CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

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CM Leadership Needed in Mass Shootings, Major Traumas

Case manager's role: Helping patients, families, and staff

Within days of the horrendous Orlando, FL, mass shooting in which 49 people were killed and more than 50 were injured, surgeons at Orlando Regional Medical Center offered insights into how they dealt with the emotional aftermath of the chaotic situation. As one doctor told Orlando FOX 35 news, "Someone said to me, 'Welcome to the club no one ever wants to be a part of.'"

In the United States in 2015, there were more than six mass shootings each week, resulting in hospitals of all sizes dealing with sudden influxes of gunshot victims.[1]

This past June's mass shooting in a gay and Latino Orlando nightclub, Pulse, which was attributed to both terrorism and hate crime, was the most devastating terrorism incident in the U.S. since Sept. 11, 2001.

While mass shootings and casualties of that magnitude call for incredible

EXECUTIVE SUMMARY

U.S. hospitals handle, on average, victims from a mass shooting every day. For most case managers, it's not a matter of whether they and their colleagues will experience that traumatic event, but when. Case managers who have gone through such events offer some advice.

- Case managers can play important leadership roles in the event of a mass shooting incident.
- Dealing with the media is a problem that many are unprepared to handle.
- Protecting patients' privacy becomes more challenging when the shooting event is widely publicized.

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community and outside resources, small and large rural and urban hospitals and communities continually must be ready to handle the far more common cases of a single gunman sending four or more victims to the hospital.

These types of traumatic events can affect everyone who works in the healthcare community, including case managers. As reported by some case managers who dealt with highly public mass shootings last year, case managers can play an important leadership role in helping patients and staff deal with both logistics and the emotional toll of such trauma.

Here's one example: Roseburg, OR, with around 22,000 residents, was the kind of rural town few people had heard of before a mass shooter on Oct. 1, 2015, shot 17 people, killing 10, at the town's Umpqua Community College campus.

Mercy Medical Center RN care manager **Geoffrey Brownell**, BSN, RN, who previously had worked as a nursing instructor at Umpqua Community College, recalls hearing the news of the shooting and worrying about the people he knew on campus.

"We weren't sure how many victims were coming in and what the situation was," Brownell recalls. "We listened to the news and tried to figure out what would happen that day."

Three of the hospital's care managers had ICU nursing experience, including Brownell. Once they learned that gunshot victims were heading to the hospital, the care managers headed to the ICU to staff that area so the ICU nurses could be extra hands in the ED as victims arrived. *(See story about CMs helping patients, staff handle traumatic events, page 87.)*

Although the case managers had years of experience in dealing with stressful situations at the hospital, this particular event was traumatic for everyone, Brownell notes.

"This is a small community, so a lot of the victims were known to many of our hospital staff," he says.

A mass shooting in a small community can be particularly fearful because everyone expects to hear that someone they knew was shot, says **Cindi Stephanos**, BSN, RN, director of risk and quality/care management for Mercy Medical Center.

Nearly nine months after the mass shooting in Roseburg, the hospital had returned to its normal routine and pace — until the Orlando shooting occurred, bringing back memories of those first hours of dealing with the aftermath of so many dead and injured students and faculty. "When this mass shooting happened in Florida and I learned about it on the news, I had almost a flashback to that day, and the memory became more vivid," Brownell says.

Stephanos was out of town when the shooting occurred, but when she returned the next day, she used her previous experience in psychiatric nursing to help staff deal with the trauma.

"We can handle things like this, but I'm getting teary thinking about it," Stephanos says. "Afterward, for weeks, it was weird around here, and I spent a lot of time talking to staff, running into people in the hall and asking, 'How are you doing?'"

For some case managers and hospitals, mass shootings and similar incidents have become so commonplace that they're less personally traumatizing. For instance, there were seven young people shot in Panama City, FL, during spring

break of March 2015, but that wasn't terribly unusual for the coastal Florida town during its college student tourist season.

"We have so many incidents like that, shootings," says **Cathy Kearns,** LCSW, case manager for the surgical ICU at Bay Medical Sacred Heart.

"We have a lot of spring break accidents, some shootings, and some pedestrians being hit by cars and some kids falling off eight-story buildings, drunk," Kearns says.

One of the most traumatic, partly because it was so unusual, was when two teenage girls were parasailing and their parasail became untethered, flying them above land and into a tall condominium building before they crashed onto a car. The girls survived, Kearns recalls.

"These two girls are walking and talking; it's just a miracle," she says.

During the more common spring break shootings and accidents, Kearns and other case managers spend time trying to locate victims' families, who often are miles away from where their children are hospitalized.

The next step is to meet with the family and do crisis intervention, helping the family understand what happened, who was involved, and to answer questions they might be asking their own children if they weren't in a hospital bed, unable to speak, Kearns says.

"We provide families with community resources, including information on where they can stay, and we educate them on what to expect," she says, adding that affordable lodging in Panama City during the spring is challenging to find, especially for families that might need a hotel room or rental for weeks while their child recovers.

"I have found two hotels that are gracious enough to lower their rates so families can afford to stay there, and those are the hotels we rely on," Kearns says.

Kearns and Brownell say the focus must be on helping patients and their families cope and transition to the next step, even as they cope with having survived a traumatic tragedy.

"You don't get to choose the patients; some come to you with issues and social concerns that are greatly amplified during that period," Brownell says. "You have got to handle whatever they are dealing with because of the mass shooting, but also because of their other social issues." ■

REFERENCE

1. Gun Violence Archive 2015. GunViolenceArchive.org. The website is maintained by Gun Violence Archive, a not-for-profit corporation that collects gun-related violence data, checking each report for accuracy and redundancy. The site defines mass shootings as four or more shot and/or killed, not including the shooter, at the same general time and location. URL: http://www.gunviolencearchive.org/past-tolls.

Case Managers Offer Advice on Handling Mass Shootings

Simply sitting and listening helps

Case managers are not the first healthcare professionals that come to mind when a mass shooting or terrorist event occurs, yet their roles can be essential.

Victims and their families might need the emotional support and knowledge of community resources that case managers can provide. Case managers also can fill in where needed and help staff deal with the aftermath of a traumatic event. They can also be go-betweens for media, families, and patients.

Case managers and others who have experienced this type of traumatic emergency offer the following suggestions for how to prepare and how case managers can be of benefit:

• **Have emergency preparedness plans in place.** "If your hospital doesn't have a protocol or some sort of plan, then go to the administration and talk about how a mass shooting event is a possibility because it doesn't matter where you live anymore," says **Cathy Kearns**, LCSW, case manager for the surgical ICU at Bay Medical Sacred Heart in Panama City, FL.

Active shooters have even targeted hospital staff, so hospitals need to be prepared for that as well, Kearns notes.

When seven spring break college students were shot in Panama City last year, there was concern that the shooter might follow victims to the hospital. It didn't happen, but the hospital was prepared for it, she says.

"We have a tight security system and when we have something like

the occurrence last year, we have a lot of police involvement, so they are monitoring the buildings and making sure there isn't a second shooter involved," Kearns says. "All hospitals have protocols for emergencies, and we have a silver code, meaning people should take cover because somebody is in the building with a gun or knife."

Other codes for Bay Medical include yellow for a bomb threat and Adam for an infant abduction, she adds.

• Active shooter drills should be part of emergency plans. When 17 people were shot at Umpqua Community College in the small community of Roseburg, OR, the local, 171-bed hospital's 1,100 employees knew exactly what to do thanks to emergency preparedness planning, says **Kevin Herskovitz**, MS, safety and security manager of Mercy Medical Center in Roseburg.

"We received notice there was an active shooting event at the college campus, so we vetted it to make sure it wasn't a training exercise or drill," Herskovitz says. "When we realized it was a real event, we set up command and the ER began preparing to receive patients by clearing out a number of rooms to have space for victims."

The hospital had teams, including clinicians and support staff, prepared to handle each person who came their way. The blood bank was ready, the operating room staff was on standby, and clergy were ready to assist with victims' families as they also arrived at the hospital.

The hospital's preparedness worked well, but there was one detail that posed an unanticipated problem: the influx of reporters and other media, Herskovitz notes.

"The media concerns were far and away the largest struggle for us to stay on top of over the next 10 days to two weeks," he says.

General disaster preparedness works well, but health systems also need specific training for these active shooter or terrorist types of public disasters. "Ironically, we had penciled in to do our own active shooter drill sometime in the fall, and we had begun discussions on how to make that drill happen when the real event occurred off our campus," Herskovitz says.

• Pay attention to patients' emotional well-being. When patients are injured from an active shooter event or another violent act, case managers can be of emotional help, says **Geoffrey Brownell**, BSN, RN, RN care manager at Mercy Medical Center.

"I talked with one of the shooting victims for a long time about what had happened," Brownell recalled. "Later, there was an article written and she was interviewed and said that only one person had asked her about the incidents of the day, and that was me, sitting in there, talking with her and letting her talk."

It's important to resolve all of these trauma patients' medical issues, but it's also important to simply listen. Just grab a chair and sit near the patient, introduce yourself, and ask him or her how he or she doing and how the pain is, he suggests.

These questions can lead to a conversation that gives patients an opportunity to open up about their experience, Brownell says.

• Help and work with families and patient gatekeepers. "I've had many families sit down in my office and cry," Kearns says. "A lot of times, families are in shock and they want to tell their stories, especially if they know their loved one is not going to make it."

So family members might pull out their phones to show pictures and talk about how their son or daughter was in law school or the president of the fraternity and was going to make something of him- or herself.

"We allow them to share; it's what I call daily counseling," Kearns says. "I'm licensed as a therapist and can talk with these individuals and family members and allow them to grieve."

Their sadness is for children who died, as well as those who will never be the same when they leave the hospital, she says.

In other situations, family members might act as gatekeepers to healthcare staff accessing the patient. This requires case managers to hone their diplomatic skills.

"We have family dynamic issues with most of our patients, but with this mass shooting circumstance, it heightens it and makes it more challenging," says **Cindi Stephanos**, BSN, RN, director of risk and quality/care management for Mercy Medical Center.

"You might have a mother who is trying to protect her child, but who might not always be rational about

EXECUTIVE SUMMARY

Case managers can help their health systems prepare for the effects of mass shooting by taking several additional emergency preparedness steps.

- Have a protocol that is specific to a mass shooting scenario.
- Practice active shooter drills.
- Address patients' emotional health after such trauma.

what she's trying to accomplish," Stephanos says. "You have to tread very lightly and be very careful because everyone is on edge."

Family members might move into gatekeeper mode and try to keep hospital staff and others away from the victim when he or she is sleeping, and it's true that patients need rest and a break. But that doesn't always work, Brownell says.

"The police and FBI show up, and how do you work with these people while making sure the patient is getting rest?" he says. "The police are on a time schedule too, and it's important they get information as soon as they can."

• **Handle the media.** When hospitals face a mass shooting or some other event that results in widespread media attention, some of the typical hospital dynamics change, case managers note.

For example, the Umpqua Community College shooting drew many reporters to the hospital as patients were being brought in, and their presence and attention was a threat to patient privacy, Brownell says.

"In a normal situation, I would call an ambulance when a patient has to be moved to another hospital, and have the ambulance by the main door, but in this circumstance, based on the attention the patient was receiving, we had to figure out how to get the ambulance to come to a side door to pick up a patient," Brownell explains.

The media's presence made logistics more challenging.

"Most media were ready and willing to play by the rules, but not all of them, and that was our biggest concern, to protect patients' privacy," Herskovitz says. "We wanted the patients and families who did not desire to have interactions with the media to remain physically private."

This was most challenging when patients were discharged or transferred to another healthcare location. "The media literally was sitting in cars by the doors of the hospital, waiting to jump out and talk to people," Herskovitz says.

In cases like this, hospitals should consider using a VIP plan in which victims of highly public tragedies receive the same attention to privacy, physical security, and protection as celebrities who are in a hospital, he adds.

This might even entail keeping patients in the hospital longer than medically warranted, Brownell says. "We had a situation where patients might have been medically able to be discharged, but because of the celebrity issue and other issues, they weren't ready to actually leave the building — so we kept them in the hospital a little bit longer to make sure their exit plan was a safe and secure plan for them."

• **Work with social workers and chaplains, and network with community resources.** Families and patients will need additional help, particularly if the family is from out of town, Kearns says.

"Most families that come to our hospital from out of town are ill-prepared for staying long periods, especially if their loved one is intubated and might be that way for weeks to come," Kearns says. "We have to sit down with them and talk about what's going on and how we don't know what the prognosis is, but the physician anticipates the patient will be here for another three to four weeks."

Then case managers call hotels and, sometimes, even homeless shelters to find families a place to stay. When mass shootings or other traumatic events happen during spring break, most hotels are full or charging very high rates, making this option difficult for the families, she notes.

Also, there are some crime victims' funds and assistance, and case managers can help patients and families obtain information about these, she says. ■

Care Management Can Drive Capitated Care Success

Case manager's role is crucial

As health systems increasingly take on more financial risk in managing patient populations and lives, their role is evolving. The same is true for healthcare professionals, especially for case managers.

Their role is changing from one of solely helping patients where they are in the continuum of care to helping patients improve without transitioning to hospital and ED care. "We look at how we can keep the patient healthy and out of the hospital," says **Linda Violas**, BSN, RN, CCM, director of clinical

effectiveness in the division of care integration for St. Joseph Heritage Healthcare in Anaheim, CA.

"We have care managers help patients and get them into self-management if they need it," Violas says. "We make consistent decisions and follow guidelines to wrap around decision-making and goals."

Case managers increasingly will hear the phrase "evidence-based decision-making," she says.

"Blue Shield gives us expanded capitation that covers hospitalization," Violas says. "We pay for the high-dollar services ourselves, so we need to do a very efficient job of preventing readmissions and making sure patients are well-educated."

Another aspect of handling population health under a capitated care or accountable care organization (ACO) arrangement involves using data to determine which patients would most benefit from case management. For St. Joseph Heritage Healthcare, the answer is to provide case managers to high-risk patients and those with catastrophic conditions.

"For example, people who are not managing their diabetes or who have chronic conditions of chronic obstructive pulmonary disease and congestive heart failure, we visit at home, spending 30 minutes to two hours," says **Elisol I. McKim**, BSN, RN, CCM, nurse care manager with CARE Connect of St. Joseph Heritage Healthcare.

McKim's goal is to try to understand why patients are having difficulty managing their diseases. Is it their medications? Are they taking the wrong ones, such as prescriptions that are old and should be discontinued?

"Here's the patient's primary care physician giving this medication, and another doctor is giving her another medication, and we need to reconcile them," McKim says. "I've seen patients who are doubling their medication prescription or taking the wrong medication."

Other patients are taking over-the-counter pills and herbal products that are contraindicated for their prescribed medications, she adds.

Sometimes it takes a home visit to resolve these issues.

Another benefit of the case management home visit is how this can reinforce the self-management training doctors and hospital providers have given the patient. McKim says a good example of how this additional instruction can be beneficial is with diabetic patients, who often dislike testing their blood sugar levels and might have trouble drawing and administering insulin.

"It takes a lot of teaching, and they might do better with pre-filled syringes, which are something we can provide for them," McKim says. "When they're in the doctor's office, they have 20 to 30 minutes to learn all of the things the doctor said."

But if a case manager introduces patients to a new device, such as a pre-filled syringe, the case manager also needs to show the patient how to use it because new technology can be stressful for some patients, particularly seniors, McKim notes. "The doctor can prescribe it, but who will teach them?"

Case managers also help patients make a habit of the daily actions they need to take to ensure their health is stable.

"When a patient has congestive heart failure, we say, 'Ms. Smith, you should weigh yourself daily,'" McKim says. "Then you call the patient a week later and ask, 'How is your weight? Have you lost or gained weight?'"

If the patient's weight has gone up, McKim will suggest the patient visits his or her doctor, rather than waiting for the problem to worsen and result in an emergency room visit.

In working with elderly patients who have multiple chronic conditions, it's important to know about potential mental health issues, family and friend caregiving resources, and their particular environmental and psychosocial situations, McKim says.

"My background is in geriatrics," she says. "I started working in nursing homes with seniors."

With this experience, McKim says she learned how to start conversations with patients that will elicit the kind of information that is most useful and can lead to insights into obstacles to maintaining their health. Having the opportunity to visit patients in their homes is crucial to the case management program's success. *(See story on improving communication*

EXECUTIVE SUMMARY

Case managers' roles are evolving through focus on capitated models that focus on keeping patients out of hospitals and emergency rooms.

- Case managers can help patients with medication reconciliation at a home visit.
- They can learn more about patients' obstacles to self-care through a conversational type of questioning.
- Case managers can reinforce physician education by giving patients hands-on experience with using new devices or tools.

with geriatric patients, below.)

"I believe in this care management program," McKim explains. "This is how we should take care of patients: building relationships and trust."

In creating a role for case managers in the ACO model, the healthcare organization merged divisions of hospital and outpatient case managers to more effectively manage patient care, Violas says.

"Now all these case managers work for the outpatient sector with one central vice president and leadership," Violas explains. "More than 300 people do care integration, which includes everything from training, standards, utilization management, inpatient and outpatient reviews, quality management, and we have a technical arm."

Case managers who meet with patients in their homes have goals to improve symptom management and engage patients into better self-care and health management, Violas says.

The program, with its strong case management focus, has been successful, she notes. "We've saved quite a lot of money — $1.4 million per year — through the ACO arrangement and through case management."

The case management program also has resulted in reducing hospital readmissions by 9%, Violas says.

"We do very well with diabetes care, keeping good A1C rates throughout the population," she says.

If data show that patients in some groups of care have better outcomes than other groups, leaders look at the better-performing group's best practices to see if these can be used by the other groups as well.

"We're still learning, finding out what to do," Violas says. "We first have mutual goals to strive for, and then we take those goals and press them further because with ACO contracts, you have to up your performance each year, step up your game." ■

Case Manager Offers Strategies to Improve Patient Communication

Geriatric experience is helpful

When working with elderly patients, it's a good idea to initiate your visit or phone call with a conversation rather than direct health-related questions, suggests a case manager who has extensive geriatric experience and visits patients at their homes.

"Instead of asking, 'How many times did you have a bowel movement today,' start with, 'How long have you lived in this house?'" says **Elisol I. McKim**, BSN, RN, CCM, nurse care manager with CARE Connect of St. Joseph Heritage Healthcare in Anaheim, CA.

"The reason I ask this question is because I am a stranger coming into their home, and they don't know what I will ask or do," McKim says. "It's better to have a conversational interaction."

Once McKim puts patients at ease, she might ask some of the questions that will help her determine the patient's ability to manage his or her medical condition, including the following:

- Do you live alone?
- Who supports you?
- How long have you had your diabetes/disease?
- How long have you been checking your blood sugar?
- How long have you had shortness of breath?
- How long have you been smoking/drinking?
- How many times have you tried to stop smoking/drinking?
- Have you tried drinking less?

"For chronic obstructive pulmonary disease [COPD] patients, I don't lecture them about stopping smoking because they're older, and I'm sure they've tried," McKim explains. "So I ask about how many cigarettes they smoke, and if I have to give them a suggestion, I say, 'You may want to think about decreasing your smoking from 20 cigarettes to 15.'"

McKim also tells them that the reason they've had health problems is because of their smoking and COPD. "Part of it is motivational interviewing," she notes. "You want to motivate them."

Another thing case managers should keep in mind is that their elderly patients might be experiencing depression, which also could have an effect on how well they follow their treatment plans.

"I've done about 200 home visits in the CARE Connect program, and I've seen a lot of depression in the elderly population," McKim says.

"Here you are as an 80-year-old patient who lives alone, and you get scammed by telephone marketers because no one else is calling you all day."

McKim has seen this firsthand: "I was visiting one patient for an hour, and the person's phone rang six times — all telemarketers."

Patients who are in their 70s and older come from a generation that stigmatized mental healthcare. "The older generation didn't want to see a psychiatrist because of the stigma that you're crazy," she says. "Some of my patients might still have that stigma, so I say, 'Why don't you see a therapist?' because they just need someone to talk to."

One way to quickly assess whether depression is an issue is to ask a patient, "When was the last time you felt joy?" McKim suggests.

"Some answer so fast, and some have to think about it. This gives you a better understanding of their depression," she says. "So if someone says they feel joy every time they see their grandkids, you can ask, 'How often do you see them?'"

If the patient's answer is "every day" or "every week," then the case manager can see that the patient's mental health status is pretty good. But if the answer is "I don't remember," then there's a hint that there's a mental health issue that should be assessed, McKim says.

A depression screening can give healthcare professionals an idea of a patient's risk, but even more information can be obtained from conversations, she says.

"I want to find out what is the reason they're not feeling happy, so how can I make them talk to give me a better picture of what their situation is?" McKim says. "In my interaction with them, it's a conversation."

Another mental health issue is that trauma from childhood and young adult experiences, including military service during war times, can resurface in older adults.

"I have one patient who is in her 90s and in good health with only a few medications," McKim says. "But when she saw her doctor, she revealed that she suddenly remembered that she was molested in her 20s, and 70 years later it resurfaced."

McKim convinced the woman to see a therapist, and the woman's physician prescribed an antidepressant.

"She saw the therapist for less than three months and then said she thought she'd be fine," McKim recalls. "I asked her, 'What happened in that 70 years? Did you ever have depression?'"

The woman said that she had never experienced depression as she was busy raising children, but she now realized that several of her marriages had failed probably because of her earlier traumatic experience.

A patient in her 70s had been molested as a child, and five decades later, she found herself crying every day, McKim says. "The person who had molested her was dead, and yet, it was as if it happened yesterday."

In hospital settings, medical professionals do not see these hidden injuries, so McKim says she appreciates that she can spend time visiting with patients and helping them cope with long-buried emotional traumas.

Case managers working with older patients also need to find out what their patients' personal goals are for their health.

When McKim asks her elderly patients what their goals are, they do not always have an answer, so she helps them think about the kinds of activities and connections they'd like to make.

"Maybe they want to see their daughter in another state or they want to be around when their great-granddaughter is born," McKim says. "So I say, 'Great. We need to take care of your congestive heart failure and diabetes to keep you healthy.'"

During home visits, case managers can identify problems before they occur, such as elderly couples where one person is failing rapidly and the spouse is ill-equipped to handle the physical and emotional demands.

For example, McKim had one patient, with multiple chronic illnesses, who was in his 80s and the sole caretaker for his wife, who had dementia. The man had medical problems and no children to help him with his wife. McKim first saw him at his doctor's clinic and scheduled a time to visit his house. When she arrived, she noted that the house was clean and the couple clearly had the financial resources to obtain help with daily activities.

"One of his burdens was taking care of his wife, who would leave the house and get lost, so he'd have to call the police," McKim explains. "She could fold the laundry and watch TV, but then she'd try to get out of the house in the middle of the night."

It took a while, but the man finally admitted that he could no longer take care of his wife, so McKim helped him find a nearby assisted living center where she could receive continual help. And McKim helped the man find a caregiver who could clean his house.

"He said to me, 'If I die today and she is by herself, she doesn't know how to call 911,'" McKim recalls. "So he felt good about the assisted living because his wife was being taken care of." ■

Training, Drills Pivotal in Mounting Response to Orlando Shooting

Emergency providers generally have some warning when a hurricane or another natural disaster poses risks to the community. However, that is rarely the case with a mass shooting, as was evident in the early morning hours of June 12, when a lone gunman opened fire inside the Pulse nightclub in Orlando, FL. There was no predicting the scope of this disaster, as it produced 50 deaths, including the gunman, and dozens of injuries — more carnage than any other mass shooting in U.S. history.

The impact of the event was reduced because a Level I trauma center, Orlando Regional Medical Center (ORMC), was only three blocks away from the scene of the shooting. ORMC had experience treating trauma patients arriving in short intervals, although no events close to the scale of what happened on June 12. Further, hospital administrators note they had only recently held large-scale training exercises on how to respond to a mass shooting event. The practice, logistics, and fine-tuning that took place during this exercise could not have been better timed to prepare both hospital staff and community partners for the challenge of the actual event.

Patients Arrived in Two Waves

As is almost always the case in a mass casualty event, the emergency response was hardly glitch-free. For instance, the first email alert notifying **Eric Alberts**, ORMC's manager of emergency preparedness, about the shooting incident failed to rouse him from sleep. It was shortly after 2 a.m. at that point. Alberts finally received word of the incident via text more than one hour later. As a result of this problem, Alberts observes that ORMC has already begun searching for a more robust notification system, but he emphasizes that the incident command structure was triggered regardless of the notification delay.

"It is a layered approach," Alberts explains. "Whoever is there is responding in whatever roles are needed during the incident ... so it is a scalable response system, and because of that, the more people we have, the more people we are able to put in those positions to respond to the emergency."

Timothy Bullard, MD, an emergency physician who is part of the incident command structure for mass casualty intake, describes another glitch that occurred shortly after he arrived at the hospital that morning around 3 a.m. At that point, the ED was briefly locked down because of false reports that a gunman was in the vicinity.

"With all these [types of events] there are a lot of rumors and questions about what is actually happening, how many shooters there are, and things like that," he explains. "It didn't last very long. We had a lot of police on site at that point in time and we had our own security ... so people were fearful for a short period of time, but that passed."

The patients arrived in two waves, with the initial surge arriving right after the shooting took place around 2 a.m., and the second surge arriving about three hours later, after police blew a hole through the nightclub, killed the gunman, and found the remaining victims. ORMC received 44 victims, nine of whom died within minutes of arrival.

There Was No Time to Organize

One of the biggest challenges facing emergency providers was the speed with which the incident unfolded, Bullard recalls.

"Normally, we would have more time in a disaster to organize. There was really no time at all," he says. "My partners who were there [at the time of the shooting] got the call that there would be a number of shooting victims, and then they showed up. Some of them weren't even brought in by ambulance. They were brought in by pickups, so there was a very narrow window of notification."

However, since ORMC is a Level I trauma facility, the hospital had the kind of expertise and resources that a smaller, community hospital might not have been able to marshal in such a short period of time.

"We have a lot of personnel in-house that we can mobilize," Bullard says. "We have two surgical critical care guys and some fellows in house; we have a cadre of emergency physicians that are normally on staff to take care of patients; and then we have some medical intensive care physicians who are available at night as well."

Also, in a fortuitous administrative quirk, all five resident physician slots on the schedule that night were filled by senior residents who were literally two weeks from finishing their training, Bullard notes.

"It was very close to the end of the year when new residents come in

and the classes change," he explains, noting that experience makes a difference at such critical times. "It would have been more difficult for us had more junior residents been available."

Surgeons had to be called in, but most of them live close to the hospital and they were on site quickly, Bullard notes.

"With all this manpower ... we were up to speed quickly," he says.

Further, with the incident occurring in the middle of the night, the ED was not overwhelmed with personnel flooding into the hospital to help out.

"That is one thing we always worry about. Everybody wants to participate and help, but sometimes it can create another level of chaos trying to organize people and just deal with personnel you actually need," Bullard adds. "Because this happened at 2 a.m., there were an awful lot of people that really didn't know about it. Most of the people who came in were called to come in."

Administrators even called hospital personnel to let them know not to come in unless they were contacted.

"If the shooting had happened during the day or earlier in the evening, the ED might have had real issues with just trying to control our own personnel and keep things at a manageable level," Bullard says.

Noise, Patient IDs Proved Challenging

One challenge clinicians faced was trying to identify patients who required treatment, but were not conscious. The hospital had procedures in place to manage this complication, Bullard notes.

"We registered [these patients] in a certain order, and that was an issue, but people went back and re-registered those patients [once they were identified] and made sure that everybody was appropriately matched with the appropriate labs and X-rays that had been done on them," he explains.

Alberts explains that the hospital leveraged many different methods, including digital fingerprinting, to ensure patients were accurately identified and that their families were informed about their status.

"When you have an unidentified patient, you will go to great lengths to [identify] who they are and to reunite them to their families, because families have a lot of say on a patient's care in the hospital, especially when the patient can't speak for himself," he explains. "We do our due diligence, not only for the patients' families, but medically speaking we have to be doing the right thing for [the patients] to make sure they are getting appropriate care."

Another challenge was the noise level, Bullard says.

"When you get in a room with six critical patients and you've got multiple teams, the noise level is always an issue," he explains. "Normally, when we have one or two trauma victims, everybody is very quiet and listening to the reports that the EMS personnel give out, but with so many patients coming in simultaneously, some of that falls apart," he says. "We were able to get our jobs done, but it was difficult at times for everyone to hear."

Bullard adds that caring for patients in the midst of a mass casualty event requires adjustments beyond the speed with which clinicians normally operate.

"You are a little bit more aggressive with patients," he explains. "If you think something needs to be done, you are not going to second-guess yourself and say, 'let's wait a while and see if the patient gets a little better.' You are going to do everything right then, because you don't have the luxury of watching them."

At one point, there were more than 90 patients in the ED, more than half for reasons unrelated to the shooting event. Would the ED have been able to manage even more patients, if needed? Yes, according to Bullard.

"The incident command would have called a lot more people in," he says. "I went down to the ED and asked my partners what they needed. They said from an emergency physician and surgeon standpoint, they were in pretty good shape, but they did ask that we get more vascular support and some more orthopedic support, so we got on the phone and got those people in."

The system worked, but Bullard emphasizes that the ability to mobilize so quickly stems from the hospital's diligence in regularly performing critical training exercises and drills. He advises colleagues to use the Orlando experience and similar incidents as motivation to drill frequently and take such exercises seriously.

"You just never know when a [mass casualty event] is going to hit your community, so that practice is first and foremost," Bullard says. "At some point, everybody is going to get saturated, but we had the latitude to take in more patients, if needed — maybe not in a three-minute window, but had we known that we were going to get a huge number of secondary patients, we could have ramped up more."

Alberts, who organized a massive training exercise for an active shooter event as recently as March, could not agree more.

"That was a big benefit to all our

team members," he says. "We had that training opportunity for them to see what a real response to an active shooter situation would look like, feel like, and sound like."

The exercise was elaborate, including 500 volunteer victims who used fake blood and other materials to make their gunshot wounds and other injuries seem as authentic as possible.

"We had 15 hospitals and 50 agencies that participated," Alberts explains. "Because of that realistic scenario, and the fact that everyone was taking it seriously, it was a true training and education opportunity for our team members."

Alberts adds that some physicians and administrators have observed that the exercise was instrumental in helping ORMC and its community partners save lives the night of the Pulse shooting. Consequently, his advice to colleagues is to take full advantage of their training exercises so that they can identify areas of opportunity to improve.

"If you don't do that, you are really failing as a healthcare provider, and you are failing as a community," he says. "You must leverage any opportunity you have to learn and grow, because in a time of need like we had, training is what comes back to people's minds. If it is ingrained in their minds enough, it becomes a rhythm, and they just kind of step into it."

When designing such exercises, be sure to incorporate the wide array of community partners that a facility would rely on in a real mass casualty event such as law enforcement, fire and rescue, and even hazardous materials teams, Alberts advises.

"The collaboration and coordination that takes place when something like this happens is just astronomical," he says. "The exercises are a great opportunity to do that because you will be able to see how each [group] reacts and responds to the incident."

If hospitals don't engage with such partners before a mass casualty event occurs, the critical element of trust may be missing, Alberts suggests.

"If you shake their hands ahead of time and you plan with them and work with them, you will get to know each other and get acclimated with one another," he says. "That is going to help you to respond in a real situation. That just shined through in this whole incident."

With the crisis over, there are more opportunities to learn from the event. Administrators are still combing through data to put together a full after-action review.

"That is going to take some time, but one of the things we identified [for improvement] already is communications," Alberts notes. "With any real emergency or exercise you are always going to have an issue with communications, so we are looking at the efforts we have undertaken with communications and how we can do things better. That is really what our process is: We look at the things that can be tweaked and try to improve them for the entire organization and also for our community."

Part of this review process involves a series of debriefings, Alberts explains.

"We grab the critical stakeholders together within our organization and we walk through the situation," he says. "We try to start at a high level with sort of a snapshot of what happened, and then we start working through some of the things where we have questions regarding what worked well, what are some of the areas of opportunity, and where can we do things better."

At press time, ORMC had already conducted three debriefing sessions about the emergency response, which then led to a number of smaller "breakout sessions," Alberts notes.

"On top of that, our team members are going through employee assistance program [EAP] briefings to make sure everyone is properly taken care of," he explains. "When you experience traumatic incidents like this, it is going to impact human beings, and it is going to impact them in different ways. Some people are more accustomed to it than others and more adept at being able to respond to it. Others aren't, so we are taking this seriously."

The hospital has been conducting many EAP group sessions, but team members also are able to arrange individual sessions.

"In addition, we have a lot of chaplains at our hospital that team members are able to talk to at any time," Alberts says. "Our team members are encouraged to use any one of those [opportunities] in any form or fashion just to make sure they are talking through and working through this in their minds so that they are comfortable and healthy for the long haul." ■

COMING IN FUTURE MONTHS

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CE QUESTIONS

1. According to some case managers and others who have dealt with mass shooting situations, what is one of the biggest unexpected obstacles to care transition at those times?

A. Patients are too afraid to move from their hospital bed to a radiology or surgical room.
B. Patients' families refuse to sign permission for emergency surgery.
C. Media converges on the hospital and threatens the privacy of patients as they are being transitioned to another hospital or healthcare facility.
D. All of the above.

2. Which of the following is a good strategy for preparing for an active shooter event, according to case management and emergency management experts?

A. Develop a protocol specific to a mass shooting scenario.
B. Have staff practice active shooter drills.
C. Pay close attention to patients' emotional health after such trauma.
D. All of the above.

3. Which of the following is a benefit of having a case manager visit with high-risk patients at their homes, according to Elisol I. McKim, BSN, RN, CCM?

A. The home visit can reinforce the self-management training doctors and hospital providers have given the patient.
B. The home visit is less costly.
C. The home visit is a mandate by most payers.
D. None of the above.

4. Which of the following is not a good question to ask patients during a home visit that has the purpose of determining the patient's ability to manage his or her medical condition?

A. Do you live alone?
B. Who supports you?
C. Do you like to cook?
D. How long have you had your diabetes/disease?