CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

MARCH 2015 Vol. 26, No. 3; p. 25-36

Experts: Market case management to younger HC professionals

"Brain drain" is fast approaching

Case management — like nursing, primary care, and other healthcare professions — is facing a major brain drain in the next decade as the bulk of its membership heads toward retirement.

New data suggest the average age of case managers is increasing: Of the nearly 8,000 case managers who responded to a survey by the Commission for Case Manager Certification (CCMC) in Mount Laurel, NJ, 43.6% are over age 55, and only 1% are under age 30, says **Patrice Sminkey**, RN, chief executive officer of CCMC.

By contrast, five years ago, only 21% of case managers surveyed were over age 55, according to the CCMC Role and Function Study, which was released at the end of January 2015. *(See study's findings in a nutshell, page 27.)*

"Most case managers come to the profession after a career in nursing or social work," Sminkey says.

The aging trend is coupled with increasing demand for case management

EXECUTIVE SUMMARY

As a group, case managers in the U.S. are growing older, with nearly 44% over age 55. Coupled with the trend of increasing roles and needs for case management services, the industry is facing a shortage over the next decade.

- Five years ago, a survey of case managers found that only 21% were over age 55.
- Healthcare is evolving to a more patient-centric, coordinated care model.
- Case management organizations are launching initiatives to market the profession to nurses, social workers, and other young healthcare professionals.

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.

AHC Media

CASE MANAGEMENT ADVISOR™

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.
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.
customerservice@ahcmedia.com.
www.ahcmedia.com
Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

EDITORIAL E-MAIL ADDRESS:
melindagyoung@att.net.

SUBSCRIPTION PRICES:
Print: 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.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Canada: $529 per year plus GST. Elsewhere: $529 per year.

Back issues: $75. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

ACCREDITATION: AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity has been approved for 15 nursing contact hours using a 60-minute contact hour. Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours. This activity is valid 24 months from the date of publication.

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

EDITOR: Melinda Young
ASSOCIATE MANAGING EDITOR: Jill Drachenberg (404) 262-5508
EXECUTIVE EDITOR: Russ Underwood (404) 262-5521, (russ.underwood@ahcmedia.com)
EDITORIAL & CONTINUING EDUCATION DIRECTOR: Lee Landenberger

services — highlighting for CCMC, its nearly 50,000 members, and other organizations the need to market the profession to younger healthcare professionals, as well as to the public. The goal is to draw more experienced nurses, social workers, and other healthcare workers to case management as a career path.

"We know that the need for case managers is increasing dramatically as healthcare evolves to a more patient-centric, coordinated model of care," Sminkey says. "So the commission is engaged in efforts to educate and inform professionals in a variety of settings about the opportunities for career advancement for qualified case managers."

Finding qualified healthcare professionals who are interested in becoming case managers can be challenging, notes **Veronica Chepak**, RN, BSN, MPA, CPC-A, clinical coordinator of Bronx-based Montefiore Medical Center and the Montefiore Care Management Organization in Yonkers, NY.

"Case management is becoming such a huge part of healthcare," Chepak says. "We need to reach out to younger people."

There is a critical need for developing a case manager workforce with younger professionals in nursing, social work, and allied health fields, Sminkey says.

"Our research shows that case management as a profession is maturing," she adds. "Not only are there many more opportunities for frontline case managers, but there is also an increase in the need for case management leaders and specialists in areas such as quality and education."

Chepak has asked case managers and healthcare leaders about their perceptions of barriers to marketing the profession. She found that top barriers are a lack of identity and a lack of relationship-building.

"One of the healthcare leaders I spoke with was starting to reach out to nursing students to have them come in and see what case management was and how it was a potential career path," Chepak says. "Care coordination is going to be such a big part of case management in the future."

Other leaders said the profession needs to use the Web and social media, including Twitter, Facebook, and even Pinterest, to reach out to younger healthcare professionals, she says.

"We need a balance of traditional methods of marketing, as well as new methods for people who might want to be a part of the profession," Chepak suggests.

The Hudson Valley Case Management Society in Tarrytown, NY, now has a committee devoted to membership, says Chepak, who is president of the chapter.

"We thought membership-building was important at the chapter level," she adds. "Each state has their geographic issues and concerns they need to address."

Chepak sent out an email blast and distributed pamphlets about an upcoming pre-test for certification for case management. The goal was to encourage social workers and nurses to consider a case management career track.

"Someone must have put it up on a bulletin board, and we were suddenly getting emails from people, saying they'd heard about the certification test and wanted to sign up for it," Chepak recalls.

Unfortunately, a number of the callers were hospital workers in areas that wouldn't be natural fits for case management, including custodial staff, dietary/nutrition area, and administrative assistants, she adds.

"We had to explain that you have to be an RN, social worker, or have a healthcare degree with two years of supervised experience," she says. "A lot of people saw the job and thought, 'Case management — I can do that and probably get better pay,' not realizing there are certain experience and knowledge details you must have."

This was Chepak's lightbulb moment — a realization that case managers and their organizations need to do a better job of marketing the profession to the public and to other healthcare professionals.

"We need to explain to people what we are, what we do, and how to become a case manager," Chepak says.

"Case managers need to go out there and advocate for their own profession," she adds. "We do a great job of advocating for our patients and families, but we don't do a good job of advocating for ourselves."

This is starting to change, however.

In mid-2014, the Case Management Society of America (CMSA) launched a new website (www.cmsa.org/e4) that explains what case management services are and what kind of work case managers do. The second phase of the site was set to be complete by March 2015, says **Danielle Marshall**, chief strategy officer of Consulting Management Innovators (CMI) of Little Rock, AR, a management company for CMSA.

"There's a real need to find ways to bring case managers into the field," Marshall says. "That's why CMSA has taken on this [e4 Web] project."

With the website's first phase, CMSA introduces case management with a competency map, a "What Is Case Management?" PDF, a flyer about case managers, a case management lexicon, and a case management program intensity grid and career framework overview.

"We're trying to build more comprehensive resources that can be used by case managers," Marshall says.

The second phase will attract new entrants to the field, and after that, CMSA will test the materials in focus groups and assess the impact, she says.

CCMC also promotes the case management profession whenever possible, Sminkey says.

"We take every opportunity to tell young nurses and social workers to consider case management, and we tell them the reasons why: personal autonomy, choice, career advancement, and opportunity," she explains.

"We also do a survey of our own board-certified case managers on a regular basis," she adds. "Last year, we discovered salaries for our board-certified managers exceeded average salaries for registered nurses and social workers — the two most common backgrounds for case managers."

Another advantage to having a case management career is that it's professionally satisfying, Sminkey says.

"As a case manager, you have a lot of choices," she explains.

"You can easily move into a new setting with a new employer and tap into that same case management skill set, because it applies across all settings," she adds. "If I were a younger case manager, I would find that very appealing." ■

New study highlights CM demographics

Results from 2014 CCMC survey

The Commission for Case Manager Certification (CCMC) of Mount Laurel, NJ, conducts a thorough survey of case managers every five years, providing a snapshot of where the profession stands.

The latest CCMC Role and Function Study was published in January 2015. Its main purpose is to ensure the CCMC credentialing exam remains current. CCMC's latest survey, conducted in May and June of 2014, involved 52,370 queries and 7,668 responses — a nearly 15% response rate.

The study's data also give a candid look at the case management profession's demographics. Here are some of the study's key findings:

• Qualified, knowledgeable case managers are more in demand than ever before. About 26% of employers now require certification, as opposed to 20% requiring certification in the 2009 survey.

• About 40% of employers financially reward certification in case management, as opposed to about 30% providing compensation for certification five years ago.

• The largest age cohort to respond to the survey was the 56-to-60-year-old group. Nearly 44% of the survey's respondents were older than age 55, a percentage that has more than doubled since the 2009 survey.

• Around 61% of case manager respondents have performed case

management work for more than six years.

• Registered nurses account for nearly 89% of case managers surveyed; 4.4% are social workers, and 2.3% are vocational rehabilitation counselors or specialists.

• More than 34% of board-certified case managers participating in the study achieved certification within the last four years.

• About 95% of case managers are women.

• About 60% of the study's participants said that the terms "care management" and "care coordination" are included in their job titles.

• There's a significant increase in emphasis on ethics and quality measurement as core competencies for professional case managers.

• Case management departments are becoming more sophisticated with dedicated leaders, supported by managers or supervisors. The study found that 65% of case manager respondents spend at least half their daily time on direct case management services, and nearly 39% spend more than 80% of their time in direct case management.

• Their work settings are diverse, with 28.8% in health insurance, 22.8% in hospitals, 11.6% in workers' comp, and 7.3% in independent case management.

For more information on the CCMC Role and Function Study, visit http://ccmcertification.org/media/media-kit/role-function-key-findings. ■

Palliative care options increase as CMs look for end-of-life care

Patient-centeredness is the goal

After more than two decades, the concept of palliative care is gaining traction among case managers and other healthcare providers, partly in response to acceptance for this type of end-of-life care under the Affordable Care Act. Advocates of palliative care cite its benefit of filling in gaps in symptom management for patients undergoing procedures at the end of life.

"By 2030, there probably will be nine million Americans who are more than 90 years old, and a huge number will suffer from chronic illnesses with chronic symptoms," says **Abdul Mondul**, MD, associate medical director, chief of palliative care services, and patient safety officer at Lincoln Medical and Mental Health Center, New York City Health and Hospitals Corp. in New York City.

Chronically ill patients at the end of life need information about their goals of care, including how healthcare providers can help them alleviate physical, spiritual, and social suffering, Mondul adds.

"It starts from having well-structured referral criteria for patients who need these services," he explains.

Palliative care focuses on pain and symptom control for patients at any stage of a serious illness. Unlike hospice care, palliative care can be given to patients who continue to receive curative treatment and who are not necessarily expected to die within six months, according to Medicare guidelines.

Case managers and providers, including hospitalists, need education about palliative care, especially when a health system begins to prioritize these services. The idea is to identify patients who would benefit from a palliative care referral or hospice care during admission, Mondul says.

"It helps in decision-making and streamlining and discharge planning," he adds. "We have set a rule that any patient who enters with heart failure needs to be evaluated by palliative care services."

An increasing number of health systems provide palliative care consultation teams, Mondul notes.

While palliative care was a difficult service to bill in its early years, now there are Medicare billing codes for it, he adds.

"As we move along with the Affordable Care Act, there will be changes in payments for components like time spent in family meetings, so palliative care teams can use that component," he says. "The next change will be the pediatric piece: There are pediatric cases that require palliative care, such as when a baby has a genetic problem."

The shift to palliative care is causing some confusion among case managers, who often are more familiar with the concept of hospice and hospice criteria than they are with palliative care, Mondul says.

Patients, their caregivers, and

other members of the public also might be unfamiliar with palliative care, says **Mei Kong**, RN, MSN, assistant vice president of corporate patient and health safety for New York City Health and Hospitals Corp.

"We encourage patients, advocates, and family members to learn about palliative care," Kong adds.

The public needs to learn what the benefits are for palliative services, expanding the knowledge beyond those concepts for referral, Mondul says.

"We need to enhance the knowledge of palliative care to get referrals early," he adds. "We need to educate everyone to what palliative care is and what the benefits are, expanding the knowledge beyond those [traditional] concepts for referral."

One way to do this is through a palliative care pamphlet that talks about when patients/caregivers should contact palliative care, and what the criteria are, Kong says.

"A booklet teaches patients to speak up about their care," Kong says. "We hope we're fostering a healthy relationship and exchanging information."

Health systems should teach their staff to speak to patients about their disease process and treatment options, she says.

"Have patients tell us what they want, what their articulated goals are," she says. "Do they want to be cured, live longer, improve their function, or be comfortable?"

At Lincoln Medical and Mental Health Center, each new employee's orientation includes a presentation about palliative care. Employees learn more through different life care modules, Mondul says. One module is about communication at the end of life, from the last days to the last hours of life.

Nurses also can take the curriculum, tailored with five hours of role-playing, music, companionship, and an art program. A case manager and social worker provide updates and share goals of palliative care with other healthcare professionals, Mondul says.

"It's so integrated with the rest of the hospital, it's part of the daily business of Lincoln, penetrating every area, even areas we don't use for referrals like surgical and emergency room," he adds. "That partnership works very well for case management; it gives us a heads up, so it's not a surprise."

Here's an example of how it can work: At Lincoln Medical, the mean number of days between hospital admission and referral to palliative care for patients who are appropriate referrals to the services is one day. In 2004, referrals to palliative services typically would occur after a month, Mondul says.

A decade ago, patients would already be dying before they were referred to palliative care, he adds. "That has completely changed over the years — that's how much everyone is aware."

Also, about 70% to 75% of the hospital's patients who die have been evaluated by the palliative care team, he says.

To achieve this level of care transition integration requires support and a multidisciplinary approach, Mondul notes.

"In the beginning, the palliative care program was myself and the chaplain," he says.

Palliative care transitions typically follow these steps:

• **Advance directives conversation.** As early as possible in patients' care, hospital case managers or other staff can have a discussion about how many invasive procedures the patient would be willing to undergo. They discuss the patient's comorbidities and diagnoses.

"Some patients will say, 'I know I'm sick, but if I'm not doing well and get intubated and things don't look good, then I don't want to be connected to life support for more than 15 days, 20 days, 7 days,'" Mondul says.

• **Talk with families.** Sometimes patients lack advance directives and are already connected to life support. So the conversation has to be with the family. It's a conversation case managers are well equipped to have, especially when they have experience working with palliative services, he says.

"We keep the mantra of palliative

EXECUTIVE SUMMARY

As palliative care gains traction among case managers and others in healthcare, the end-of-life service is filling in gaps in symptom management.

- Palliative care focuses on pain and symptom control for patients with a serious illness.
- Unlike hospice care, palliative care can be given to patients who continue to receive curative treatment and who are not necessarily going to die within six months.
- Once providers learn more about palliative care, they begin to make referrals sooner and more often.

care, which is patient-centeredness," Mondul says. "All conversation should be around the patient's known wishes, which is where the conversation starts."

The palliative care team gives patients' families enough information about ventilator withdrawal that they can make an informed decision: "There's a process and way of explaining what to expect and how we keep patients comfortable during that process," Mondul says.

Palliative teams have experience in guiding families into making decisions based on what the patient's decision would have been in that situation, he adds.

• **Provide palliative services.** Palliative and hospice services are similar. They include options such as music therapy, art therapy, and symptom and pain management.

The other piece is coordination of care. "What case managers and palliative care teams can do is get everyone on the same page," he says. Palliative teams work with case managers to coordinate care with surgeons, oncologists, cardiologists, and providers. The goal is to put the separate medical pieces together and treat the patient holistically.

"Listening is the number-one goal," Mondul says. "A lot of studies show how quickly physicians interrupt patients."

Doctors and case managers might think they know what the patient wants, but until they ask, this isn't certain, Kong says.

"We have to communicate and ask patients what they really want and work with the team to make sure we're all on the same page," she adds. "It's an important component."

• **Support families.** Palliative end-of-life services include memorial services for patients who died while in the hospital and one-year follow-up with the families, Mondul says.

Lincoln Medical holds memorial services every three months, inviting all relatives to attend the ceremony, he says.

"We encourage them to talk about their relatives and it's very touching," he says. "And we keep providing support for the death of their loved ones for a year." ■

Use screening tools, partnerships to improve identification, care of victims of IPV

Studies show emergency staff often fail to ask questions

With all the problems that emergency providers face on a daily basis, it can be especially difficult to identify and manage patients who may be victims of intimate partner violence (IPV). Some of these individuals are reluctant to share that they are in danger at home, and providers are often hesitant to push for this information — either because they lack ready access to resources to respond, or they aren't sure what the next steps should be.

However, with ample evidence that victims of IPV often frequent EDs for care, it's clear that emergency staff have an opportunity to not just provide treatment to these individuals, but also to connect them with resources that can help to make them safe from further harm.

Improve identification, response

Researchers have found that there is considerable room for improvement in the way victims of IPV are managed in the emergency setting. For instance, a study by investigators at the University of Pennsylvania in Philadelphia found that while most women who are victims of IPV visit EDs for medical problems, most (72%) are not identified as being victims of abuse. Further, while most hospitals have social workers to counsel patients, researchers found that these services are only used infrequently.[1]

In another study, researchers concluded that while up to one-third of ED patients have a history of IPV, identification of the problem by healthcare practitioners is very low, ranging between 4% and 10%. Investigators also found that most victims of IPV say they would be comfortable disclosing the problem to their physicians, but identification and referral tend to be "inconsistent."[2]

Investigators at The Emory Center for Injury Control (ECIC) in the Department of Emergency Medicine at Emory University

School of Medicine in Atlanta have been looking at ways to potentially improve the identification of IPV in the emergency setting for several years. One of the techniques they have tested involves using a kiosk so that patients can answer screening questions about IPV without human interaction, and without taking up precious provider time.

"Our screening tools actually screened for a lot of things like drug use, alcohol use, and other types of safety behavior … and patients would get a printed handout that was very specific to what they screened positive for, including IPV, with a list of referrals related to whatever the issues were," explains **Shakiyla Smith**, MPH, administrative director at ECIC.

There have been several iterations of the study, but one of the things researchers noticed is that it is hard to get patients to use the kiosks without having research assistants on hand to draw them over to the machines. "We had pretty good success or acceptability of the patients to take the screening, which is good, but then if someone was not directing them there, that was an issue," says Smith.

For EDs that are already using a kiosk to retrieve other types of patient information, adding screening questions about IPV would be a simple modification, notes Smith. "That is probably ideal," she says. "You could easily add two to five questions or so, and it wouldn't amount to a huge burden."

However, Smith stresses that if EDs are going to ask screening questions about IPV, then they need to be prepared to do something about it when patients indicate that they may indeed be at risk. "A lot of hospital systems have questions [that they ask] as part of their intake process, but then they don't do anything about it when a patient says yes," she explains. "Someone needs to follow up, at least with flyers or resources that you can refer the patient to … because I think it is worse to ask and not do anything than to just not ask at all."

RESEARCHERS HAVE FOUND THAT THERE IS CONSIDERABLE ROOM FOR IMPROVEMENT IN THE WAY VICTIMS OF IPV ARE MANAGED IN THE EMERGENCY SETTING.

When inquiring about IPV, it is important to keep the questions behavior-specific because while most victims know they have relationship issues, they may not frame them in terms of IPV, says Smith. For example, rather than querying whether someone has experienced domestic violence, it is better to ask whether they have ever been punched or slapped by a partner. Such questions remove the ambiguity and leave little room for misinterpretation.

You can find several validated screening instruments for IPV on the website of the CDC's National Center for Injury Prevention and Control: http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html.

One of the most commonly used instruments is a four-item screener called HITS, which was copyrighted in 2003 by Kevin Sherin, MD, MPH, MBA, FACPM, FAAFP, health officer and director of the Florida Department of Health in Orlando, FL. Each item is scored from one to five, and a score of greater than ten is considered positive for IPV. The instrument can be viewed here: http://www.orchd.com/violence/documents/HITS_eng.pdf.

Prioritize screening

Jacqueline Campbell, PhD, RN, FAAN, a professor and noted expert on IPV at Johns Hopkins University School of Nursing in Baltimore, says there needs to be a renewed commitment to routine screening for IPV in all healthcare settings, but she also notes that clinicians need to persevere when patients are not forthcoming on the issue or they are unable to respond.

"What happens oftentimes when you look at ED records is that the question [regarding IPV] was just never asked," says Campbell. "One assumes that it was because there was no privacy or that the patient was half conscious or in a physical state in which they were unable to respond, but [in such situations] the question needs to be flagged as 'not asked' or 'needs to be asked,'" she says. "Then it is up to the staff in the back to make sure that the question gets asked."

Campbell points out that emergency staff would not forget to ask patients about whether they are allergic to medications, so questions

about IPV need to be similarly prioritized, she says.

What stops some clinicians from inquiring about IPV is they are unsure of how to respond if a patient reports she or he faces danger or violence at home. Having established relationships with community organizations is vital in these instances, says Campbell.

"We are very fortunate in this country that almost every community has domestic violence service organizations that would be thrilled to work with EDs to make sure [clinicians and staff] know where to call, how to call, and who to call," explains Campbell. "We also have the National Domestic Violence Hotline, which is oftentimes used just to set the victim up with a phone and some privacy, and then they can make that call themselves. But we have to make it easy for the provider to allow that to happen." (The Hotline numbers are: 1-800-799-7233 or 1-800-787-3224. You can also visit the website for the Hotline at www.thehotline.org.)

Consider TBI protocols

In Washington, DC, an organization called DC Safe is working with EDs and urgent care centers in the region to improve the emergency response when victims of IPV present for care. "There needs to be a building of capacity in terms of how to deal with these cases in a crisis situation because when someone walks into an ED, the [personnel there] have so many patients that their system is strained, especially in a city like the District of Columbia. They are trying to get someone in and out, and they are just moving so quickly that sometimes things get missed," explains **Natalia Marlow-Otero**, the executive director at DC Safe. "The intent is to have … all of the nurses, or at least the head nurse [at these facilities] trained on how to administer a risk assessment, and to call our response line to dispatch a forensic nurse examiner and crisis advocate so that the client can get all of [his or her] needs met within the first 24 hours."

> "THEY ARE TRYING TO GET SOMEONE IN AND OUT, AND THEY ARE JUST MOVING SO QUICKLY THAT SOMETIMES THINGS GET MISSED."

There is also an accountability aspect to the quick response, says Otero. "We find that when there is an intervention early on, within the first 24 hours, the [offender] in these cases tends to be arrested five days earlier, and the probability of the client being re-assaulted or worse goes down considerably," she says.

Otero acknowledges that recent media attention related to the mass circulation of a video depicting the wife of a prominent NFL player getting punched in an elevator may, at least, be heightening awareness of the scope of the problem. "I think sometimes people have a very specific picture in their minds about who a victim should be, and I think it is these kinds of cases that make them think, well, maybe they were wrong. Maybe a victim can be just about anybody," she says.

Campbell agrees, noting that she has been asked more questions about the healthcare response to IPV in recent months than she has in a long time. "There is increased attention to this across the board," she says.

The Joint Commission requires hospitals to have protocols in place to deal with family violence, and these should include links to appropriate local resources, but the relationships need to be set up and nurtured, says Campbell. Further, she says the policies and procedures surrounding these relationships need to be continually revisited as the leaders and personnel within a typical ED are constantly changing. Things can easily slip when a key manger or clinical champion leaves, she says.

Another problem Campbell has observed in her work with EDs is that traumatic brain injury (TBI) is often not considered in women who present with head injuries, broken jaws, or black eyes. "We are really good now, fortunately, at identifying athletes who have had a concussion and making sure that we use [the appropriate] protocols on them," she says. "But we just haven't made that translation [to abused women], so there needs to be some TBI protocols geared toward anyone who is in the ED, either because they have been involved in a fight or have been physically assaulted."

REFERENCES

1. Rhodes K, et al. Intimate partner violence identification and response: Time for a change in strategy. *Journal of General Internal Medicine* 2011; DOI 10.1007/s11606-011-1662-4.
2. Daugherty J, et al. Intimate partner violence screening in the emergency department. *Journal of Postgraduate Medicine* 2008; 54:301-305. ■

Nurses report bullying, disrespectful behavior by other nurses similiar to 'hazing'

A hierarchical order that 'eats their young'

A common perception is that a lot of the bullying and disrespect that can create a toxic work culture in healthcare settings is directed by physicians toward nurses. Surprisingly, nurses appear to observe a hierarchy within their own ranks that may be just as mean-spirited, says **Elaine Larson**, PhD, RN, FAAN, CIC, associate dean for research at the Columbia School of Nursing in New York.

"A doctoral student who just graduated did her dissertation on bullying among nurses," Larson says. "Actually, there is quite a body of literature on bullying within the profession of nursing, and it is rather common. What she found was that a majority of nurses at some time in their career have been harassed or bullied by a colleague in nursing. So I don't think it is specifically just physicians to nurses."

Factors contributing to such behavior include a high-stress work environment where lives could literally be at stake. Any bullying or disturbing disrespect on top of the normal job stress can endanger the health of both patients and workers.

"The tradition in medical education has been much more confrontational," Larson says. "There is such a high level of stress and rushing around that a sense of respect and mutual kindness [is lost]."

As a result, some healthcare cultures "eat their young," to borrow a disturbing phrase from the aforementioned dissertation. "Some of the rude and aggressive behaviors probably have to do with self-protection," Larson adds. "There are some people who have learned to move along the blame as much as possible and cover their backs."

In another study, a 2014 survey of more than 2,000 nursing school graduates found that 48% were concerned about being the victims of bullying or working in a hostile environment, according to Kaplan Test Prep of New York City.[1]

"It's a pretty common phenomenon that nurses talk about," says **Susan Sanders**, DNP, RN, NEA-BC, vice president for Kaplan Nursing.

The organization conducted its survey to see if the problem was pervasive, Sanders says.

"Sure enough, the majority of new nurses had heard about bullying, knew someone who experienced it, or experienced it themselves," she adds.

They primarily described peer-to-peer bullying, Sanders says.

"It's thought to be the result of having high-pressure jobs," she notes. "In general, nurses are very collaborative and yet they have high expectations, so if you come into our environment and are not meeting our expectations for whatever reason, it falls on us to do more."

Resentment of new and inexperienced or otherwise slower nurses can set in and result in bullying behavior, she adds. Kaplan Test Prep's survey found that 79% of nursing school graduates think nursing schools should provide special training on how to handle workplace bullying or hostile work environments.

ANA developing position paper

The issue of workplace violence and bullying has become a major topic of discussion among healthcare leaders. For instance, the American Nurses Association (ANA) of Silver Spring, MD, has convened a professional issues panel on workplace violence, bullying, and civility.

"Our focus is to develop a position statement for RNs and employers, and it includes background research," says **Jaime Murphy Dawson**, MPH, senior policy analyst in the department for nursing practice and work environment at ANA.

ANA's panel of 25 healthcare professionals now is working on the draft document. ANA also formed an advisory panel of more than 400 registered nurses.

"The exciting part is when we develop these policy foundational statements, we'll do continuing education programs and toolkits," Dawson says. "This is the first step in a multipronged initiative to address workplace bullying and violence."

ANA recently surveyed nurses, asking about bullying and violence, as part of the preparation for the panel. Four thousand nurses responded to the unpublished survey, and a majority said they were interested in the topic of violence

and bullying because they wanted to create a safer healthcare workplace, Dawson says.

Nurses reported the groups most likely to commit a violent act were patients and their family members, and the groups most likely to exhibit incivility were their colleagues, including nurses and physicians, she says.

"For a long time, bullying and violence were accepted as part of the job," Dawson notes. "We hope that culture is changing and nurses will be comfortable reporting incidents."

Employee health leaders can help reduce bullying and incivility by encouraging employees to report incidents and also by teaching them the difference between acceptable and unacceptable behaviors, she suggests.

"Then you have to show nurses that what they're reporting is leading to policy changes," she adds.

Akin to hazing

Research into hospital workplace bullying suggests there is a hazing culture among nurses, says **James Blando**, PhD, an assistant professor at Old Dominion University College of Health Sciences in Norfolk, VA.

"It's an 'I had to deal with it, so you have to deal with it,' attitude," he says. "Bullying goes beyond name-calling."

While interviewing nurses for research into hospital violence, Blando found that some forms of bullying had major impacts on their home life. For instance, some nurses reported that one way a hospital manager might get back at an employee is by cutting their work hours when they count on the extra income or by giving them less desirable tasks.

"That's a real significant issue because healthcare is the type of work where you have to work together," Blando says.

Another commonly reported problem was bullying by physicians, he says.

"Since physicians are the money-generators, nurses would say they felt management was extremely permissive toward them," Blando says.

In one example, there was an emergency department nurse who made a decision about putting a patient on a fast track. A doctor disagreed angrily, throwing a clipboard at her and breaking her nose, Blando recalls.

"He was reprimanded, and that was it," he says. "We heard of another surgeon who was operating on a patient and then threw a bloody scalpel at a nurse who was not moving fast enough. The patient had AIDS, and the physician's hospital visiting privileges were revoked, but he went on to another hospital."

The key to preventing these incidents and other less extreme forms of bullying is to teach nurses and other hospital staff that putting up with bad behavior is not part of their jobs, Blando says.

"You should have respectful behavior among all of your coworkers," he says.

Bullying in hospitals is not a new phenomenon, says **Susan King**, MS, RN, executive director of Oregon Nurses Association (ONA) in Tualatin, OR. ONA has addressed the issue with resources about bullying available online (http://www.oregonrn.org/?103).

The bigger issue is the hostile work environment that many nurses and other healthcare employees experience, King says.

"Nurses, whether in a hospital or long-term care facility, are finding that individuals who are making decisions are not clinicians and have little understanding of what patient care requires," King says. "Yet they are making decisions on staffing, and front-line managers are responsible for implementing and upholding bad decision-making."

Hospital employee health leaders could identify bullying as an important worker health issue and take preliminary steps to determine if there is a problem in their hospital, Sanders suggests.

They can do this with a staff survey that asks:

- Have you ever experienced bullying?
- Have you seen bullying occur?
- Is there something happening in our organization that is causing bullying?

The goal is to identify patterns and trends. For instance, if there is a high nursing turnover rate, then stress and factors like bullying could play a role, Sanders notes.

Employee health has an opportunity to identify what's going on and determine ways to support new nurses and other staff to prevent resignations due to a hostile work environment, she adds.

"There is literature that says one-third of nurses leave their nursing jobs within the first year," Sanders says. "It may be due to bullying or to not recognizing what the nursing career is about, but that's a huge financial impact on the hospital."

REFERENCE

1. Kaplan Test Prep. Kaplan Survey: Nearly Half of Recent Nursing School Graduates Are Concerned About Working in a Hostile Environment or Becoming Victims of Workplace Bullying. Aug. 28, 2014: http://bit.ly/1tZ4Dwt. ■

Only 1 HCW confirmed as occupationally infected with HIV in last 15 years, with 12 'possible' cases

Safer devices, PEP reduce risk of exposure and seroconversion

In the 1990s, tragic cases of healthcare workers who acquired AIDS and hepatitis on the job helped propel the movement for sharps safety. The evidence now shows the success of safer devices, standard precautions and post-exposure prophylaxis: In the past 15 years, only one health care worker developed HIV in a confirmed occupational exposure, according to a report from the Centers for Disease Control and Prevention.[1]

Twelve other healthcare workers had HIV infections that were possibly occupationally linked, CDC says.

The improvement in HIV treatment often means lower viral loads for patients and better post-exposure prophylaxis for healthcare workers, says **David Kuhar**, MD, medical officer with CDC's Division of Healthcare Quality Promotion. But healthcare workers must report their exposures and receive prompt evaluation and follow up, he says.

"It remains critical to report these injuries and take them seriously, and not just [out of concern] for HIV," he says. "There's also risk for infection with other bloodborne pathogens."

The only recent confirmed case of occupationally acquired HIV involved a technician in a research laboratory who sustained a needlestick with an HIV-positive culture in 2008. The technician did not take antiviral medications for post-exposure prophylaxis, says **Patricia Joyce**, MD, medical officer and epidemiologist with CDC's Division of HIV/AIDS Prevention.

"We don't know all the factors and decisions that were made in the clinical management of this case," she says. But Joyce adds that testing, evaluation and follow up need to be done in a timely manner.

Nurses at high risk

Between 1985 and 2000, 57 healthcare workers had documented cases of occupationally acquired HIV. Twenty-four (42%) of them were nurses and 16 (28%) were laboratory technicians. Some 88% of the incidents involved hollow-bore needles.[2]

Of the 12 cases since 2003 that were deemed to have a possible occupational link, five were clinical lab technicians, two were nurses, and one was a non-surgical physician, Joyce says. "Nurses are among the highest risk [groups] both for the confirmed and the possible [cases]," she says.

Joyce also notes that hospice nurses and health aides have potential exposure to blood and body fluids and also are at risk of HIV and other bloodborne pathogens.

The small number of occupationally acquired HIV cases shows the effectiveness of precautions, safer devices and prophylaxis. But that shouldn't be interpreted as evidence that there's less risk of getting HIV from a needlestick or other exposure, say Joyce and Kuhar.

"We don't know how many people were at risk and because they followed [recommended protocols] and took post-exposure prophylaxis didn't get infected," says Joyce.

REFERENCES

1. Joyce MP, Kuhar D and Brooke JT. Notes from the field: Occupationally acquired HIV infection among health care workers — United States, 1985–2013. *MMWR* 2015; 63:1245-1246/
2. Do AN, Ciesielski CA, Metler RP, et al. Occupationally acquired human immunodeficiency virus (HIV) infection: National case surveillance data during 20 years of the HIV epidemic in the United States. *Infect Control Hosp Epidemiol* 2003; 24:86-96. ■

COMING IN FUTURE MONTHS

- Home coaching decreases re-admission and costs
- ACOs offer new roles for case managers
- Removing barriers to care access
- Pain management through the care continuum

CASE MANAGEMENT ADVISOR™

CNE INSTRUCTIONS

To earn credit for this activity, please follow 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; tests are taken after each issue. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

CNE QUESTIONS

1. According to a 2014 study by the Commission for Case Manager Certification (CCMC) in Mount Laurel, NJ, what percentage of case managers is over age 55?

A. 25.3%
B. 38.3%
C. 43.6%
D. 55.2%

2. The 2014 CCMC study found that what percentage of case managers comes from a registered nursing background?

A. 54%
B. 68%
C. 73%
D. 89%

3. Which of the following most accurately describes the difference between palliative care and hospice care, according to Medicare guidelines?

A. Palliative care, while focusing on pain and symptom control, is for patients at any stage of a serious illness and not just for patients who are discontinuing curative treatment and who are expected to die within six months.
B. Palliative care is more focused on pain and symptom control, while hospice care is about creating a holistic and spiritual environment of caring for patients at the end of life.
C. Palliative care is for patients who have between six and 12 months of life expectancy, while hospice care is for people who have less than six months of expected life expectancy.
D. None of the above

4. From a case management perspective, what is a major goal of palliative care?

A. Case managers can refer patients to palliative care services for the purpose of providing optimal end-of-life care in the last few months of their lives.
B. Case managers can help families and patients develop advance directives that will facilitate their palliative care.
C. Case managers work with palliative teams to coordinate care with surgeons, oncologists, cardiologists, and providers and to put the separate medical pieces together, treating patients holistically.
D. None of the above