, politicians, and individual patients are recognizing care coordination as a valuable service, and people are beginning to understand how the care coordination piece benefits the bottom line," says Leonard, senior vice president for clinical services at Hudson Health Plan in Tarrytown, NY, a member of MVP Health Care family of companies.

"The Affordable Care Act and other healthcare reform legislation all include the concept of care coordination as a standard of quality for healthcare. This is opening up new areas of practice for us and creating a whole world of new opportunities," she adds.

Leonard, Nurse Planner for *Case Management Advisor*, was recently presented the Lifetime Achievement Award by the Case Management Society of America, an organization Leonard has served as president and board member as well as chair of numerous task forces and committees.

EXECUTIVE SUMMARY
Margaret Leonard, who recently was presented the Lifetime Achievement Award by the Case Management Society of America, points out that the Affordable Care Act and other legislation all include the concept of care coordination.
• As president of CMSA, Leonard focused on increasing awareness of the value of case management.
• These days, case management representatives are meeting with the White House and officials at the U. S. Department of Health and Human Services.
• She urges other case managers to get involved at the organizational, local, state, and national levels and make their voices heard.

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She is only the sixth recipient of the prestigious award.

Through the years, her tireless work to gain recognition for case management has earned her a national reputation as a case management advocate.

When Leonard became president of CMSA in 2009, her focus was increasing recognition of the value of case management, particularly among lawmakers and movers-and-shakers in the healthcare field.

In an interview with *Case Management Advisor* at the time, she commented: "We've gotten into the legislative game. We are working with partners who have political action arms, and they have been very generous in sharing their knowledge and their connections at the Centers for Medicare & Medicaid Services and the Office of Budget and Management."

After her term of office was up, she continued to work for recognition of case management. She was chair of the CMSA Public Policy Committee for eight years and now holds the title of chair emeritus. She also serves as chair of the National Transitions of Care Collaborative Public Policy Task Force. Both organizations are working for legislation that promotes transitions of care and care coordination, Leonard says.

Those early efforts paid off. Representatives of both organizations, including Leonard, have been invited to discussions about healthcare at the White House and at the U.S. Department of Health and Human Services.

"We are not changing the world overnight, but we are being listened to at every meeting. Policymakers are beginning to recognize and pay attention to case management and the standards we promote," she says.

It was when she was working with the Visiting Nurse Services of New York in the mid-1980s that Leonard began to recognize the value of care coordination. "When I was a nurse on the medical surgery unit and in the coronary care unit at South Nassau Community Hospital, I educated the patients using the teach-back method and thought they understood their post-discharge treatment plan. But when I became a home care nurse, I realized that patients were still confused about what to do and where to get their questions answered when they got home," she says.

Her patients were taking multiple medications and receiving services from multiple providers and had difficulty taking it all in, she recalls. As a home care nurse, she took it on herself to identify her patients' needs, help them understand how to manage their own care, and communicate with their providers.

"The concept of coordinated care was foreign to those of us in the healthcare industry at the time. I didn't think of what I was doing as coordinating care. It was just helping people get the services they needed, but I did observe that patients who had the best coordinated care got better quicker," she says.

At the time, the concept of managed care was just coming into play. Leonard was appointed

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to the New York State Senate Healthcare Task Force on Managed Care and was able to learn early on what was going to happen. "From there, I was able to make the jump into working in managed care. I knew I could make a difference if I took what I had learned about what care coordination meant to a patient and applied it to patients enrolled in a health plan. The transition from direct care to advocate care was rewarding because I could make a difference to a larger group of patients," she says.

When she started at Hudson Health Plan, Leonard had only one nurse in the clinical department. Today, she leads a 40-person team and has launched new programs for the health plan and collaborated with other organizations in the community to provide coordinated care across the continuum. Among her projects are The Westchester Cares Action Program, an award-winning Chronic Illness Demonstration Project that became a model for New York State's Health Homes, a Special Care Program to manage special needs members who receive supplemental Social Security benefits because of disabilities and chronic disease, and the Mommy and Me Program, which provides consistent outreach and coaching by nurse case managers for members at risk for pregnancy and childbirth complications.

"If you look at many of the innovative programs that Hudson has introduced to the field of managed care, you will see Peggy's fingerprints somewhere. She understands that patients lead complicated lives and that case managers have to find innovative ways to address both social and medical issues if they hope to make a real difference in a patient's health," says **Georganne Chapin**, president and chief executive officer of Hudson Health Plan and executive vice president for corporate affairs at MVP Health Care.

Throughout her career, Leonard has been active in professional organizations and has received numerous awards and other recognition, including the CMSA Case Management Research Award, CMSA National Case Manager of the Year Award, CMSA National Award of Excellence in Adherence Management, Medicaid Managed Care Congress Medicaid Health Plan Innovation Award, Visiting Nurse Services Community Leadership Award, and New York State Nurses Association Legislative Award, to name a few.

She has served as a delegate to the Roundtable on U.S. Critical Care Policy since 2009, is vice president and a member of the board of directors of the Case Management Foundation, is a member of the Agency for Healthcare Research and Quality's Transitions of Care Technical Expert Panel, and a member of the Quality Measurement, Research and Improvement Council and the Health Plan Council of the National Quality Forum. Her other activities include co-chair of the New York State Department of Health, Health Home Advisory Work Group; Certified Nurse at Large for the American Nurses Credentialing Center; Technical Expert Panel member for the Centers for Medicare & Medicaid Services Care Transitions Project since 2009; and is an adjunct instructor at the College of New Rochelle School of Nursing.

Her advice to case managers who want to make a difference: Volunteer to be on a committee in your department, with your local case management organization, and at a state and national level.

"Being on a committee gives case managers the opportunity to be at the same level as the senior leadership of the hospital or managed care organization. It gives you a voice and the opportunity to be seen as someone to go to for a solution," she says. ■

Health plan helps at-risk expectant mothers

Multidisciplinary team provides support

A multidisciplinary team at CareSource supports Medicaid members with high-risk pregnancies through the pregnancy and for as long as needed after the birth.

"We proactively identify members who need our support to make sure they are getting the services they need and to remove the barriers to prenatal care. We know that the earlier we can start supporting these moms, the better the outcomes," says **Marcia Lange**, RN, BSN, CCM, care management director of the Dayton, OH-based health plan.

Referrals come from providers, community agencies, and CareSource staff such as medical management and the health plan's 24-hour nurse advice lines, as well as from the members themselves. The health plan also identifies members

who are at high risk based on historical information such as problems with a prior pregnancy, chronic medical conditions that could affect the pregnancy, behavioral health issues, and social service needs.

Care for the pregnant members is coordinated by a multidisciplinary team that includes RN case managers, social workers, licensed practical nurses, and navigators who are non-clinicians but have experience in community settings and are familiar with resources in the community.

"We hired staff in communities across the state because we want them to be familiar with the challenges and the resources in the areas they serve," Lange says. The multidisciplinary team members spend most of their time in the field, at community agencies, clinics, and seeing members in their homes.

When members are identified for the program, a member of the multidisciplinary team calls them, explains the program, and enrolls members if they want to participate.

An RN case manager with experience in prenatal care conducts an extensive assessment, either in person or over the telephone. "The assessment covers everything about the member. It's not just pregnancy-related, but includes other medical issues and social needs as well," Lange says. After the assessment, the case manager develops a care plan with input from the member and her providers. "The care plan focuses on what the member wants to work on and what is important to her," Lange says.

Components of the care plan may include managing blood sugar, obtaining supplies for the baby, transportation assistance, education on how to take their medications, nutritional advice, and reinforcing the importance of prenatal physician visits.

The interventions a member receives depend on her needs. If she has medical issues, the nurse works with her. The social worker steps in when the member needs community resources.

"The program is member-driven and depends on the needs of the mother and the baby. We tailor the care plan and the services and support to the member," Lange says.

In between visits and calls from the clinical staff, the navigators provide support and guidance to help the members navigate the healthcare system, Lange says. They may accompany the women to their physician visits if they don't want to go alone, help them get food or clothing from local organizations, and remind them of their physician appointments and the importance of receiving regular medical care during pregnancy.

The case managers contact the members in the program at least once a month, depending on the members' needs and preferences. A team member meets in person with the members at least every quarter, often more frequently, she says.

"The case manager gets back to the member as needed. If the woman is having urgent problems, the case manager may speak with her several times in one day. If her situation seems to be stable, the case manager may call just once every few weeks," Lange says.

The women are encouraged to have a home health visit when they go home after the baby is born. "Our team does a lot of educating to make sure the moms go to their post-partum visits and that they take their babies for well child visits. We call to remind them of the appointments and arrange transportation if needed," she says.

When infants are admitted to the neonatal intensive care unit (NICU), the nurse case manager contacts the mother to let her know that support is available and checks in with her periodically to answer questions and see if she needs anything. When the infants are about to be discharged from the NICU, the case managers go over the discharge instructions and medications, and help the parents understand how to use equipment such as monitors, oxygen, and suction equipment.

The team provides support for up to a year or longer, depending on the mother's and baby's needs. In some cases, the mothers may have been in high-risk case management before pregnancy and continue to need support. In other instances, the babies have complications and medical issues

EXECUTIVE SUMMARY

A multidisciplinary team at CareSource, a Dayton, OH-based health plan, coordinates care for at-risk pregnant women and follows them for a year, or longer, after the birth.

- The team includes RN case managers, social workers, licensed practical nurses, and social workers.
- When women are identified for the program, an RN case manager with experience in prenatal care conducts a thorough assessment of medical and social needs and works with the women and their providers to develop a care plan.
- The team provides whatever support the women need throughout the pregnancy and after the birth.

and the mothers need assistance in caring for them.

The mothers and case managers often forge long-lasting bonds. "Some of the women don't have anyone else to turn to and they appreciate the support from the team," Lange says.

CareSource also has developed the Babies First program to encourage all pregnant women to see their providers for prenatal and postnatal visits. Participants receive a My CareSource Rewards gift card and can earn money on the card when they see their doctor during pregnancy and after delivery and when they take their children for well child visits. The health plan has partnered with local stores to allow the women to use the card for specific items such as baby supplies, first-aid products, family planning items, and nutritious food.

"The CareSource mission is to make a difference in the lives of the underserved by improving healthcare. These programs enable us to start early and help our members have healthy babies," Lange says. ■

Navigators assist with non-clinical needs

Team works in primary care practices

For EmblemHealth members who receive point-of-care case management, care navigators are the go-to people when patients have questions or need assistance.

The care navigators are part of a five-person team the New York City-based health plan embeds in offices of Manhattan's Physician Group and Staten Island Physician Practice, which are now part of AdvantageCare Physicians, one of the largest physician practices in the New York metropolitan area. The five-person team includes a nurse case manager, a pharmacy case manager, a social work case manager and two care navigators who help guide patients through the system.

"If there is a question about a bill, the navigators can get patients to the right people. They can help people access community resources, make sure they are connected to their physicians, and along with the care team, identify any red flags that indicate the patient should contact the physician or go to the emergency department," says **Andrew Kolbasovsky**, PsyD, MBA, vice president of quality and care coordination at Advantage Care Physicians.

The care navigators are not clinicians, but previously worked in other areas of EmblemHealth where they had direct contact with patients. Some came from the behavioral health department or worked as case manager assistants.

"What we looked for was the ability to communicate. It's really important for the navigators to be able to connect with people. We felt that we could teach them the information they needed to know, but it would be the hardest to teach them how to be an effective communicator," he says.

The navigators meet with patients and help them with all the non-clinical issues that can keep them from following their treatment plan. They work closely with the case managers, pharmacy case manager, and social worker and call on them when patients have clinical issues.

The navigators get most of their referrals from hospital admissions but physicians, nurses, or other people on the care team can refer patients if they need extra help. Some patients hear about the service from a friend or relative and refer themselves, Kolbasovsky says.

When EmblemHealth members who are patients in one of the participating practices are hospitalized, the health plan alerts the navigator, who contacts them while they are still in the hospital whenever possible, he says. The navigator introduces himself or herself as someone who is working with the patient's physician and who is available to help when the patient gets home. He or she explains how the program works and makes sure the contact information in the patient record is up to date. The navigator helps patients set up a follow-up visit with their physician, but

EXECUTIVE SUMMARY

Care navigators meet with EmblemHealth members at primary care practices and coordinate all their non-clinical needs.

- Most of the time, navigators get a referral when patients are in the hospital and contact them before discharge.
- They meet with patients when they come into the office and follow up by telephone.
- They work closely with the embedded clinicians that include a nurse case manager, a pharmacy case manager, and a social work case manager.

asks them to check in with him or her before the appointment.

The navigators meet with patients when they come into the office, and follow up by telephone, Kolbasovsky says. The frequency of the interventions depends on the patient's conditions and risk factors.

When patients transition to home from the hospital, the navigators make sure any needed equipment has been delivered and that the patients understand their conditions and treatment plan, and follow up regularly for several weeks, he says.

When the navigators get a referral, they perform a screening for patient needs and help them access community services such as housing or utility assistance programs, and resources for food and transportation as well as health plan benefits, Kolbasovsky says.

The health plan assigns navigators to physician practices in the community in which they live whenever possible. "They not only know the community resources in the area where patients live, they also know the bus and train system," he says.

The navigators follow protocols that guide them on how and when they connect with other members of the point-of-care case management team. For instance, if a patient has behavioral health issues, the navigator calls the social worker and arranges a meeting. Or if the patient says he can't afford the co-pay for his medication, the navigator can call in the pharmacist, who may be able to identify another medication or another form of medication, then work with the patient's physician to make the switch.

"Once they make that connection, the navigators become a real resource for the patients and their family members. They are another person that patients can call on to answer questions or help them get the services they need," Kolbasovsky says.

For instance, a physician may say that if a patient's pain gets worse, he or she should call the doctor or nurse. The navigator follows up with the patient and monitors the pain.

The navigators are located in the physician offices, which gives them access to the care team. "When an issue comes up, they can walk down the hall and consult the doctor or nurse. If they were in the corporate office, they would have to leave a message, and if the doctor returns calls after office hours, they would have left for the day," he says.

The navigators have the extra time to spend with patients and develop a close relationship. Often, the patients tell the navigators things they don't tell their physicians or other providers, Kolbasovsky says.

"The patients say the navigators make them feel like people really care about them. The navigators frequently receive cakes, flowers, and other gifts from their patients," he says. ■

Primary care at home keeps patients safe

Program targets medical, psychosocial needs

After a pilot project resulted in a 47% decrease in emergency department visits and inpatient admissions for 90 at-risk patients, Priority Health, a Grand Rapids, MI-based health plan, is expanding its home-based primary care program in which a team of providers cares for patients in their home.

The program began as a pilot with Spectrum Health Medical Group and a group of 90 patients with advanced illness and has expanded since then to include more than 200 patients, says **Mary Cooley**, RN, BSN, associate vice president for care management and operations. Spectrum Health Medical Group provides care for patients in a three-county area in western Michigan. Most of the patients in the program are members of Priority Health's Medicare Advantage program, although some are covered by Medicaid or private insurance.

Patients in the home-based primary care program have advanced chronic illnesses and multiple medical conditions that are complicated by functional or cognitive limitations. "They not only require complex medical care, but are unable to access care. Many are functionally challenged, isolated without a lot of caregiver support, and are no longer able to drive. Their situations make it difficult for them to adequately access traditional modalities of care," Cooley says.

The program goes beyond just providing medical care for the patients and works to line up all the medical and social services the patients need to live safely at home. A team of providers including a primary care physician, a nurse practitioner, a registered nurse case manager, and a social worker see the patients in their homes and provide

whatever medical services they need. In addition, the program has partnered with a psychiatric provider, a volunteer organization, and the local emergency medical services to provide support whenever the patients need it.

"This program is fundamentally changing the way care is delivered. It's a holistic approach that provides all of the support patients need in their homes. The program harnesses the support of the entire village. It's a team-based model that leverages the resources available in the community," Cooley says.

Using claims data and the knowledge they have about the members, the care managers at Priority Health send primary care providers a list of patients who may be appropriate for the program, Cooley says. The providers review information they receive from the health plan and refer patients to the program.

The interdisciplinary team meets every Monday and reviews all of the patients, including those who have just been referred to the program, she says. The team determines the best clinician to make the initial visit to the home. In most cases, the case manager is the first to visit and conduct the assessment. If the patient has a lot of social issues, the social worker may make the first visit.

The goal is to visit the patients within 72 hours after they are referred to the program, Cooley says.

The first clinician to visit the patient conducts a comprehensive health assessment, a full assessment of his or her cognitive abilities, and a thorough assessment of the living situation to ensure that the patient is living safely, she says.

The home visits are an essential part of identifying patient needs, Cooley says. "Many can button their shirts and comb their hair, and they seem OK when they have a 10-minute visit at the doctor's office. But when we get into the home and see how they are living, we recognize that they have many needs," she says.

The team reviews the information from the assessments and develops an individual plan that includes all of the patient's medical and social needs, she says. The patient's primary care physician signs off on the plan. The case manager coordinates all of the provider visits and other services the patient needs and calls on the social worker to assist with managing social needs, which run the gamut from housing support and transportation issues to assistance with cognition deficits.

At their weekly meetings, the team reviews the progress of patients in the program and revises the care plans as needed, she says.

Patients in the program receive routine and preventive care in their homes, 24-hour-a-day support, education about their conditions and medication regimen, telemonitoring if appropriate, and other in-home services including occupational, physical, and speech therapy, Cooley says.

A key part of the program is a rapid response protocol to provide support 24 hours a day, seven days a week. The protocol is based on what the team anticipates that each patient is likely to need after normal business hours, she says.

"For instance, if the patient has heart failure and has been admitted to the hospital multiple times for fluid volume overload, we determine what potentially will happen and what supplies, such as furosemide, will be needed if the patient needs stabilizing after hours, and place them in the home. If the patient or family member calls at 2 a.m., we can contact the emergency medical service who will deploy a clinician to the home to administer the medication that will stabilize the patient's fluid levels," she says.

Keeping patients safe in their homes is a top priority, Cooley says. "That is non-negotiable. We have to make sure they are safe even if it means arranging for someone to touch base every day to make sure they are eating and taking their medication," she says.

For instance, if the patients are isolated without a caregiver and no family nearby, the case manager enlists the volunteer corps to send someone out to visit the patient at regular intervals. The volunteers are mostly from local churches,

EXECUTIVE SUMMARY

When a team of physicians, nurse practitioners, case managers, and social workers provided care for at-risk members of Priority Health health plan in their homes, emergency department visits and inpatient admissions for patients in the program dropped by 47%.

- Patients in the program have advanced chronic illnesses and multiple medical conditions as well as functional or cognitive limitations.
- The program coordinates all of the patients' medical needs as well as whatever community resources will help them live safely at home.
- The program includes a rapid response protocol that provides support for patients 24 hours a day, seven days a week.

Cooley says.

"Our goal is to keep these patients at the highest threshold of wellness and provide whatever support they need so they can live well in the community and avoid having to go to a nursing home. We understand their barriers to healthcare and staying well, and work to help them overcome the barriers and stay out of the emergency department and the hospital," she says. ■

Case Management Week is your time to shine

Make plans now for October festivities

Case managers are beginning to get the recognition they deserve and National Case Management Week— Oct. 12-18 — is the time to celebrate all the contributions that case managers bring to the healthcare arena.

"The week is a time to recognize all the nurses, social workers, and other healthcare professionals who work in the practice of case management, care management, or care coordination and the value they bring to the clinical team and to patients and family members," says **Cheri Lattimer**, RN, BSN, executive director of the Case Management Society of America (CMSA).

Widespread recognition of case management was highlighted with the implementation of the Affordable Care Act and other legislation that promotes care coordination as an important part in improving the delivery of healthcare, Lattimer adds.

"The significant value that case managers bring to the healthcare system is being recognized. Case Management Week is a time for bringing attention to the contributions and commitments that case managers make," she says.

The U.S. Congress passed a proclamation declaring Oct. 12-18, 2014, National Case Management Week and honoring all healthcare professionals in the practice of case management, Lattimer says. "This is the first time that we have gotten recognition at the federal level, although many chapters have gotten recognition on the state and local level," she says.

"Case Management Week was begun to educate payers, providers, lawmakers, and consumers about the important contributions case managers make in the successful delivery of healthcare through our role as patient advocates, our knowledge of resources, and our ability to communicate with the clinical team, patients, and family members as patients transition through the continuum of care," she adds.

Organizations and individual case managers are encouraged to create special activities to recognize case managers during Case Management Week, Lattimer says. This year's theme is, "Building Steps for a Brighter Future."

The CMSA website contains suggestions for a wide range of activities that include organizing breakfasts or luncheons honoring case managers, publishing profiles of case managers in the company newsletter, submitting guest editorials on the positive impact of case management to newspapers or magazines, creating special displays and posters in the workplace, and hosting community events to educate the public on what case managers do.

"There are a lot of different activities to choose from, but what is important is that case managers are recognized for the service and value they bring to patients and the healthcare system as a whole," Lattimer says. For more information and ideas on celebrating National Case Management Week, visit: http://www.cmsa.org/Individual/Education/NationalCaseManagementWeek/tabid/304/Default.aspx. ■

ED telemedicine extends to mental health care

Telemed helps with mental health patients

Like many hospitals around the country, Mercy San Juan Medical Center in Carmichael, CA, has seen a steady increase in patients presenting to the ED with mental health problems. Officials attribute the problem to dwindling resources for mental health care and, in particular, the closing of an inpatient psychiatric unit in the region in 2009. Many of the patients who previously would have been stabilized in the inpatient unit are now showing up in the ED.

Until recently, these mental health patients would often sit and wait in the ED for as long as a week, in some cases, to receive definitive care.

However, taking a page from the hospital's neurology department, which leverages telemedicine to bring expert guidance from a neurologist's home directly into the ED, many of these mental health patients are now being quickly linked to a psychiatrist who beams in from a remote location to speak with the patient and, when needed, to advise emergency providers on appropriate treatment. The technology required for the remote sessions is contained on robots that can move from room to room in the ED.

Thus far, the approach has been well received by patients, and providers welcome the expert input when they have patients with mental health problems. "We get to have physician-to-physician conversations immediately [after the patient encounter]," explains **Seth Thomas**, MD, FACEP, medical director of the ED. "I don't remember ever having that available to me at any other facility I have ever worked, so it is truly remarkable and it makes us feel a lot better about the care we are providing."

Consider patient, ED needs

The ED at Mercy San Juan Medical Center sees about 73,000 patients per year, but it has been significantly impacted in recent years by an influx of patients requiring mental health care. "Our ED, at any given moment, could have 10 to 15 or more mental health patients on a hold in our department, and we saw no other way to give them definitive care except to wait," says Thomas. "We said that is unacceptable and we need to look at other ways of evaluating these patients and potentially starting treatment on them while they are in the department. We felt it was cruel and unusual to keep them in the department [for such long periods of time]."

With the technological capabilities already in place to carry out telemedicine visits, it made sense to apply the approach to psychiatry, given the needs of both patients and the ED. "This is a county that is extraordinarily impacted by the volume of mental health patients and the lack of resources," says Thomas. Consequently, in October 2013, the ED began using what Thomas refers to as tele-mental health as an evaluation tool.

The hospital's partner in this approach is Aligned TeleHealth, an Agoura, CA-based company that specializes in linking hospitals and EDs to psychiatrists who are available on a 24/7 basis. The Dignity Health Telemedicine Network contracts with Aligned TeleHealth to make the psychiatrists available to Mercy San Juan Medical Center, which is one of the hospitals under the San Francisco-based Dignity Health umbrella.

Decide how to use the approach

The ED primarily uses tele-mental health with two groups of patients, explains Thomas. The biggest group is comprised of patients who present to the ED with a mental health complaint for which the physicians themselves don't feel comfortable initiating treatment without having the patient evaluated by a psychiatrist. Further, these patients may not meet the criteria for an inpatient stay.

For instance, Thomas explains that patients who come in saying they feel anxious or depressed, but are not suicidal, are the type of patients who stand to benefit from a tele-mental health visit because they can get started on a treatment and then pursue outpatient follow-up.

The second group targeted for tele-mental health visits includes patients who have been in the ED for an extended period of time, and it is clear that they will not be transported to an inpatient psychiatric facility any time soon, says Thomas. "We want to start treatment on them, so we will look to the [remote] psychiatrists to give us advice on what to start, and to do a formal consultation," he says. "They can then also do follow-up consultations [while the patients are still in the ED] to assess if the treatment is working, and whether the patients still meet the criteria for inpatient psychiatric consultation."

After a day or two of treatment, some of the patients improve to the point at which they can be released, adds Thomas. "That is a huge benefit to this. We are really reserving inpatient beds for those who really need them, as opposed to those who could be managed as well, if not better, in their home environment with outpatient visits to a psychiatrist or counselor," he says. "We are initiating care much sooner based on [the remote psychiatrist's] recommendations."

The need for psychiatric input has increased, in part, because more and more patients are being placed on involuntary holds, explains **Pei-Huey Nie**, MD, the regional medical director at Aligned TeleHealth. "Since the 1960s, with the whole deinstitutionalization of psychiatric patients and psychiatric facilities being closed, a lot of patients with chronic mental illness have been becoming home-

less, put in jail, or they have come to the ED," says Nie. "I have been told that a major part of a hospital's budget is just holding these patients while they wait for a psychiatric bed, and that is extremely costly to the ED."

Nie adds that involuntary holds are often placed on patients by police officers. "Police do their best, but they are not mental health providers, so what happens is emergency physicians will ask us to weigh in," she says. "By state law [in California], a physician appointed by the hospital can discontinue these holds."

With expert guidance from the remote psychiatrists, emergency physicians can not only initiate appropriate treatment, but also direct patients to appropriate care more expeditiously, says Nie. "The ED physicians can ask us at any time to [evaluate] a patient and see if we really need to maintain the involuntary hold and wait for an inpatient hospital bed," she says. "Emergency physicians like to have the backing of a psychiatrist, so we will beam in, we will assess the situation, someone will read the 'hold' to us, and then we will advise that yes, we think the patient should be hospitalized, or no, this patient does not meet the criteria, which suggests follow-up in a clinic or [a disposition of that nature]."

Establish a comfort level

While the hospital has not yet tabulated specific results from the intervention, Thomas believes that the length-of-stay (LOS) for patients who undergo tele-mental health evaluations and are released has decreased. "Every time I have used tele-mental health I know the LOS of those patients, particularly if they are discharged, is much improved," he says.

Unfortunately, since Mercy San Juan Medical Center began offering the tele-mental health visits, the number of mental health patients presenting to the ED for care has continued to increase. "I don't know if that is because we are offering the service or if it is related to county-wide issues and resources becoming scarcer, but I suspect it is the latter," says Thomas.

However, Thomas says the ED is providing better care with treatment for mental health patients being initiated earlier and earlier. "Probably the biggest benefit of all of this is that we are allowing individuals who may not have mental health disorders or complaints to receive treatment more quickly," he says. "We are really trying to better utilize our resources here."

At first, Thomas acknowledges that there was some pushback to the intervention from nurses who were concerned that a mental evaluation via a remote psychiatrist would not be effective, especially in cases in which a patient was psychotic, but he says such concerns have mostly gone by the wayside as both clinicians and patients have gotten comfortable with the technology. "Patients interact with [the computer screen] as well, if not better than an in-person individual," says Thomas. "I have not yet had a patient who refuses to talk to the robot. It is actually very personal, and there is a phone handset on it for privacy so [others] cannot hear any of the conversation at all."

Nie acknowledges that she has encountered a handful of patients who do not respond well to communicating via video screen. "In these cases, I invite them to use the telephone … and I think that makes people feel a little bit more comfortable," she says. "Usually the people who are uncomfortable are older in age or paranoid, but there are some good stories too. Pediatric patients — patients as young as 8 — I have found do extremely well with it."

Nie stresses that both the provider and the patient need to be comfortable communicating remotely for the visits to be successful. "If the provider, like myself, is comfortable interacting in this way, that will translate across the screen, and if the patient is comfortable engaging in this way, and willing to open up to someone on the screen, it can work perfectly. It is really just a matter of getting both parties interested and comfortable with it."

Look at costs, benefits

Thomas believes a tele-mental health solution could fit many EDs that are struggling with an influx of patients with mental health needs, but there are many factors to consider. "Look at your needs first and determine if this is an area where you feel you are struggling to care for these patients," he says. "What is your LOS and what is your volume?"

Administrators should also look at what resources they already have available to them, adds Thomas. "Do you have psychiatrists on the medical staff? Do you have social workers or trained mental health workers who can assess these patients and help you with your needs?"

he says. "If you feel as though those internal resources are not enough, then this could be a definite possibility."

However, organizations also need to take a close look at whether this type of intervention is going to be a cost-saving measure or not. "By initiating the tele-mental health coverage, we are finding that the cost has actually decreased," says Thomas. "We have mental health workers who come from the county to assess patients, but the cost of those individuals is relatively high compared to tele-mental health consultations by psychiatrists, so that is one benefit. But we also find that when we decrease the LOS of these individuals, we are opening up resources and utilizing nurses and security guards for other purposes."

When calculating costs, be sure to consider what the expenditures associated with boarding mental health patients in your department are, and whether such practices are preventing other patients from coming into the ED, says Thomas. Also, consider what providers in your region offer tele-mental health, what credentialing would be involved, and what the technology requirements would be, he says.

Mercy San Juan Medical Center is part of Dignity Health's telehealth network, so there was already an infrastructure in place to manage the tele-mental health visits, but the technical hurdles for some organizations could be much higher.

Nie adds that ED administrators who are considering the use of tele-mental health should identify a private space they can use for the patient-psychiatrist encounters. "Emergency departments can be very tight on space, but if this is something administrators are considering, a dedicated corner or room would be very helpful logistically," she says. "There should be privacy."

The approach has worked well enough at Mercy San Juan Medical Center that Thomas is interested in further ramping up the use of tele-mental health in the ED. "Right now, 25%-30% of our mental health patients are being touched by the tele-mental health psychiatrists," he says. "Maybe we need to look at [using tele-mental health with] 50% or 75% of those patients, and potentially doing regular rounds."

For instance, once a day, or perhaps on days when the ED is particularly impacted by mental health patients, Thomas envisions going through all of the mental health patients with the remote psychiatrists to evaluate whether there are opportunities to discharge some of the patients, or perhaps alter treatment or arrange follow-up. "I think the psychiatrists would be very receptive to that, and I would be interested in seeing how that could help us in the long run," says Thomas. "That might be our next big step." ■

COMING IN FUTURE MONTHS

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- Leveraging technology in care coordination

CNE QUESTIONS

1. Margaret Leonard, recipient of the prestigious Lifetime Achievement Award from the Case Management Society of America, suggests that case managers who want to make a difference volunteer for committees at their organization, and at the local, state, and national levels of their professional organizations.
A. True
B. False

2. How long do the case managers in CareSource's high-risk pregnancy program follow mothers and babies?
A. A month after delivery
B. Six weeks after delivery
C. Six weeks after discharge from the hospital
D. Up to a year or longer if needed

3. What is the main source of referrals to the care navigators in EmblemHealth's point-of-care case management program?
A. Health plan data mining
B. Referrals from members of the physician practice team
C. Referrals from EmblemHealth staff
D. Hospital admissions

4. When patients are referred to Priority Health's home-based primary care program, the goal is for a team member to make a home visit in what period of time?
A. Within 24 hours
B. Within 72 hours
C. Within a week
D. Within 10 days

CNE OBJECTIVES

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

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