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AHC Media

Case managers are a natural fit for roles in public policy advocacy

They only need to get started

Professional case managers (CMs) make natural public policy advocates because of their broad knowledge of healthcare and their leadership experience. Such skills especially are needed to ensure case managers can have an impact on healthcare legislation and rules during this time of a changing healthcare landscape, according to several case management leaders and speakers about public policy involvement.

"Case managers' involvement in public policy is critical," says **Patricia Noonan**, RN, MBA, CCM, director of transitional and ambulatory care management at Northeast PHO in Beverly, MA. Noonan has spoken at conferences and written about public policy and case managers.

"With the healthcare landscape rapidly changing, it's important the professional case manager's voice is at the legislative table," she adds.

"Case managers can be champions of public policy," says **Chriss Wheeler**, RN, MSN, CCM, partner at Innovative Care Consultants in

EXECUTIVE SUMMARY

Case managers have skills and experience that make them natural public policy advocates. This is a role that's greatly needed in this era of an evolving healthcare landscape, experts say.

- Case managers can influence public policy on the federal level as rules and guidelines continue to be written as part of the Affordable Care Act.
- States also need to hear from case managers about issues that affect the field and practice of healthcare.
- A goal should be to build long-term relationships with policymakers at all levels.

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

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EDITOR: Melinda Young.
MANAGING EDITOR: Jill Drachenberg (404) 262-5508
EDITORIAL & CONTINUING EDUCATION DIRECTOR: Lee Landenberger

Independence, MO.

CMs are leaders with social influence and often have the elements of transformational leaders, including the ability to influence, inspire, motivate, stimulate intellectually, and consider individuals and what skills and talent they bring to the table, Wheeler explains. *(See story on evolving into a CM leader, page 112.)*

Organizations representing case managers have spent years advocating for the profession in public policy, says **Connie Sunderhaus**, RN-BC, CCM, vice president of CXJ Corporation in Glen Ellyn, IL. Sunderhaus and Wheeler have also spoken at conferences about public policy.

"Legislators need to be aware of how case managers coordinate care," Sunderhaus says.

This has been especially true in recent years with the Affordable Care Act, she adds.

"With the passing of the Affordable Care Act [ACA] in 2010, we have all seen the healthcare landscape really be transformed and provide so many opportunities for new healthcare models that include professional case managers," Noonan explains. "The fact remains that case managers have been blazing trails to advance quality healthcare in America for a long time."

Federal grants and incentives have propelled the new care models of accountable care organizations (ACOs), patient-centered medical homes (PCMHs), and community care transitions, she adds.

Centers for Medicare & Medicaid Services (CMS) transition grants are being used to improve the quality of care across the country, particularly for people living with chronic conditions, Noonan says.

"We know clearly from the latest published reports that one of the challenges our country faces is the growing aging population," Noonan notes. "And we know that as the population ages, they are faced with chronic conditions."

These realities provide an opportunity for professional case managers to work with patients and providers and take lead as part of a care team that is driving and advancing quality care, she adds.

When CMs decide to become more involved in public policy, the next step is to decide how they would like to be involved. There are multiple opportunities and needs right now, Noonan and Sunderhaus say.

For instance, the following are several examples:

• **Federal policy advocacy.** The Affordable Care Act has resulted in many policy and regulatory changes that often are introduced without any input from case managers, Noonan says.

"Some of these policies may contain funding or specific language as to who can be a provider or be funded for the provision of services to various populations," she explains. "So it's critical that case managers be an active participant in reaching out to their legislators."

Each person has a right as a constituent to talk with federal or state lawmakers and to show them how case managers are helping to advance quality care across the nation, Noonan says.

"We can do that by simply writing a letter or contacting our federal legislator and asking for an opportunity to meet and share information about how professional case managers are involved in healthcare and advancing quality care as part of the care team," she adds.

One of the ACA's missions is to improve care quality through a focus on prevention and management of chronic conditions while also reducing unnecessary costs and hospital readmissions. This mission fits in very well with what case management is all about, and it's important that CMs meet with legislators and their staffs to help them understand how important case management is to improving healthcare, Noonan explains.

Professional organizations representing case managers have been meeting with federal lawmakers about ACA and other issues. So one easy way for individual CMs to get involved is to join a case management organization and support that group's public policy efforts, Noonan says.

"It's important we take the mystique out of getting involved in public policy," she notes. "We have so many professional organizations that have mentors and public policy champions and individuals who would be happy to share and help or mentor and lead the way with case managers who want to be more actively involved in public policy."

Case managers who are RNs could join the American Nurses Association (ANA) and the Case Management Society of America (CMSA) — both of which have public policy tabs on their websites, Wheeler says.

"Their websites have information about different bills that the professional organization is following," Wheeler notes. "I receive e-blasts from ANA saying, 'ANA is supporting this bill,' and then they give me information about the bill, and if I want to make sure my legislators know about that bill and that I support it, I can put my name on a letter that they wrote."

The organizations even provide a quick ZIP code search for CMs to find their local legislators, she adds. "It takes 10 to 15 minutes."

CMs also could help influence federal policy by learning more about Congressional action telehealth, Wheeler suggests.

"Telehealth is something that can impact case managers," Wheeler notes. "Some case managers are following patients [by telephone] from the hospital all the way into the primary care physician's office."

Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 in April, and this bill addresses telehealth policy, providing merit-based incentive payments for the use of telehealth to communicate test results and to use remote monitoring as part of care coordination. Also, the 21st Century Cures Act was passed by the U.S. House of Representatives and is now being considered in the U.S. Senate, where some senators have expressed interest in adding language that would address telehealth.

Wheeler has met with CMS officials when they've visited her city to discuss concerns over how Medicare defines case management services and to express concern that it isn't defined so generally that it is meaningless when a healthcare organization says that it uses case management and meets Medicare rules: "I shared my concern that if we don't have the right person doing the right job, then patients won't have the right outcomes."

• State policy advocacy. A current example of how case managers can influence state policies involves the Nurse Licensure Compact (NLC).

The NLC allows nurses to have one multistate license for states involved in the compact. It was revised on May 4, 2015, after initially being launched in 2000 by the National Council of State Boards of Nursing (NCSBN) in Chicago.

The NLC was revised to address some states' concerns that the original compact did not require criminal background checks, Sunderhaus says.

The original compact was approved by 25 states, but the new one must be approved again. *(See story about NLC, page 113.)*

"This is a state-based issue and our state legislators need to make decisions about it," Noonan says. "They could learn from case managers in states that have not joined the compact why it's important that this particular state join the compact."

When legislators are in their local districts, there is a good opportunity to meet with them and explain why the compact would benefit healthcare, as well as case managers and nurses, she adds. "Set up an appointment and be an active participant."

• Build relationships with policymakers. Even at the local level, it is important for CMs to meet with council representatives and other policymakers to share information about case management, Noonan says.

"Seek out opportunities to meet with your local legislators at a town hall meeting," she suggests.

"My personal best opportunity has been to contact my local legislators' office and find out when they'll have their next town meeting," Noonan says. "Then I set up an appointment and can be an active participant."

Town meetings with constituents provide some of the best times to meet with policymakers to discuss issues that concern case managers and quality healthcare, she adds.

"Our legislators are interested in hearing from their constituents and

hearing what are the issues impacting the population in their local district," Noonan explains. "They're interested in hearing from professional case managers."

Meeting with your policymakers — both state and federal — when in their local district, also helps to build long-term relationships, Noonan and Wheeler note.

"It's about individuals getting their voices out there, even if it's to say, 'Hey, I'm a case manager, and there's a lot going on in healthcare. If you ever have any questions about case management, I'd love to help,'" Wheeler says.

"Our stories and our passion really resonate each time we meet with either local policymakers or legislators on Capitol Hill," Noonan says. "It's a great activity — to advocate for our professional practice." ■

Here are some tips on helping CMs evolve into policy leaders

Network and take a chance

Case managers just need a little confidence and a big mission to become public policy leaders, experts say.

"We're in the frontlines and we see healthcare's fragmentation every day," says **Chriss Wheeler**, RN, MSN, CCM, a partner with Innovative Care Consultants in Independence, MO. Wheeler also has served in public policy roles for case management organizations and has spoken about public policy leadership at national conferences.

"Our role is to pull together the pieces to get what the patient needs, and at the same time you have to spend a little money up front and have cost effectiveness show up on the backside," Wheeler says. "There's a disconnect between specialists, sometimes, and how they look at their own piece of the pie."

But case managers see the whole pie and, as such, have a story to tell the public about how case management can help patients and move them through the continuum of care for optimum wellness for whatever health they have, she explains.

Wheeler offers the following tips on how case managers can evolve into public policy leaders:

• **Address national quality initiatives.** CMS has quality initiatives including the National Quality Strategy, which has six goals:

- Make care safer by reducing the harm caused in the delivery of care.
- Strengthen person and family engagement as partners in their care.
- Promote effective communication and coordination of care.
- Promote effective prevention and treatment of chronic disease.
- Work with communities to promote best practices in healthy living.
- Make care affordable.

Case managers can address these goals in their advocacy for case management services, which are well aligned with those goals, Wheeler suggests.

"You can become a public policy champion at the national level," she adds.

Or they can be informal leaders, advocating within healthcare organizations for case management's involvement in the continuum of care as one of the ways organizations can meet the CMS quality goals.

• **Get involved in local case management organization chapters.** Most chapters have a public liaison role, and that's a good way to get started in being involved in public policy, Wheeler says.

"You can find out what's happening nationally and how that will impact the state level," she suggests.

This position of authority also is a great way to network and meet case management peers across the country and within national organizations.

From there, a case manager might become involved with a public policy committee at the national organizational level or become involved in the national organization's governmental affairs, Wheeler says.

• **Educate yourself about national and state policies that affect case management.** "We don't get a whole lot of education about policy and policymaking," Wheeler says. "So I think sometimes we have a lack of confidence that holds us back from reaching out to our legislators at the local, state, and federal levels."

By researching various pending bills and issues that are important to case managers and healthcare, case managers will gain confidence and be able to discuss issues with policymakers when they meet at conferences or in scheduled meetings.

"An ah-ha moment for me was when I at a meeting where the president of CMSA [Case Management Society of America] gave us a little pep talk, saying, 'You are the experts in your practice,'" Wheeler recalls. "I had never thought of myself as an expert, and yet, in order to take ownership of your practice, you really need to realize you bring value and an expertise that other people don't have."

Case managers can add value to the policymaking process and their input is necessary, she adds.

• Attend the annual CMSA day on Capitol Hill. Each year the CMSA invites case managers to join CMSA leaders on Capitol Hill to meet with House and Senate representatives. They highlight the critical role CMs play in healthcare delivery, and they learn more about grassroots advocacy. This year's meeting was held on Sept. 17, 2015.

"There's a networking reception, continuing education unit meeting in the evening, and then they divide case managers by regional groups, making sure there's one seasoned person in each group," Wheeler says. "The first year we did this, folks would ask, 'What is a case manager?' By the third year, the same Congressional staffers were saying, 'I know what a case manager is, but tell me about your caseload,' and you could tell they were starting to understand." ■

Having states pass the revised Nurse Licensure Compact could help CMs

Bills are pending in six states

A new Nurse Licensure Compact (NLC) would allow registered nurses or licensed practical/vocational nurses to possess a multistate license that permits them to practice in their home states and other NLC states.

Case managers who have nursing licenses could be affected by the compact because their jobs sometimes can include working with patients across state borders — whether through telemedicine, workers' comp, or in multistate health organizations, says **Connie Sunderhaus**, RN-BC, CCM, vice president of CXJ Corporation in Glen Ellyn, IL.

The NLC originally was created in 2000 by the National Council of State Boards of Nursing (NCSBN) and in 2015, it included 24 states with an additional state — Montana — added this year. The NCSBN's goal was to base a mutual-recognition model on state driver's licenses so nurses could practice in states other than the state where their license was issued, according to NCSBN's *Nurse Licensure Compact* article, which can be found at http://bit.ly/1XpOonK.

But the new version, adopted May 4, 2015, also has to be approved through legislation in each state that previously approved the compact. So far there are bills pending in Illinois, Massachusetts, Minnesota, New Jersey, New York, and Oklahoma. Montana has passed a bill approving the new NLC, and it will be implemented Oct. 1, 2015.

There are 24 states that previously supported the NLC, but have not acted on the new compact, and those states are where case managers could have a big effect in public policy, Sunderhaus says.

"That's an issue that's very close to case managers because they're very often the ones that have to deal with patients in other states," Sunderhaus says. "They're following patients to an appointment or with telephonic support."

For instance, CMs who work on workers' comp cases might not even realize that if they have a patient who lives in a neighboring state, they

EXECUTIVE SUMMARY

Since 2000, when the original Nurse Licensure Compact (NLC) was created, 25 states adopted the compact, which allows nurses to possess a multistate license for practice in NLC states. Now the compact has been updated, and only a handful of states have pending bills to approve the compact.

- The compact applies to registered nurses or licensed practical/vocational nurses.
- The NLC simplifies practice across state lines for case managers with nursing degrees.
- Without the NLC, CMs and nurses would need a license for every state in which they practice.

personally would need licensure from the patient's home state to be able to work with that patient, she says.

"I've heard of nurses getting up to 20 licenses in different states," Sunderhaus says.

This is very complicated because each state has different rules regarding continuing education units and other criteria, she says.

In other cases, nurses might practice in other states without realizing that they needed a license in each state of practice unless the states were all part of the NLC, she adds.

"As recently as five or six years ago, some employers would tell nurses [who practice in multiple states with no NLC], 'Don't worry about it,'" Sunderhaus says. "But the nurse is the one at risk."

The NLC simplifies things for all nurses, including CMs with nursing licenses. This is why case managers need to advocate for their states to pass the new NLC, Sunderhaus adds.

"Case managers' voice is important," she says. "They can call their state legislators, write letters, send emails, and stop by and visit each one."

The NCSBN website provides information about the NLC and talking points to use when speaking with state legislators about why it should be adopted.

For example, the NLC "clarifies the authority of nurses currently practicing telenursing or interstate practices," the policymaker sheet says.

Another benefit to point out to legislators is that the compact improves "state and facility access to licensed nurses during a disaster or other times of great need for qualified nursing services," it says.

More than two dozen professional organizations support the NLC, including the Case Management Society of America and the Case Management Leadership Coalition.

The states that implemented the previous NLC, but still need to act on the new one, include: Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin. ■

New CM model strives for more efficient transitions

Goal is to improve quality & efficiency

One of the healthcare problems that case management can address involves effective transitions of care from acute care facilities to skilled nursing facilities (SNFs). When these transitions go well, patients benefit and healthcare resources are used efficiently.

The Affordable Care Act created the Community-based Care Transitions Program to test models for improving care transitions from the hospital to other settings and to reduce readmissions among high-risk Medicare patients. CMS has encouraged all organizations to create their own models.

One Maine organization recognized early in 2014 the need to improve their members' transitions from acute care to SNFs. The transitions were not as effective or as speedy as they needed to be, partly because of a prior approval requirement, says **Maggie J. Kelley**, MSN, APRN-CNP, COHN-S, director of medical services for complex care management at Maine Community Health Options in Lewiston.

"We re-evaluated that experience and said that when members need SNF, we should make that experience happen quickly," Kelley says. "So we removed the authorization requirement and communicated that to the network providers."

Network providers were told that if a transition — over a weekend or holiday period — was medically necessary then they should go ahead and transition the person. "Then we ask them to submit clinical documentation," Kelley says.

Previously, providers had to wait for approval to move a patient. Now they make the transition, and simply seek approval within three days of the transition. This takes care of weekend transitions and prevents patients from being kept in the acute care facility longer than medically appropriate.

"It's worked out fabulously well," Kelley says.

This simple change also meets CMS goals for improving care transition, she notes.

"CMS was looking at quality of care, timeliness, member experience, improving population health, and reducing costs," Kelley notes.

"It's a three-pronged approach of providing high-value services,

exemplary member experience, and then reducing costs," Kelley says. "And that's the baseline of our approach."

This is one example of changes the organization made to be more nimble with care transition and to overcome barriers, says **Melissa M. Gerry**, RN, CCM, lead care manager of complex care management at Maine Community Health Options.

Another example involves a care/case manager (CM) finding community resources to help a patient receive the care she needed at her own home, Gerry says.

"We had a member who was in her 40s and diagnosed with brain cancer," she explains. "She had a young child and was married to a person who was the sole provider of a business. When she became impaired neurologically, she was unable to take care of herself and had to have 24/7 care."

The woman's husband took her to different providers, and a care manager became involved with the case, Gerry recalls.

"The care manager connected with the spouse," she notes. "The member's neurological changes did not allow her to have conversations with the care manager."

After her disease progressed and treatment options were exhausted, the woman needed to live in a skilled nursing facility — at least until she regained her strength enough to function at home, Gerry says.

"She ended up accepting hospice care at the skilled nursing facility, and she really wanted to go home," she adds. "The benefit plan doesn't provide for custodial care, so the care manager went through an alternative plan of care process, looking at what this member needed and what was medically necessary."

After assessing community resources and family support, the CM created an alternative plan that included a cost-benefit analysis for proposed in-home coverage of eight hours per day, five days a week. This was the time the spouse needed to manage his business, Gerry says.

"We were able to make this happen, and the member was able to go home with hospice support," she adds.

Alternative plans of care go into effect only under extraordinary circumstances, Kelley notes.

The driver for implementing an alternative plan of care is what type of care the member needs and the CM being an advocate for the patient, Gerry says.

"We have to balance it with stewardship, which is why it's a rigorous process of looking at what's appropriate for the member," she adds.

Once an organization focuses on CMS' three-pronged approach, case managers and leaders can come up with other ways to improve care, as well as costs.

For instance, a value-based insurance design promotes high-value care that aligns member incentives with out-of-pocket cost, guided by evidence-based outcomes in treatment of chronic conditions such as asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes, and hypertension, Kelley says.

"With those conditions, there is strong evidence that if the individual follows guidelines for routine management, they'll have better outcomes and improved costs," she explains. "So we eliminated out-of-pocket costs."

Also, while most health plans provide diabetic patients with a glucometer, but not the strips, they've included test strips for up to 150 every three months and they'll consider more if needed, Kelley says.

In the area of behavioral health, the plan removes the out-of-pocket costs for the first three behavioral health visits, including counseling and psychiatric management, she says.

"We help members get the right care at the right time," Kelley adds.

For instance, if a member has been in an acute inpatient psychiatric setting and needs to see a medical provider after discharge, the plan will allow a same day visit because transportation can be a barrier for patients, and the connection with the outside provider might prevent the person's relapse and readmission, Kelley explains.

"We've contracted with community care teams to put boots on the ground if needed," she adds.

"So if we have a very vulnerable member, we can use the care team's service," Kelley says. "We also have behavioral health clinicians on our care management team, as well as RNs and MSWs." ■

EXECUTIVE SUMMARY

An efficient transition of care system can provide faster transitions from acute care facilities to skilled nursing facilities.

- A Maine organization developed a faster transition model after noting that patients often were transitioned too slowly due to approval lag times.
- Transitions were particularly problematic over weekend periods.
- The new model gives providers the chance to make transitions when medically necessary without prior authorization.

Study suggests more training, support for nurses treating patients with behavioral health concerns

Specialized protocols can speed care, put providers and patients on the same page

Caring for patients with behavioral health (BH) concerns presents a number of challenges in the emergency setting. Studies have shown that such patients often experience long lengths-of-stay (LOS) while awaiting care from a specialist or referral to another facility. These problems, in turn, can lead to crowding, boarding, and other issues that ultimately affect non-BH patients in the ED as well.

What can EDs do from a nursing perspective to improve care for this patient population while also eliminating some of the spill-over effects on other patients? A new study from the Emergency Nurses Association (ENA) suggests nurses perceive that more guidance in terms of practice guidelines and specialized protocols is needed in this area. Further, they voice frustration about what they perceive as a lack of tailored education as well as resources to optimally care for BH patients presenting with mental health crises and concerns.

An analysis of survey data and information gleaned from focus group sessions suggests there are several interventions that, at least from a nursing perspective, could potentially improve the care BH patients receive in the emergency setting and shorten their stay there as well.[1]

Address gaps in training

The study involved a combination of self-report surveys and focus group responses on a range of issues not well covered in the literature, explains **Lisa Wolf**, PhD, RN, CEN, FAEN, the lead author of the study, director of ENA's Institute for Emergency Nursing Research, and a clinical assistant professor of nursing at the University of Massachusetts in Amherst. "There was really not a lot of information on such things as LOS, models of care, or the role of nursing in the care of BH patients," she says. "So we developed a survey to perhaps answer some questions about what kind of care models were being used, what nurses felt in terms of preparation, and what they felt about attitudes toward BH patients."

The 35-item survey was developed in concert with a committee of emergency nurses with expertise in BH care, and it covered topics related to preparation/training, confidence levels, average LOS, the use of protocols, availability of dedicated BH staff, the use of chemical and physical restraints, and dedicated space for BH care.

"We sent out [the survey] and got about 1,230 responses, and then we triangulated that data, using focus groups at our annual conference in Nashville in 2013," Wolf explains. "We had about 20 nurses split into two groups ... and we told them to tell us about their experience in caring for BH patients, and really put flesh on the bones of those quantitative [survey] questions."

The survey responses and focus group comments indicate that while nurses want to provide good care to BH patients, they feel they are inadequately prepared to do so, Wolf explains.

"There is that sense of operating in an informational vacuum a little bit," she adds. "Plus, our physician colleagues are also not well-prepared to care for these patients. They are very reluctant to do so. They don't get a lot of training in emergency psychiatry."

The researchers found a huge proportion of nurses had received no training in BH beyond nursing school. What this means, according to Wolf, is that while a nurse is likely to receive a lot of information about strokes, heart attacks, and similar crises, information about BH crises is not presented in a way that is clinically available. "That lack of understanding produces a lot of frustration," she says.

For example, while it is quite common in any given ED to find emergency nurses who specialize in trauma, cardiac emergencies, or pediatrics, there also should be nurses trained in caring for people with BH emergencies, Wolf notes.

Employ BH nurses

Study participants reported that the average LOS for BH patients who present to the ED is 18.5 hours, a statistic that is problematic given that studies have shown that such lengthy stays adversely impact care. More than half of the participants (57%) noted their hospitals have no inpatient psychiatric unit, and 51% indicated their hospitals have no dedicated treatment area for BH patients. Just 35% of respondents

reported their EDs had dedicated BH staff to assist with the management and care of BH patients, and 24% said they did not have a standardized protocol for managing this patient population.

What factors seemed to make the biggest difference on LOS? Researchers found the presence of a specially trained BH nurse reduced LOS substantially. "The limitation is that this is nurse-level data, but I would say anyone who uses electronic tracking can look at their board and get a pretty good idea of what the average LOS is in their department," Wolf says. "Our finding of 18.5 hours is certainly not outside the realm of plausibility, but using that number, we do see a significant reduction in LOS, given the presence of a nurse trained in BH emergencies."

Nurses trained in BH do not necessarily have to have prescribing ability to be effective, Wolf says. "When you have someone who has specific training in any given sub-specialty of emergency medicine, they know what the plan should be, and they know how to advocate," she explains. "They can move the care of the patient along and advocate for them in a way that someone without that training might not be able to do."

Another step that individual departments could initiate is to identify and adopt a protocol so that the care of BH patients is standardized, Wolf says. "Is everybody doing the same thing when a BH patient comes into the ED from triage to the physician? Is everybody on the same page? Protocols help you to do that," she says. "I would say the first thing that most departments could probably put into place without an incursion of financial obligations is a protocol to move things along, to have a map for the care of these patients."

Wolf also advises ED administrators to consider staff training on how to effectively care for patients with BH emergencies. "This can involve the suicidal patient, the schizophrenic patient who is off his or her medicines, the depressed patient who maybe doesn't have a plan [for suicide] but you don't really know for sure, or the potential overdose," says Wolf. "How do we keep people safe when there are no external markers?"

> "IF EVERYONE IS ON THE SAME PAGE IN TERMS OF CARE, YOU HAVE LESS AGITATION BECAUSE EVERYONE IS CLEAR AND EVERYONE IS NOT ADRIFT. THEY KNOW WHAT HAPPENS NEXT — BOTH NURSES AND PATIENTS."

Wolf adds that ED administrators should consider implementing a steady dose of in-service training to address such issues. "Dealing with patients with BH crises should be a part of every ED orientation," she says. "If everyone is on the same page in terms of care, you have less agitation because everyone is clear and everyone is not adrift. They know what happens next — both nurses and patients. That is important."

A more difficult problem to tackle is the lack of inpatient space for BH patients who are waiting for a bed. Researchers found that this problem certainly leads to extended LOS, but a solution to the problem requires attention at an institutional or societal level, Wolf acknowledges.

Stress education, support

EDs that have effective BH protocols in place as well as a trained BH nurse on site might want to proceed to the next level of care — the use of a psychiatric nurse practitioner, Wolf says. However, she observes that most EDs still have plenty of room to improve on the implementation of the earlier steps.

"The majority of EDs struggle with this because these long lengths-of-stay tie up beds, contribute to crowding, and reduce the ability of people to care for the other people in the ED," Wolf notes. "The nurses we spoke to [as part of this study] were passionate in their wish to provide really excellent care to this population. Nurses want this education. They want to do this well, so if this study goes anywhere towards stressing education, training, and support for the nurses caring for BH patients, then we are on the right track."

REFERENCE

1. Wolf L, et al. U.S. emergency nurses' perceptions of challenges and facilitators in the management of behavioural health patients in the emergency department: A mixed-methods study. *Australas Emerg Nurs* J 2015 Apr 28 [Epub ahead of print]. ■

Providers must tread carefully if patient objects to caregiver

Patients voice opinions on race, gender, religion, or sexual orientation

Recent racial controversies have prompted some risk managers to wonder how to respond if a patient objects to the race, gender, religion, or sexual orientation of a caregiver. The situation is difficult, and labor law experts advise risk managers to step very carefully once the issue is raised.

The dilemma is arising more as healthcare employers hire a diverse staff, says **Tom Harrington**, JD, principal with The Employment Law Group in Los Angeles. The patient's objection might involve the caregiver's religious attire, such as a head scarf, or the person's race or sexual orientation.

Conceding to the demands of the patient can put the hospital at risk of a discrimination claim by the employee, Harrington says. Even if the employer acknowledges that the action is taken only to mollify the patient and there is no endorsement of the discrimination, the employee still might suffer adverse consequences, he says.

"Even when the employer claims that the worker was not denied any hours or pay, and that the discrimination will not affect the employee's status or opportunity for advancement, it still is an inherently untenable position," Harrington says.

Accommodation

Patients do object to their caregivers with some regularity, according to researchers at the University of Michigan Health System, the University of Pennsylvania, and the University of Rochester. In 2010, they published the results of a study that confirmed what they called an open secret among healthcare workers: Patients frequently request providers of the same gender, race, or religion, and their requests often are accommodated.[1]

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To study the "culture of accommodation" in the hospital setting, the researchers surveyed 127 emergency physicians from around the United States. Participants reported that patients often request a physician of a race, gender, or religion different from the one assigned, and the facility often complies, especially when the patient is a woman, a racial minority, or a Muslim.

Some requests are related to modesty issues, such as when a woman prefers to be examined by a female nurse or doctor, but the researchers found that black, Hispanic, and Asian patients sometimes believe that they receive better care from doctors of the same race. The decision on accommodation usually falls to the physician, and the study found that female physicians are more likely to say yes.

Civil Rights Act applies

The 1964 Civil Rights Act (CRA) addresses various types of discrimination, and Title VII of the act prohibits employers from making any decisions about job assignments, promotions, or other terms of employment based on the person's status in a protected category, Harrington says. Those protected categories include race, gender, national origin, disability, age, and, in some jurisdictions, sexual orientation.

"That would extend to customer preferences because, ultimately, if the employer gives in to the biased requests of their customers, they are making an assignment based on the discriminatory preferences of their customers," he explains. "They would be ratifying the discriminatory

preference and extending that to their employees."

Employees might not even realize they have been discriminated against until some time later, but that situation does not mitigate the liability risk, Harrington says. Employees who find out after the fact that the hospital barred them specifically, or a person of their race, national origin, or other category, can make a claim that the discrimination adversely affected their job status.

"The question would be what the employee's damages would be. They would have to prove that they suffered economically in some way from the discrimination," Harrington says. "Even if you canvassed all your employees and got them to agree that it's OK to allow the patient to be treated by who he or she chooses, it is still discrimination. Being able to prove that you discussed it openly and there were no objections at the time of the discrimination would not make a lot of difference later when one of those employees takes you to court."

Case holds lessons

The bona fide occupational qualification (BFOQ) defense would be helpful only in limited circumstances, says **Kimani Paul-Emile**, JD, an associate professor of law at Fordham University School of Law in New York City. Title VII permits discrimination on the basis of "religion, sex, or national origin in those instances where religion, sex, or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business or enterprise." The BFOQ is usually not valid in regard to race discrimination, she explains, but it could be used in the small number of circumstances in which customer privacy is a concern.

"For example, although the BFOQ defense will not serve as a valid justification for an airline to hire only women as flight attendants to comply with male customer preferences, the privacy interests of psychiatric patients can justify a BFOQ for personal hygiene attendants of the same sex," Paul-Emile says. "To this end, courts have held that for certain workers, such as nursing assistants, hospital delivery room nursing staff, and others involved in assisting individuals with dressing, disrobing, or bathing, gender may be a legitimate BFOQ for accommodating patients' privacy or modesty interests."

The most relevant case, however, indicates that race is unlikely to be considered a BFOQ, she says. In Chaney v. Plainfield Healthcare Center, the court addressed a situation in which a nursing home had agreed to a patient's request to bar black nurses from her care. The court held that race is not a relevant factor to consider in addressing privacy concerns.

Though instructive, the Chaney case is not a direct parallel to the most common scenarios involving racial requests, Paul-Emile says. The decision to accommodate a patient's request is usually made by the treating physician rather than a hospital administrator, she explained in the *UCLA Law Review*. The different roles of physician and administrator are key, Paul-Emile said. *(Her analysis of the case is available online at http://tinyurl.com/pwpr3bm.)*

Accommodating the request can be seen as the physicians deciding among themselves how best to meet each patient's needs, Paul-Emile explains, and courts generally give physicians wide latitude in that regard. Physicians' willingness to accommodate is "likely due to the unique nature of the physician–patient relationship, which contrasts sharply with that of a CNA and nursing home resident," she says.

Harrington says the advice for risk managers is clear.

"It would be a mistake to go along with the patient's demands just to smooth things over," Harrington says. "It would expose you to significant liability."

REFERENCE

1. Padela AI, Schneider SM, Ali Z, et al. Patient choice of provider type in the emergency department: Perceptions and factors relating to accommodation of requests for care providers. *Emerg Med J* 2010; 6:465-469. ■

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CNE QUESTIONS

1. Why do case management policy advocates and leaders say it's so important for case managers to speak with their federal lawmakers about the case management role?

A. The Affordable Care Act has resulted in many policy and regulatory changes that often are introduced without input from case managers
B. Case managers can speak with their own state's legislators to explain how case managers help advance quality care nationally
C. A chief ACA mission is to improve quality care through prevention and management of chronic conditions, and this is a natural fit with case management services
D. All of the above

2. Which of the following is not one of the goals in the National Quality Strategy by CMS?

A. Make care safer by reducing harm caused in the delivery of care
B. Promote effective communication and coordination of care
C. Make certain each patient receives the best quality of care regardless of the cost
D. Promote effective prevention and treatment of chronic disease

3. Why is the Nurse Licensure Compact (NLC) important to case managers?

A. Nurse case managers often have to deal with patients in other states with in-person or telephonic support, and without the compact they would need a nursing license in each state
B. The NLC is equivalent to a national driver's license, and once it's passed, nurse CMs will be able to travel anywhere in the U.S. and its territories and practice nursing and case management without additional licensure
C. Nurse CMs will not need to keep up with continuing education credits once the NLC is passed
D. All of the above

4. CMS has a three-pronged approach to improving care quality, timeliness, member experience, population health, and reducing costs. Which of the following is included in the approach?

A. Providing high-value services
B. Exemplary member experience
C. Reducing costs
D. All of the above