CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

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Case management is crucial component of population health

Focus is on high-risk patients

Payer contracts increasingly nudge health systems toward a population health model with the goal of reducing healthcare growth while improving coordination and enhancing the quality of care. When cost drivers are analyzed, health systems invariably find that a small percentage of patients are driving healthcare costs, which suggests that focused case management (CM) can have a big effect on costs, as well as the quality of healthcare.

"There can be unnecessary and duplication of services for the highest cost patients," says **Sreekanth Chaguturu**, MD, vice president for population health management at Partners HealthCare in Boston.

"Having case managers work side-by-side with patients to help them navigate our complicated health system when they're most sick and most fragile is very important," Chaguturu adds. "This is a strategy to control costs; patients appreciate it because it helps them

EXECUTIVE SUMMARY

The population health model in healthcare is gaining ground as the industry recognizes the benefits in quality improvement, reduced costs, and improved health.

- Case management can have a big effect in population health through a concerted focus on high-risk patients within a population.
- CMs support patients and help facilitate patients' learning skills of health self-management.
- Data collection is an essential component to population health management.

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navigate the healthcare system, and physicians like it because it improves care coordination."

Accountable care organizations (ACOs) are perfect vehicles for population health and case management because they offer full services to a population, says **Cheri Lattimer**, RN, BSN, executive director of the Case Management Society of America in Little Rock, AR.

Other models such as patient-centered medical homes (PCMH) and having case managers embedded in primary care practices also work well with a population health focus, she adds.

"Sometimes people want to define a population in a narrow pathway, disease state, or age limit," Lattimer says. "When I talk about population health, I talk about the total population you serve: from birth to end of life."

Among the services this population needs are case management and complex case management with a behavioral health component and partnerships to enhance other necessary services, Lattimer says.

The big question is how to coordinate and integrate that transfer of information, Lattimer says.

"We've talked about population health for years, and now we can make it a center of excellence," she says. "There's a great opportunity to build a collaborative clinical team with the patient and family caregiver in the center of the team and to help them navigate this continuous care."

Case managers are there to support patients as they develop self-management skills, Lattimer says. "I really see this as a great opportunity."

Case management in a population health model can work very well when it's embedded with primary care provider services, but moving CMs to these offices can be challenging, Chaguturu notes.

"We have to make sure primary care has the bandwidth to take on this new type of work, including time, compensation, and also the space to have case managers sitting side by side in the offices," he says. "Before you introduce high-risk case management, you should make sure case management is well structured."

The Centers for Medicare & Medicaid Services (CMS) is beginning to provide financial incentives for case management and care coordination through new codes, including chronic care management codes, Lattimer notes.

"It's a code that a primary care office can charge for engagement and management of patients with two or more chronic diseases," she explains. "It includes thorough assessment, interaction, and engagement with the patient."

While only physicians, advanced practice nurses, and physician extenders can bill with those codes, nurses and case managers can provide the services, and the codes can be used for telephone and electronic health record services as well, Lattimer says. "It's a great recognition from CMS about the importance of managing chronic care and focusing on population health management."

Partners HealthCare has different initiatives within the context of population health management (PHM), says **Jennifer Wright**, RN, CCM, manager for the Integrated Care Management Program (iCMP) at Newton-Wellesley Physician Hospital Organization in Newton, MA.

"The first initiative to get launched under that umbrella was the Integrated Care Management Program," Wright says. "We also

have a behavioral health initiative and patient-centered medical home [PCMH]."

The iCMP is charged with managing the most medically complex and chronically ill patients, who have both high utilization and high cost across the continuum, Wright says.

Partners HealthCare has about 100 care managers to work with nearly 1,000 primary care physicians, Chaguturu says.

"We generally find that a case load of about 200 patients for a care manager is the right balance," he adds. "We've seen some health systems with as low as 50 patients per care manager and others with as high as 400 patients; we're trying to find the right ratio of care managers to patients."

The iCMP's caseload derives from claims-based data, Wright notes.

"We get a list of patients and review their medical records to see if they are appropriate for care coordination," she says. "Then we validate that list with our primary care providers."

Also, providers identify patients who need case management services, but are not yet on the claims list. So CMs work with primary care physicians to find patients who would benefit from the service, Wright says.

Case managers and social workers work together as a team. Case managers first meet with physicians, review the records and when it's agreed that certain patients are appropriate for enrollment, case managers will reach out to patients telephonically or face to face at their doctor's office, skilled nursing facility, hospital, or home, she explains.

"The way we've had the most success is when case managers are viewed as part of the primary care provider's team," Wright says.

Patients see the case managers as being part of their primary care provider's practice and are accepting of their services, she adds.

"We build on the relationship the patient has with their primary care providers," Wright says. "The primary care provider will say, 'This will be a great service for you.'"

Then case managers can work with patients to help them navigate through the healthcare process. *(See story on how embedded CMs help patients, page 4.)*

> "THE VIEW IN HEALTHCARE HAS TO BE THAT ONE IN THREE OR FOUR PEOPLE YOU ENCOUNTER HAS A SIGNIFICANT BEHAVIORAL HEALTH ISSUE THAT NEEDS TO BE ADDRESSED."

With a population health model, the key is to use data to determine which patients in a total population are at high risk and to target that subset, Chaguturu says.

Just focusing on managing specific diseases has yielded minimal savings over the years because many patients have more than one disease, he says.

High-risk patients typically have comorbidities and high rates of hospitalization and emergency department (ED) visits. Their comorbidities usually include a mental health issue, says **Monica Cooke**, MA, RNC, CPHQ, CPHRM, FASHRM, chief executive officer for Quality Plus Solutions in Annapolis, MD.

Case managers should keep mental health issues in mind when looking at population health, Cooke suggests.

"The view in healthcare has to be that one in three or four people you encounter has a significant behavioral health issue that needs to be addressed," Cooke says. "And we have very few resources in mental health because we've basically dismantled the behavioral health system in this country."

Once patients with mental health problems are identified, someone — often a case manager — has a responsibility to refer them and work with them to get them the appropriate resources they need, Cooke says. *(See story on finding resources for mental health issues, page 5.)*

"We do see that mental healthcare in the primary care setting is critically important," Chaguturu says.

"Say you have two patients — one with diabetes and one with diabetes and depression," he explains. "The one with both diabetes and depression will have 40% higher costs, so treating the patient's depression will reduce costs."

Referrals to mental health professionals are challenging because there is greater need for these services than there are professionals able to provide the services, Chaguturu notes.

"We know there will never be enough psychiatrists to treat all the mental health issues that exist in our patient populations, so we need to find ways to integrate them into primary care," Chaguturu says. "We need to spend time thinking about anxiety and substance use and depression — the three commonly seen issues in mental health settings — and we need to create new protocols and pathways to treat those patients." ■

Here's a snapshot of a model for case managers embedded with PCPs

CMs focus on high-risk patients

Case managers (CMs) embedded in primary care provider practices are at the right place and right time to help patients most in need of care coordination and engagement. These high-risk patients need help before they return to the hospital or are in crisis.

Healthcare providers now have financial, as well as quality, incentives to help their highest-utilization patients improve their health because the government under the Affordable Care Act (ACA) is holding providers accountable for healthcare costs, says **Sreekanth Chaguturu**, MD, vice president for population health management at Partners HealthCare in Boston.

"Over the last couple of years, we've seen a growth in healthcare expenditures, and the government passed new regulations that hold us accountable for healthcare cost growth," Chaguturu says.

Partners HealthCare has succeeded in reducing healthcare costs in 2006 MGH demonstration projects targeting Medicare patients with community-based practices. These projects led to a commitment to population health management and the expansion of case management services to other primary care settings within the Partners HealthCare community, says **Jennifer Wright**, RN, CCM, manager for the Integrated Care Management Program (iCMP) at Newton-Wellesley Physician Hospital Organization in Newton, MA.

Wright describes the following examples of how case management embedded in primary care helps high-risk patients:

• Case managers identify services primary care patients need to overcome barriers. CMs help patients identify social agencies and community services that are appropriate and might help them maintain optimal health. "We identify elder service agencies and programs and work aggressively with trying to help elderly patients [when appropriate] with referrals to hospice or palliative care in the community," Wright says.

Case managers help patients achieve their own goals and desires when faced with major healthcare decisions, she adds.

"For example, one case manager had an 89-year-old patient who had been in and out of the hospital with shortness of breath from congestive heart failure," she says. "His daughter brought him to the emergency department, and he refused to be hospitalized."

So the iCMP case manager, embedded in the primary care practice, worked with a home care agency and infusion company to help the patient receive his diuretic at home. These intensive home services allowed him to breathe more comfortably and to stay home, honoring his preference.

"We also arranged with the patient and his daughter, connecting them with hospice in the event the treatment didn't work," Wright recalls.

The man was able to live at home for six months before being placed in hospice care, she adds.

"We needed outside-of-the-box thinking because as healthcare changes and evolves so quickly with all of its moving pieces, it's hard for folks to manage," Wright explains.

The CM team also includes social workers who work with nurses and others to assist patients with psychosocial health issues, including substance use, food stamps, transportation, at-home needs, and getting to doctors' appointments.

• Case managers field curbside questions. As CMs enroll patients and see patients with whom they have established a relationship, they become a resource for primary care staff and patients, Wright says.

EXECUTIVE SUMMARY

Some healthcare organizations are finding that embedding case managers in primary care provider practices is an ideal way to help high-risk patients receive the care coordination and engagement they need to remain healthy.

- Case managers help identify services patients need to overcome barriers.
- When patients and primary care staff have questions, embedded CMs are there to provide "curbside" help.
- Case managers can facilitate warm handoffs.

"They field curbside questions," she says. "Even though they have a defined group of patients, they become a resource for the practice for other challenging situations/patients; we're education ambassadors."

For instance, primary care providers often ask CMs questions, such as the following:

- How do I connect this patient to hospice care?

- What kind of services are available in this area for this patient?

The curbside consult helps patients, but also improves relationships with primary care staff, Wright notes.

It's understood that the curbside consults are limited and intended to help PCP staff learn more about available community resources so they could eventually handle these patient questions on their own, she says. "The social worker might say, 'I can do a limited engagement with this patient, but I can't manage them long-term,'" she adds. "We want to be helpful to our PCPs and the big universe of patients, but we have to be mindful about how we set that expectation as our core population includes those in our risk contracts."

The goal is for patients to work with staff at the practice, and having the staff seek consulting or coaching help from case managers as necessary, she explains.

• **Case managers facilitate warm handoffs.** "They do home visits from time to time," Wright says. "We have elders who have mental health issues or social isolation, and when we're introducing them to a different agency, our social worker or CM will go to their house to be a warm handoff to the new service."

Also, when patients are seen at the emergency department, case managers are notified and when it's feasible, they will head to the ED to meet with the patient, she adds.

• **CMs market primary care services to patients.** There is a two-page integrated care management brochure that patients can pick up at their providers' offices. It includes photos of the care management team and explains a little about what they do.

For example, the brochure, sponsored by Partners' Integrated Care Management Program, says, "Patients are matched with a nurse care manager who works closely with them and their loved ones to develop a customized healthcare plan to address their specific healthcare needs…"

CM services are listed, including these examples:

- care coordination led by a nurse care manager,

- access to specialized resources such as mental health, pharmacy, and community resources expertise, and

- direct patient involvement through health coaching and shared decision-making.

The brochure also has testimonials with photos and several frequently asked questions. ■

Experts: Population health needs to address mental health

On the rise: depression, anxiety, substance use

Researchers recently made a startling discovery: White, middle-aged Americans have a higher mortality rate now than they have in previous generations. This group includes non-Hispanic men and women between 1999 and 2013. The study found that their rising death rate could be largely accounted for by drug and alcohol poisonings, suicide, chronic liver diseases, and cirrhosis.[1]

For case managers and others who work with this population, the findings confirm their anecdotal evidence that behavioral and mental health issues are a major comorbidity with middle-aged and older patients.

"We need population health that focuses on the whole person and the multiple complexities the person might have," says **Monica Cooke**, MA, RNC, CPHQ, CPHRM, FASHRM, chief executive officer of Quality Plus Solutions in Annapolis, MD.

These complexities include depression, anxiety, substance use, and other behavioral-mental health issues, she adds.

"We refer to it as complex case management," says **Cheri Lattimer**, RN, BSN, executive director of the Case Management Society of America in Little Rock, AR.

Case managers treat the whole person, and this includes behavioral health, she adds.

"I know of no patients who say, 'I'm here for my medical,' or 'I'm here for my behavioral.'"

Patients often are dealing with depression, and that has to be part of

the equation, she says.

Addressing behavioral health is a challenge for case managers because community resources are few and far between, Cooke notes.

"It will be many years before we as a nation build up the behavioral and mental health services this society needs," she adds. "Nothing will change dramatically in the next 10 years, but if we center help around the population, then we need to include behavioral health."

Case managers need to do a little research to find the community resources that patients might need and then link them to the service, Cooke suggests.

A first step is to acknowledge the effect and importance of behavioral healthcare, she says.

Patients who receive treatment for mental health and substance use issues will become healthier and feel better, Cooke says.

When CMs have a positive attitude about behavioral health services, so will their patients, she notes.

"Case managers' role is to link a person to these services and to get them the levels of care they need," she says.

True, it's an additional workload for CMs, and there is no easy access to behavioral health services, so it will require multiple phone calls, Cooke says.

"It's not like scheduling an eye exam — it's not that simple," she adds.

About one out of four inpatient community hospitals in the U.S. has an inpatient psychiatric unit, Cooke notes.

This suggests a needs gap as research has shown that people with comorbid medical and mental health diagnoses are admitted to the hospital from the emergency department at twice the rate of patients who do not have a mental health diagnosis.[2]

This gap in need versus availability of services creates a situation where many psychiatric services and beds are limited and often have long waiting lists.

"And then they have to convince the person to accept the care because no one wants to think they're depressed or have an anxiety disorder or are psychotic," Cooke says.

Patients with a comorbid psychiatric condition can be a lot of work for a case manager who likely already has a huge caseload, but the need for CM services is there, Cooke says.

Case managers need to facilitate mental healthcare and evaluate every patient for a mental health comorbidity, she adds. "There are plenty of tools out there to screen patients and ask questions and see where they are in terms of mental health."

EXECUTIVE SUMMARY

White, middle-aged Americans have an increasing mortality rate due to behavioral and mental health issues, demonstrating the need for population health to address behavioral health.

- Case managers can treat the whole person, including behavioral health problems.
- A first step is to have a positive attitude about identifying mental health issues.
- Although finding mental and behavioral health treatment services is challenging, it's a task at which CMs can succeed.

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Improve communication for effective case management

It starts with mental readiness

Case management takes place in a fast-paced world where communication is the fuel that keeps the engine running. As such, case managers might take a look at their own communication skills and strategies to see if they need a tune-up.

"There are so many calls that have to be made in a day and so many cases to get sorted out and to hold in your mind," says **Claire Casselman**,

MSW, LMSW, psychosocial intake case manager at the University of Michigan Comprehensive Cancer Center in Ann Arbor, MI. Casselman spoke about strategies for patient encounters at a case management conference on Nov. 10, 2015, at the Michigan State University College of Nursing in East Lansing.

"So what are some skills and strategies that we can bring with us to work each day — not only in the global sense as case managers, but also on a more micro level of what happens in the moment?" she says. "We need to take a two-pronged look at what keeps us at our best and what we call upon to stay in the moment with the patient or in this situation."

Casselman offers the following suggestions for improving communication and mental readiness:

• **Focus on mindfulness.** "It's an overexposed term that is a very practical way of being self-aware during interactions — whether you're on the fly, and monitoring what your body is telling you at any point in time," Casselman says.

Each person should make sure they're taking opportunities for time out from work stress. Moments of mindfulness can help them replenish their brains, contributing to fitness and balance, she explains.

Exercise helps with mindfulness, as do yoga, tai chi, and meditation.

"I practice meditation and yoga, which I know shifts my brain chemistry into that place that is restorative and helps to clear my thinking," Casselman says. "Simple breathing exercises, journaling, mindful meditation, yoga, and tai chi are the things that increase our breathing and increase the release of helpful chemicals, and they also generate community and connection with our colleagues and peers."

Mindfulness is not luxury; it's essential for one's professional mental health: "If we really want to be effective and stay in the game for the long haul, then we have to protect our finest resource, which is our self," Casselman says.

Time is not the obstacle that people believe it is, she adds.

"I've met plenty of people with kids at home who've built these activities into their daily lives," Casselman says. "It's not necessarily taking a lot of time; a mindfulness practice can be accomplished in 5 to 10 minutes a day."

• **Notice your inner voice.** It's important to be aware of self-talk, which affects mood and motivation.

"Our own self-talk can be soothing and comforting, or it can be harsh and very critical and demanding," Casselman says. "Make sure you're getting enough sleep, exercise, and are soothing your inner critic."

The first step is noticing one's self-talk, she notes. "A lot of us run on autopilot every day and don't have an awareness of how hard we are on ourselves."

Once aware, a case manager should identify the beliefs behind negative thoughts and rationally check those assumptions, asking if that is really what you think, Casselman says.

"The question is, whose voice is that? Who am I channeling right now? Usually I can back that up to a parent, teacher, or significant adult in my life," she says.

If a CM notices that the self-talk suggests feelings of stress, then it might be time for a breathing exercise, she adds.

• **Build calming moments into the day.** "Preparing yourself for your day includes building in calming moments," Casselman says.

One difficult phone call can set a negative tone for the day, so case managers need to re-collect themselves with calming moments at those kinds of times. This strategy begins before heading for work, she says.

"Start with an intention for the day, saying, 'No matter what happens today, I am going to — fill in the blank: eat a healthy lunch, walk for 10 minutes, go outside for 10 minutes,'" she explains. "The cues help to remind yourself how to manage [stress] during the day."

Casselman keeps something in her pocket that serves as a touchstone; touching it is soothing and alleviates worry. "I have a physiological reaction to it."

Case managers also can build calming moments into their interactions with patients through learning to partner with patients and

EXECUTIVE SUMMARY

Case managers need to maintain optimal communication skills, and one way to do this is to make sure they're mindful of their own stress levels and emotional health needs.

- CMs can focus on mindfulness, which is a strategy for being in touch with one's own work stress, and can be accomplished through meditation, yoga, and other activities.
- Self-talk can be negative and defeating, so CMs should be aware of it.
- Motivational interviewing and other practiced communication skills help facilitate better rapport with patients.

evolving to guiding them rather than directing them, she says.

• Use practiced communication skills. Motivational interviewing and other communication skills help improve the case manager's relationship with patients, she adds.

"Help them feel like they are your partner in this, as opposed to your being the person who says, 'Here's what you do,'" Casselman says.

The goal is to obtain a patient's buy-in and clarity: "If they feel like their needs aren't being heard, then they're less likely to have buy-in," she explains. "The care manager is asking the patient what the patient needs so the person feels like a partner with whoever is on the other side of the bed or desk."

A good start is to ask patients what they hope for their health outcome.

"Often, the answer is what we expect to hear, but sometimes we're missing something," Casselman says. "They might have a desired outcome that doesn't seem to fit with our need to get them services in the home or whatever it might be."

The strategy is to start the conversation from the point of how the patient frames the problem and what is utmost in importance to the patient in this situation, she adds.

"Now we can understand the patient a little more, and we're listening for and hearing in the patient what the patient is motivated to do and try," Casselman explains. "With that information, we can figure out how to connect the patient dots with the provider dots so that we're not handling it in a prescriptive fashion."

Case managers make it their goal to make a connection with patients where the patient is. "If we do that, we'll say, 'Do you think that will help you with your largest concern? How will that help?'"

Following this strategy might take a little more time up front, but it can save time down the road and reduce the chance of the patients returning to the doctor to complain that they heard some information from the case manager that they don't understand, Casselman says.

"It won't work for everybody, but if we can invest in assessment and relationship-building outside the gate, then it creates a connection to patients and increases the chance of a buy-in," she adds. ■

TJC: Time to curb patient falls in healthcare settings

With troubling data in hand about patient injuries and deaths, The Joint Commission (TJC) has issued a Sentinel Event Alert, notifying healthcare organizations that they need to up their game when it comes to preventing patient falls. Since 2009, the accrediting agency says it has received 465 reports of patient falls with injuries, with 63% of these falls resulting in death. Further, the agency reports that patient falls with serious injury are among the top 10 sentinel events that are reported to the agency. While some of these falls occur in non-hospital organizations, TJC says the majority occur in hospital settings.

Why are patients falling in healthcare settings? In reviewing five years of data collected on patient falls with injury, TJC reviewers note that the most common contributing factors are inadequate fall assessments, communication failures, and a lack of adherence to protocols and safety practices. TJC also cites deficiencies in staff orientation about patient falls, supervision, and problems with staffing levels or the skill mix. Other key contributing factors include deficiencies in the physical environment and a lack of leadership around this issue.

TJC makes clear that this is not just a matter of patient safety, although that is of prime importance. Falls also hit hospitals hard in the pocketbook. Studies suggest that patient falls with injury can add a number of days to a patient's hospital stay. In fact, TJC reports that the average cost associated with a fall with injury is about $14,000. When you consider that hundreds of thousands of patients fall in hospitals every year, with 30% to 50% of these falls resulting in injury, it is easy to see how such costs can pile up.

Identify risk at triage

To prevent falls, TJC recommends that hospitals initiate several steps, starting with a high-profile effort to raise awareness of the need to address the issue. The agency also calls on healthcare organizations to establish an interdisciplinary falls injury prevention team, use a standardized, validated tool to identify fall risk factors, develop individualized care plans for identified fall and injury risks, standardize and apply best practices, including a standardized handoff communication process

and one-to-one patient education, and conduct a series of post-fall management practices such as post-fall huddles and a system of reporting and analyzing falls. *(See TJC's recommendations and supporting information at www.jointcommission.org/sea_issue_55/.)*

However, the fast-paced environment of a busy ED presents some unique challenges. For example, most of the existing fall risk assessments are really geared more to the inpatient setting, says **Danette Alexander**, the nurse director of the ED at Hartford Hospital, a level I trauma center in Hartford, CT, that sees more than 96,000 patients a year.

"It is not necessarily that they won't work well, but you need to identify [patients at risk for a fall] quickly at triage, and the inpatient tools typically are done every four to six hours," she explains.

Observing that triage nurses don't have the time to go through all the elements on a standard fall risk assessment, Alexander teamed up with colleagues to develop a streamlined fall risk assessment tool that could be integrated easily into the triage process without slowing the workflow.

"I came from the inpatient side. I had never been in the ED. I sort of brought that inpatient mentality with me," Alexander adds.

Terry Kinsley, RN, MSN, CEN, who is now director of the nursing learning lab and simulation at the University of St. Joseph in West Hartford, CT, worked with Alexander on developing and implementing the tool. At the time, Kinsley was the nurse educator in the ED at Hartford Hospital.

"We were not capturing our patients who were at risk of falling because all the risk assessment tools were just so cumbersome and long. So we broke it down into the basics," Kinsley explains.

For example, the resulting instrument, which Alexander and Kinsley refer to as the Kinder 1 Fall Risk Assessment Tool, identifies five risk areas, any one of which will flag a patient as being at risk for a fall when they go through triage in the ED. The risk areas include the following:

- patient presented to the ED because of a fall;
- age older than 70;
- altered mental status;
- impaired mobility;
- nursing judgment of fall risk.

A "yes" to any of the criteria denotes a patient as being at risk for a fall. Even if a patient does not have any of the first four risks, the triage nurse can flag that the patient is, indeed, a fall risk if he or she has any concerns.

"The other thing that is very different about this [tool] is that there is no scoring, there is no high fall risk, moderate fall risk, low fall risk," Kinsley says. "In our minds, they are all the same. If you are a moderate or a low fall risk and you fall and hit your head, you are still going to get a bleed. If you are a high fall risk and you fall and hit your head, you are going to get a bleed, so it doesn't really matter the amount of risk."

Kinsley adds that a retrospective chart audit of all the patients who had fallen showed that the risk assessment tool would likely have captured 85% of these patients if it had been applied at triage.

The risk assessment questions have been embedded in the electronic medical record so that triage nurses can complete the process quickly as part of their regular workflow process, Kinsley explains. Further, once a patient has been flagged as a fall risk, he or she remains a fall risk for their entire stay in the ED. For patients who are not deemed a fall risk, they must be reassessed every two hours to see if their status has changed.

While many people may not think of the ED as a setting where falls typically occur, it is in fact a high-risk area, Alexander says.

"Even if you come in and you are not at risk for falling, but you have pain and we are giving you narcotics, we could make you at risk of falling," she explains. "Actually you are pretty high risk the instant you cross the threshold of the ED because even if you are not at risk, we may do things to you that put you at risk."

Implement post-fall huddles

However, identifying fall risk is only the first step in Hartford Hospital's program to prevent falls in the ED. The second part is equally important, and involves a series of interventions aimed at making a patient's stay in the ED safe and free from falls. For instance, patients identified as at risk for a fall in triage are provided green bracelets so that it is easy for clinicians to recognize their fall status.

Also, each of the rooms in the ED has been equipped with fall alarms so that nurses don't have to search for the alarms when they have a patient wearing a green bracelet.

"That makes it very easy for each of the nurses to be successful," Alexander says.

While nurses are key players in preventing falls in the ED, it is also important to involve physicians in the program, Alexander adds.

"All the attending and resident physicians are aware of [our fall prevention efforts], so they will put up the side rails after they have performed an exam of a patient,"

Alexander says. "Involving them from the get-go is very, very important. It keeps the channels of communication open for feedback on how we can get better."

Another key to the effort is performing a "fall huddle" every time a patient falls in the ED.

"That is where you find out about systems issues," Alexander explains. "When someone has a fall and we perform a post-fall huddle, we try to make it as non-punitive as possible."

In the past, nurses would never call the charge nurse to report a fall, but such calls are routine now, Alexander says.

"When a nurse calls and reports that they have had a fall, we all go and look at it, and if they did everything they possibly could to prevent the fall, then it is a non-punitive process," she explains. "Obviously, you would have issues if someone was blatantly neglectful, but usually they are not. They just need support."

Kinsley adds that one practice that goes hand-in-hand with the fall prevention interventions is hourly rounding.

"I wish we had implemented that even sooner," she says. "It doesn't have to necessarily just be nurses performing the rounding, as long as someone is going in and logging some face time with the patient every hour."

Change the culture

While the fall prevention program is well-integrated into ED operations now, it took about a year for the nurses to buy into the approach, Kinsley recalls.

"We just kept plugging away. Danette and I were very visible on the unit, and we did lots of selling of the program," she explains. "It was very labor-intensive on our part."

However, Kinsley notes that a key turning point occurred after the fall prevention program had been in place for about eight months.

"We had a patient who had come into the ED in the very early morning because she had fallen," Kinsley says. "She was an older lady from an Alzheimer's unit."

The day shift was just coming on board, and care of the patient was being transferred from a travel nurse to the oncoming day shift nurse.

> "WHEN A NURSE CALLS AND REPORTS THAT THEY HAVE HAD A FALL, WE ALL GO AND LOOK AT IT, AND IF THEY DID EVERYTHING THEY POSSIBLY COULD TO PREVENT THE FALL, THEN IT IS A NON-PUNITIVE PROCESS."

"As they were finishing up report, they heard the sound that you hear when a head hits the floor," Kinsley notes. "The patient had fallen out of bed and it turned out that no fall precautions had been put in place."

The patient eventually passed away, although it is impossible to determine whether this was the result of her first fall or the fall that occurred in the ED, Kinsley explains. Nonetheless, the incident received everyone's immediate attention.

"It just really shifted the whole culture," Kinsley adds. "That is when we saw the tide turn."

Since then, nurses have embraced the program.

"It is a matter of getting one person on the bandwagon, and then everybody else follows," Kinsley notes.

In fact, while all of the interventions have made a difference in curbing serious injuries from falls, what has worked best is the way the program has focused awareness on the issue, Alexander explains.

"We will have a lot of falls for a variety of reasons. Sometimes they are [due to] behavioral health [reasons] where people will throw themselves on the floor. We also get a lot of intoxicated people, whether due to alcohol or other types of substances," she says. "What we have tracked over the past two or three years on our dashboard unit is whether someone has experienced a serious injury from a fall, and … that has been relatively flat."

Also, since first reporting on Hartford Hospital's ED fall prevention efforts in the summer of 2013,[1] Alexander says she has heard from other EDs that have adopted the Kinder 1 tool. She notes that now the EMS personnel who bring patients to the hospital will often put the green bracelets on patients even before they arrive.

Soon, the Kinder 1 tool will be shared with the other EDs in the hospital system, and Alexander is hoping this will provide an opportunity to conduct a formal observational study on the effectiveness of the tool.

REFERENCE

1. Alexander D, et al. Journey to a safe environment: Fall prevention in an emergency department at a level I trauma center. *J Emerg Nurs* 2013;39:346-352. ■

Going to a passive needle safety system reduces injuries and costs

New devices for subcutaneous meds never expose HCWs to needles

Switching from active to passive needle safety device dramatically reduced needlesticks in an 11-facility healthcare system, creating cost avoidance in reporting, treating, and follow-up that justified the additional expenditure for the devices, reported **Ashleigh J. Goris**, RN, BSN, MPH, CIC, manager of infection prevention and control at Missouri Baptist Medical Center in St. Louis.

The hospital is part of the BJC HealthCare system, where active safety engineered devices were widely used for subcutaneous delivery of medications. The active devices, which require the user to slide a shield over the needle after use, accounted for roughly 35% of the total number of needlesticks in the health system, Goris said in Nashville at the 2015 conference of the Association for Professionals in Infection Control and Epidemiology (APIC).

"These were devices that require an active motion by the nurse or provider of the medication — an active motion typically toward the needle point," she said.

Given the needlestick problem, the decision was made to go to a completely passive device for subcutaneous medications.

"Passive safety engineered devices do not require any active motion or changing of hand position of healthcare providers who administer medication," Goris says. "[The] devices automatically and instantly retract the needle from the patient into the barrel of the syringe once the medication is delivered. By design, the device is safer during use, after use, and prior to disposal because the needle is never exposed outside of the patient."

The passive device was implemented at the BJC system's largest academic facility, with rather striking results. "We did a nine-month trial at our largest facility and in four of our medical surgical units there, and also one of our ICUs, our needlestick injury rate went down to zero," she said.

Based on those results, the decision was made to implement the passive devices systemwide.

"The existing active safety devices were removed from all of our facilities and replaced with the same size passive retractable needles, specifically a .5 ml, a 1 ml and most recently a 3 ml," Goris says.

The cost impact was immediate, as swapping out the devices led to a net expenditure increase of $21,000. However, that cost was more than offset as the systemwide needlestick rate fell 31% in one year.

"Cost saving or cost avoidance due to needlestick injuries was evaluated at our facilities," she says. "These consisted of occupational health department hours for both nursing and administrative staff when needlestick injuries were reported. That included the time to report and also respond to healthcare providers. It included the laboratory tests and the analysis needed for both source patients and employees for up to 12 months depending on the nature of exposure. It also included exposed employee hours for reporting and testing. It included HIV post-exposure medications, typically a 28-day regimen."

During the 24-month pre-implementation period, 404 needlesticks with active devices were reported, with a rate of 0.58 injuries per 100,000 productive employee hours. During the 12-month implementation period, 160 needlesticks were reported for a rate of 0.46 injuries per 100,000 productive hours. Goris calculated an overall cost savings/avoidance of $11,000.

Of course, there is no cost value to assign for the absence of anxiety and dread that can accompany a needlestick exposure to a patient infected with a bloodborne pathogen, let alone a subsequent seroconversion. It might be priceless. ■

COMING IN FUTURE MONTHS

- Strategies for building a care continuum
- Case management and medication management of the elderly
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CNE QUESTIONS

1. Which of the following is a good strategy for health organizations to employ for a successful population health program, according to Sreekanth Chaguturu and Cheri Lattimer?

A. Have case managers meet with patients entering the emergency department to help with triage and managing their multiple healthcare issues
B. Hire pharmacist case managers to develop medication management plans for all patients in a population health program
C. Embed case managers in primary care provider practices to work with high-risk patients
D. All of the above

2. Which of the following is a benefit of having case managers embedded in primary care provider practices, according to Jennifer Wright, RN, CCM?

A. Case managers identify services primary care patients need to overcome barriers
B. CMs field curbside questions for patients and PCP staff
C. CMs market primary care services to patients
D. All of the above

3. A November 2015 study about the rising mortality rate of white, middle-aged Americans found that the main factors contributing to their increasing death rate included which of the following?

A. Drug and alcohol poisoning, suicide, and liver disease
B. Lung, prostate, and breast cancer
C. Murders and auto accidents
D. None of the above

4. What is "mindfulness," according to Claire Casselman, MSW, LMSW?

A. It's the practice of martial arts
B. It's a practical way of being self-aware during interactions and monitoring what your body needs
C. It's being considerate of others' feelings and needs
D. None of the above

CASE MANAGEMENT ADVISOR™

New Year begins with the "hottest time" for case management jobs

Case manager pipeline in long-term trouble

The nation's healthcare expansion into population health models and moving payment away from fee-for-service toward pay for quality performance and financial stewardship has created an unprecedented need for experienced case managers, and their salaries are climbing, according to case management professionals and the 2015 *Case Management Advisor* Salary Survey.

"It's the hottest time for case managers," says **Margaret Leonard**, MS, RN-BC, FNP, vice president for medical management at MVP Healthcare in Schenectady, NY.

"We can't find qualified candidates," Leonard adds.

"I've been in this business since 1986, and the opportunity for case managers is unprecedented," says **Sandra L. Lowery**, RN, BSN, CCM, CNLCP, president of CCMI Associates of Humboldt, AZ.

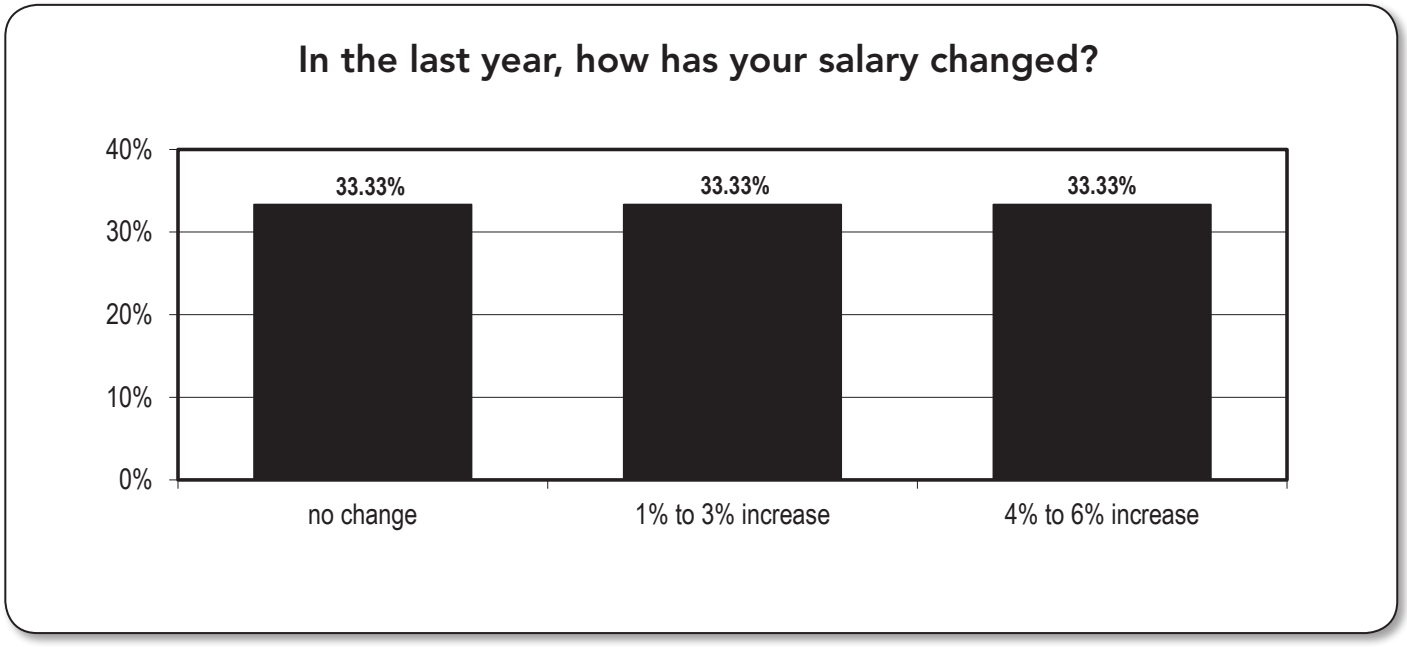
"It's amazing to see the practice setting expanding in so many areas," Lowery says. "Every day, I find a new avenue: We have case managers working on cruise ships, and in the Peace Corps."

Case managers are well compensated, anecdotal evidence suggests: Respondents to *Case Management Advisor*'s 2015 Salary Survey report a median salary of $100,000 and annual raises that range between 1% and 6%.

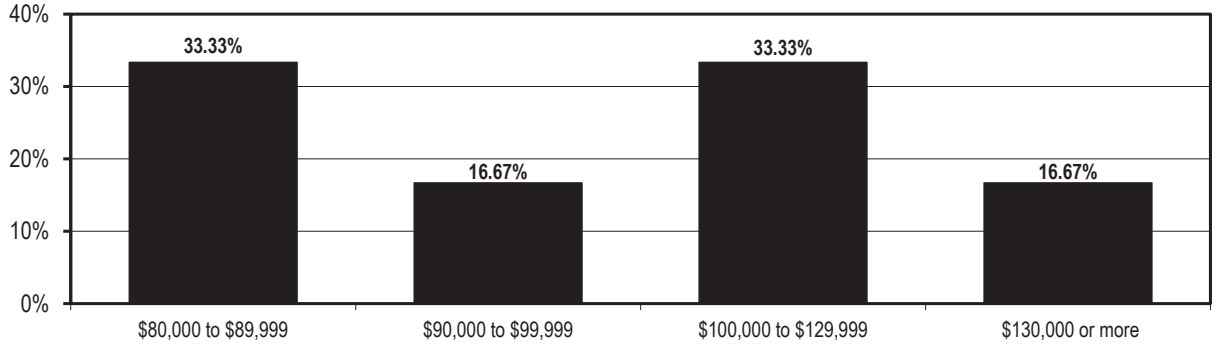
Half of the people responding to the survey also say they have had an increase in the number of employees in the past year.

And they're working a considerable amount of hours: No respondents had a 40-hour work week, and the range of hours worked rose to 65-plus.

"Across the board, generally speaking, case managers have a higher case load than they can handle most



What is your annual gross income?



effectively," Lowery says. "Either they work hard on those cases they can, or they put out fires and are not getting the outcomes they could produce."

The survey does not ask about case managers' backgrounds prior to moving into that role, but anecdotal evidence suggests this also is changing.

"We're seeing a great deal of emphasis being put on pharmacists," Leonard says. "They're an important part of the team whether or not they are geared for or have the time to do care coordination."

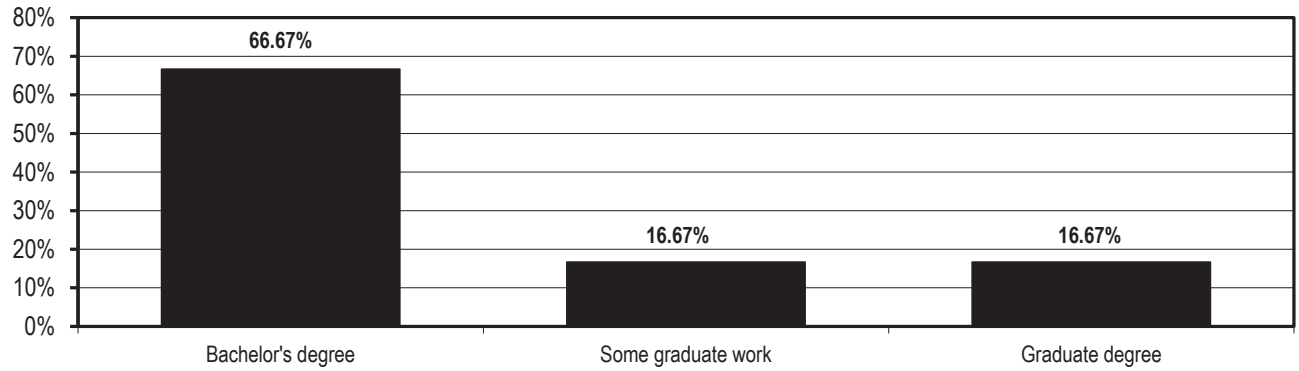
The case management job market is much different than it was a decade ago, with CMs moving into a variety of work settings other than hospitals and workers' compensation offices, says **LuRae Ahrendt**, RN, CRRN, CCM, CLCP, rehab nurse case manager at Ahrendt Rehabilitation in Lawrenceville, GA.

"One of the things that is so interesting to me about case managers is that it's unusual to have a practice area where so many different types of education and backgrounds are brought together under one umbrella," Ahrendt explains. "There could be master's level psychology majors, MSWs, and others."

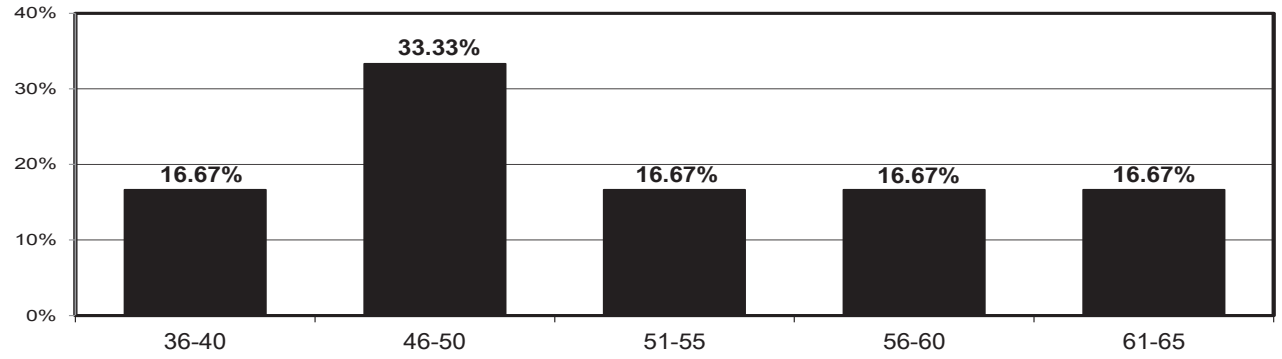
In Ahrendt's field of rehab case management, there are more nurses and vocational counselors: "I love the fact that people's individual licenses don't define them," she says.

The increase in demand for case managers is driven partly by the need to better coordinate care in an evolving healthcare world in which bad outcomes will cost providers.

What is your highest degree?



What is your age?



"As we look at the evolution of healthcare, there are more and more studies that talk about how not only does healthcare case management change in a positive way the outcomes of individuals, but it also is shown to be cost effective," Ahrendt says.

In the payer setting, there appears to be an increase in Medicare-Medicaid HMOs, which are hiring case managers to handle dual eligible populations, Lowery says.

"We're also seeing an increase in special needs programs that need case managers, and the other area I see growth in is in the military," she adds. "I almost always have someone in my program from the military who is encouraged to get certified."

Population health disease management programs are growing under the Affordable Care Act (ACA), and they're specifically targeting high-risk populations, Lowery says.

"A lot of case managers who have experience with analytics know what high risk is and how to identify it," she explains. "What I do is nurse life care planning for case managers."

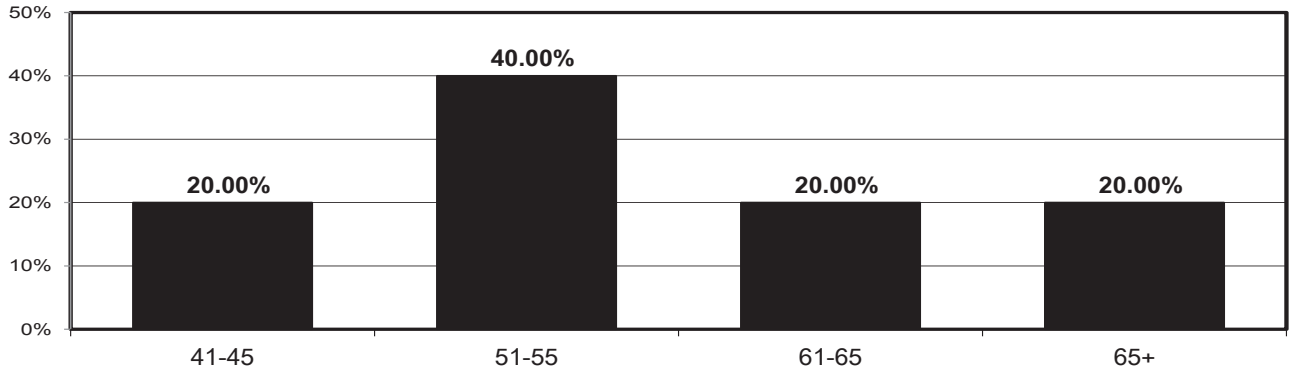
This is a relatively recent professional career path for case managers, she notes.

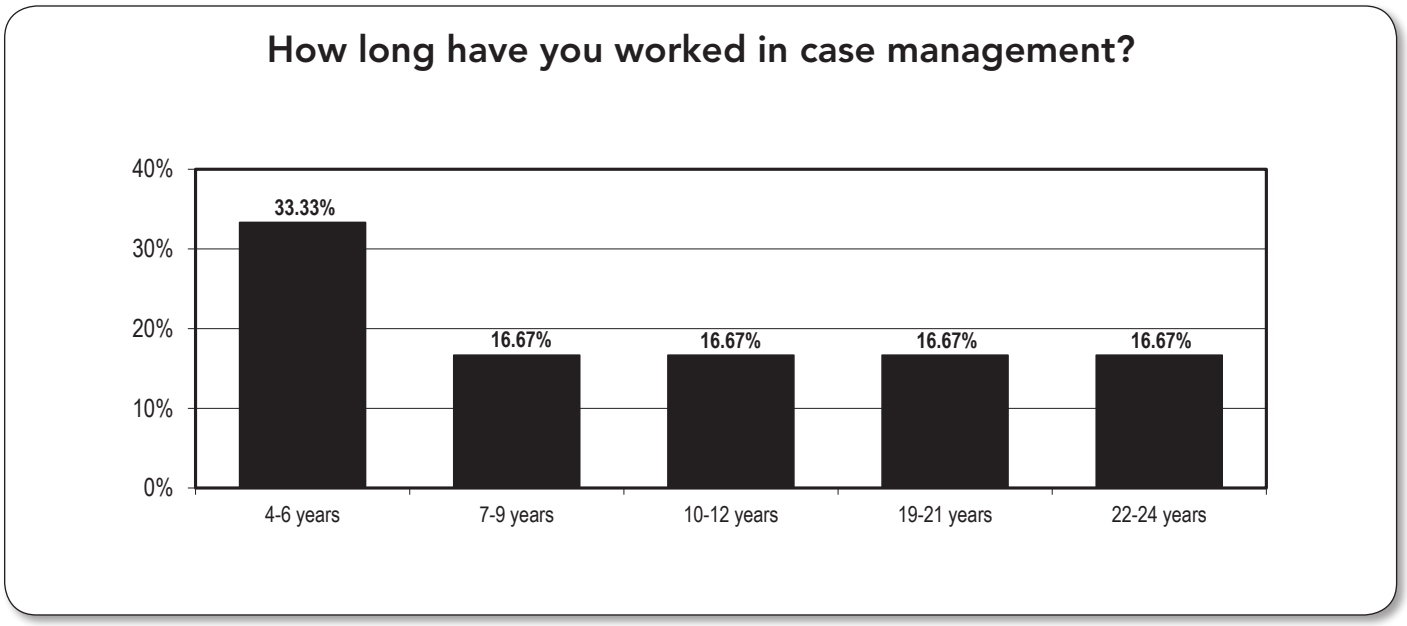
"Attorneys have discovered that case managers have the necessary experience to develop life care plans for catastrophically injured populations," Lowery says. "You develop life care plans for third-party lawsuits."

For example, a person whose spinal cord or brain was injured in an auto accident will need some type of health and other assistance for life, she explains.

The person is suing a third party for damages, but it's necessary to know what type of care they'll need to sustain them for life, and case managers are the

How many hours a week do you work?





professionals who best can predict their care continuum needs, Lowery says.

While the need for case management professionals is growing, the pipeline is falling short.

"There are not enough people in the pipeline for case management," Lowery says. "Where I don't see shortages now, I definitely think we're not growing enough."

This is one of the reasons why more paraprofessionals are being hired to do case management work: Paraprofessionals, including occupational therapy assistants, medical technicians, and LPNs, are being hired for care management work — not because they don't want a more qualified person, but the market doesn't provide enough availability of staff, Lowery says.

"The average age of case managers keeps increasing with boomers, and we're well into our 50s now," she adds. "This is not an entry level job, and it takes someone who has healthcare experience."

The *Case Management Advisor* 2015 Salary Survey suggests the same trend of aging CMs: Survey respondents were age 36 to 65, with most middle-aged, in their 40s and 50s.

There's the conundrum: To become a fully qualified case manager, the job requires a professional healthcare background with some years or decades of experience, followed by case management training and, increasingly, credentialing.

"The job really needs someone with experience in doing case management," Leonard notes. "It takes a lot of training, and in some cases we're willing to make that investment for a new orientee."

But the ideal case management employee is someone who understands what care coordination is and has some understanding of what patients' different needs are, she adds.

Ahrendt offers a solution to the CM pipeline problem, saying experienced case managers have a professional responsibility to mentor nurses and others who desire making a career change to case management.

"I've been mentoring nurses and rehab counselors," Ahrendt says. "I do a lot of pediatric case management, and there's a small number of people who do that, so I've taken a person under my wing to work with me."

Knowing that her area has a huge deficit in bilingual pediatric case managers, she's mentored a bilingual young woman she met through a professional conference. The woman — with Ahrendt's guidance — is learning case management skills with a pediatric population.

"I live in a very diverse community, so having an individual who can work with non-English-speaking families with specialty in children is a gift to the community," Ahrendt says. "Whether we like it or not, those of us moving into the middle years have a professional responsibility to mentor others."

Experienced case managers can embrace mentoring for altruistic or even personal reasons, she observes. "I guess some of it is selfish on my part," Ahrendt says. "I don't know that I won't need a case manager myself someday."

While the bigger picture shows a serious gap between need for case managers in the future and the current pipeline, it also suggests that today's case management professionals are well-positioned in their careers for decades to come.

"I do think the evolution of healthcare, whichever direction it goes, will continue to value the importance and impact of case management," Ahrendt says. ■