CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

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Multistate Database Connects Case Managers with Community

Patient needs a plumber? No problem!

Case managers nationwide use their experience and skills to find creative solutions to their patients' medical obstacles and problems. But what if finding precisely the right answer was as simple as putting a word in a search engine?

That's essentially what is happening with WellCare Health Plans of Tampa, FL, and the company's HealthConnections program.

"HealthConnections is the connection between the synchronization of services across social, clinical, and behavioral health services," says **Pamme Taylor**, vice president for advocacy and community-based programs for WellCare, an insurance company.

"This model embeds social service delivery right smack dab in the middle of care management," Taylor says.

"We've created a database with social services that spans 32 different states and 150,000 social service partners and 73 categories of services," Taylor says. "They span adoption, advocacy, all the way to youth support services."

The program has connected about

EXECUTIVE SUMMARY

WellCare Health Plans has created a large database that lists community organizations that provide services to WellCare's regions.

- The HealthConnections program's database covers 32 states and 150,000 social service partners.
- About 16,000 people have used the service since 2011.
- Care managers identify a patient's social needs and obstacles, put the need in the search engine, and find answers to their patient's problems.

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16,000 people to 50,000 services since 2011, she says.

WellCare's program covers Medicaid and Medicare populations with about 16,000 people enrolled in case management. HealthConnections helps enrollees with issues that might affect their medical care indirectly, such as housing, transportation, food, and other needs, she explains.

For example, a member might not be able to leave the house due to lack of a good wheelchair.

"Recently, I went to evaluate a person to make sure they had an appropriate wheelchair," says **Kendra St. Vincent**, RN, CCM, senior field service coordinator for WellCare Kentucky.

"Basically, the person's wheelchair didn't have an appropriate leg rest and it wasn't able to recline," St. Vincent says. "The patient needed it to be functional to leave the house."

Using HealthConnections, St. Vincent found a better wheelchair and was able to have it delivered to the member's home.

HealthConnections, which is continuously updated, has included many community services for urban areas, but rural services sometimes are lacking, Taylor notes.

"We found in rural communities that there is a general lack of services across many different categories, and social services is one of them," she says. "Trying to find multiple services in rural areas is extraordinarily difficult."

As a result, WellCare created HealthConnections Council with local teams that bring different people together to create a new service and fill a gap, she explains.

"Those are called community health investment programs, where we take savings from our model and reinvest the money in the community in the social services gap," Taylor says.

For instance, WellCare has worked with local transportation providers to put bus routes in a loop, so a person could get on the bus, go to a doctor's visit, and then go to a pharmacy and grocery store before heading home, she says.

"An evaluation of the change demonstrated its impact on health outcomes, reducing avoidable ER visits, so absolutely, it was worth the effort," Taylor adds.

Part of Taylor's passion for the HealthConnections program comes from her personal experience and understanding of how difficult it can be for people to manage their health when they have basic living needs that are unmet. "I'm a former Medicaid recipient, a part of the foster care system," she says.

"When you're worried about whether or not you have a roof over your head or have food that day, then you're not worried about what your future will be," Taylor explains.

Sometimes, even an experienced care manager can be shocked by how seemingly minor bumps in life's road can sideline families.

For example, St. Vincent recalls visiting the home of a non-English-speaking WellCare member. When she walked into the rental home, she could see that the kitchen sink, which didn't have a garbage disposal, was stopped up from food and was unusable. The family had been washing dishes in the tub and carrying buckets of water from the tub to the backyard. This had been going on for three months.

"I called the landlord for them, and the landlord said it was their responsibility to fix the sink," St. Vincent says.

Using HealthConnections, St. Vincent found a community church

that donated funds to fix the sink. After a plumber replaced the elbow of the sink's pipes, St. Vincent educated the family on how to avoid putting food refuse down the sink. She also taught them how to change a light bulb because they were refugees from an area that didn't have plumbing or electricity.

Sometimes, transportation barriers for members is not as simple as finding a community organization that provides rides to doctor's appointments. This is where the extensive database and the ability to ask for help through a database query can be helpful. For instance, one homebound member in a wheelchair had multiple health issues, including obesity, diabetes, heart failure, and hypertension, but he couldn't always get to the doctor, recalls **Charles Talbert**, regional communication manager for WellCare Kentucky.

"During the winter months, his driveway was impassable, so the care manager took it upon herself to contact a local paving company," Talbert says. "The paving company was so moved by the care manager reaching out that the company donated 100 tons of gravel to get the driveway passable."

Once the driveway was made passable, the transportation company could pick up the patient to go to doctors' appointments.

"We have a laundry list of gaps in these types of care," Talbert says. "When people are confronted with a stopped-up drain and driveway, this is where a care manager comes in and moves heaven and earth to get the help the person needs." ■

Here's How HealthConnections Gives Case Managers Ways to Help Patients

No matter the need, someone can help

The following is how WellCare's HealthConnections program helps case managers provide social service support to their patients:

• **Connecting members to community aid.** WellCare patients are connected with care management because of their chronic illnesses, including diabetes. If a care manager finds that the person needs access to healthy food or rent assistance, then the care manager can look on the HealthConnections database for local organizations that provide that type of help, says **Pamme Taylor**, vice president for advocacy and community-based programs for health insurer WellCare.

"The database lists all the social services, including rental assistance, utility assistance, food pantry, farmer's market, and others," she says. "This is right in the middle of our care coordination model, so care managers look up services, reach out to the organization, and let them know we have a patient in need."

Each of these connections is captured in the health record, alongside the clinical care and comorbid conditions, Taylor adds.

"It's all at the case manager's fingertips," she says.

• **Collecting information.** "We maintain network information, and it's constantly growing and evolving," Taylor says.

The team working on HealthConnections consists of 65 people, half of whom are spread across the states covered by WellCare. Their job includes maintaining data on which resources in the database were used by plan members.

• **Connecting with community organizations.** Part of the team's work is to find available services that could meet patients' gaps. They search in areas where WellCare has members who might need the help. They reach out to churches, nonprofits, and any group that provides services for economically disadvantaged people, says **Charles Talbert**, regional communications manager for WellCare Kentucky.

"They say, 'Do you provide services for these things?' and then we put them in the database," he says. "That's through our advocacy program."

Sometimes, a community doesn't have adequate transportation, housing, or other types of help, so community advocates will convene organizations and discuss how many people have obstacles to receiving healthcare, Talbert explains.

Together, the groups might start a pilot program to help with unmet needs. For example, in Hopkins County, KY, a community advocate worked with a local transportation company to create a voucher system that patients could use to get to medical appointments, Talbert says.

"We find organizations, identify a gap, and create a resource," he

adds. "This is a living organism that continues to grow."

• Provide a community assistance line. The program has 32 people who work on the community assistance line to help people in the community who are not in the case management program, but who also might need help.

"Oftentimes, people in the community who need services don't know how to find them," Taylor says.

The database is available to the larger community, including plan members' family and friends, she says. "We wanted to make it available to our caregiver network."

Expanding access to the database is a way to do outreach.

"We wanted to see if we could capture some of the audience that is not in care management, but could be, and we can make them aware of options," Taylor says. "As part of our diversity and inclusion program, we set up a call center and hired individuals through the workforce innovation programs like Welfare to Work."

These workers have been enrolled in Medicaid or Medicare, and they can be seniors with disabilities, caregivers, students, and individuals who know how to navigate the social safety net but need a little help to get to the right social services, Taylor explains.

• Empower care managers. "While every care manager completes a health risk assessment, they're also trained on how to identify when a member has a social need," Taylor says. "So if a case manager is meeting with a member face-to-face, they can pick up on visual cues that show what's happening in the person's environment."

Case managers develop rapport with members and quickly figure out what they need. "Then they turn to the online database to find those resources," Taylor says.

One common need involves food, says **Kendra St. Vincent**, RN, CCM, senior field service coordinator for WellCare Kentucky.

"I see people who have difficulty accessing healthy food or who can't buy enough food to last the month," St. Vincent says. "The database can pull up the food bank in a member's area, and we can give the person that information about where they can get fresh food and vegetables that meet their budget."

Housing is another basic need that some members lack. "Here in Bowling Green we have Hotel Inc., which is a street medicine program with homeless members," she says.

Through a partnership with Hotel Inc., WellCare case managers can help with health check-ups, while Hotel Inc. helps WellCare workers find homeless patients.

"The ultimate goal of the program is we want to find long-term housing for the homeless," St. Vincent says. "We have found that a lot of homeless members fear getting a healthcare check-up, getting a colonoscopy or mammogram, and we realize we can make a real difference in their lives."

For instance, one member who was found by Hotel Inc. had not seen a doctor in years. His vision was poor, and a case manager helped him connect with an organization that gave him glasses, Talbert says.

In another case, a plan member needed dentures, and HealthConnections didn't have the resources to give them to the member, St. Vincent says.

So St. Vincent put a "gap" need in the database, asking for dental care, and someone responded with a solution, she says.

The man got his dentures and could again eat his favorite food of steak, she recalls.

"If a person's basic needs are not met, then they cannot focus on health needs," St. Vincent says. "Our ultimate goal is to get them healthy." ■

Diabetes Protocol is Recipe for Success in Telehealth Case Management Program

Blood glucose averages drop

Case management can be combined with treatment-specific protocols to quickly react to patients' medical problems, resulting in better chronic disease maintenance, administrators of a telehealth program found.

A diabetes insulin adjustment protocol, used with a virtual case management program, helps reduce average blood sugar levels among at-risk diabetic patients. RN case managers were trained to use the protocol, which resulted in a reduction of average baseline A1c from 9.646 to an average of 7.685 A1c post-protocol use among about 150 patients, says **Nancy Brown**,

MSN, ARNP, ANP-BC, advanced registered nurse practitioner at Mann-Grandstaff VA Medical Center in Spokane, WA.

"With diabetic patients we can manage them, and even adjust their insulin, over the phone," says **Freta L. Leddige**, BSN, RN, nurse manager for home telehealth at Mann-Grandstaff VA Medical Center.

Before developing the protocol, the VA medical center had difficulty improving multi-complex patients' diabetes, Brown says.

Previously, insulin adjustments could take weeks or months because physicians might wait until they saw the patient in their offices to make changes.

"I'm a provider, and before I started working with home telehealth nurses, I'd be in clinic, busy seeing patients — and then in the middle of the day the blood sugar numbers would pop up with a summary," Brown explains. "I'd say, 'I'll look at it when I see the patient next month rather than break out of my clinic day and give a nurse an order to adjust the patient's insulin.'"

Brown researched insulin adjustment strategies in the literature and attended a number of diabetes conferences, learning as much as she could. Evidence pointed to patients being able to self-adjust their basal insulin safely with instructions by nurses, who follow a standard order. In other words, a telehealth model could work.

The key is to create a protocol order that will be pre-approved by a medical review board and used by well-trained nurses to adjust treatment, Brown says. *(See related story on the protocol's use with technology, page 102.)*

"So I worked with home telehealth nurses on an order they could use to adjust their patients' insulin levels over the phone," she explains. "We did an improvement project to see if this helped improve their A1c goal."

They found that before the insulin adjustment protocol it took an average of eight to nine months to get patients' blood sugar levels down to the desired level, but after using the protocol it took two to three months for improvement.

"We thought this was really exciting, so nurses started having more and more interest in managing their patients' diabetes," Brown says.

The following is how the protocol program works:

• **Develop a protocol.** The diabetes insulin adjustment protocol gives nurses a clear recipe for when to adjust insulin levels, Brown says. *(See template table, page 103.)*

There are fields for the patient's diet, exercise, medication compliance, rotating injection sites, and symptoms of hypoglycemia or hyperglycemia in the medical center's insulin adjustment note template.

There are also fields for listing the current insulin dose and the last adjusted dose, including basal, prandial, average dose of prandial insulin at each meal, and total daily dose of insulin.

Other fields include average blood glucose for the past three days, recent blood glucose transmissions, the blood glucose chart, and a listing of whether blood glucose was not at individual glycemic goal.

Finally, the protocol's insulin adjustment note template lists these four steps:

1. Patient is instructed on changing the basal insulin dose and prandial insulin dose.
2. Nurse reviews individual glycemic goal, signs/symptoms of hypo/hyperglycemia, treatment, and prevention of low blood sugars, including the 15-15 rule of hypoglycemia, diet/meal planning, and exercise as tolerated.
3. Patient agrees with and verbalizes understanding of above plan and offers no questions or concerns.
4. Continue home telehealth monitoring and insulin adjustment as needed.

• **Obtain approval from a medical review board.** A medical review board first had to approve the protocol, says **Barbara Carrara**, MSN, RN, home telehealth case manager at Mann-Grandstaff VA Medical Center.

"A lot of doctors are hesitant to allow nurses to adjust medication, especially insulin, so that's a big barrier," Carrara notes. "That wasn't just a barrier here, but also throughout the VHA system."

With support from a Mann-Grandstaff nurse executive, Nancy Benton, PhD, RN, CNS, they overcame that barrier: "She would go to these high-level meetings

EXECUTIVE SUMMARY

A telehealth program has case managers who follow a diabetes insulin adjustment protocol to better manage patients' disease.

- Nurse case managers were trained before they could use the protocol.
- The protocol showed positive health improvement results.
- Providers responded positively to the program.

and say, 'My nurses can do this,' and she'd present the protocol to them, convincing them that it was something that would be good for us," Carrara says.

• Provide proper training for nurses. "In order to make the protocol safe and effective, nurses utilizing it must have advanced education in diabetes," Carrara says. "They don't need to be certified diabetes educators, but they must have enough education to develop a solid understanding of diabetes, diabetes medications, and how these are affected by exercise, diet, illness, etc."

Each case manager in the program received more than 20 hours of didactic education before the protocol was launched. Also, Brown provided nurse case managers with one-on-one mentoring, Carrara says.

The VHA facility created competencies through online training and mentoring, along with an annual test nurses must pass, Brown says.

• Obtain physician buy-in. Physicians select patients who would benefit from the protocol and write an order for it. Obtaining physician buy-in was a challenge, but the pilot project's results helped to build trust, Carrara says.

"One of the outcomes that our study supported was that there were no serious episodes of hypoglycemia during the study," she adds.

In one case, a new provider was skeptical of approving the protocol, and she planned to pull her diabetic patients out of the home telehealth program and manage them herself, Carrara recalls.

"Thanks in good part to Freta's education and support, she decided to give it a try, and now she refers all the diabetics she has a hard time controlling," Carrara says. "We've developed such a good relationship with our providers."

• Ensure nurses follow stated rules. "When nurses are going to be utilizing a protocol that involves medication adjustment, they need to check with their state board of nursing, wherever they happen to be licensed, to make sure the state board says it's okay to follow a protocol under your license," Carrara says. ■

Diabetes Insulin Protocol is Most Useful with Technology

A telehealth case management program's use of a diabetes insulin adjustment protocol works well with technology to keep data fresh, and a commitment to assessing and adjusting as needed, according to protocol administrators.

Nurses can review blood glucose data as it comes in, assessing for trends, says **Nancy Brown**, MSN, ARNP, ANP-BC, advanced registered nurse practitioner at Mann-Grandstaff VA Medical Center in Spokane, WA.

Diabetic patients who are eligible for the protocol use technology to send their blood glucose numbers to vendors that contract with the Veterans Health Administration, says **Barbara Carrara**, MSN, RN, home telehealth case manager at Mann-Grandstaff VA Medical Center.

The data is analyzed for averages and trends. "For example, I have a patient in front of me and I can see all of his blood sugar ratings for the past 14 days, and I can go back 180 days," Carrara says. "This real-time data coming in through the vendor website is so important because when you're making insulin adjustments, you're making them based on patterns over time, and it makes the outcome much safer."

Nurses always have the patient's blood glucose data available before they begin the telehealth call with the patient, Carrara adds.

"We don't even call the patient until we see their numbers," she says. "Another real advantage to going to the system we use is if there's something wrong, like an extreme high or a low number, we can react in real time to that."

As the protocol was developed, Brown's goal was to keep it simple and easy to follow. After testing, she found that it also had to be very specific.

"You couldn't do a range order, saying, 'If the blood sugar is greater than 200 for X amount of days,' you could not say, 'Adjust by 2 to 4,'" Brown says. "You had to be specific."

The Joint Commission, the health system's accrediting body, does not allow range orders because of the potential for errors or adverse outcomes, Carrara notes.

After a year of using the protocol, they decided it may be too restrictive: "Nurses' hands were tied in certain instances, such as when a patient had low blood sugar or multiple low blood sugars," Brown explains.

Providers gave patients a sliding scale for bolus insulin adjustment, and they changed the sliding scale

to a PRN mealtime insulin chart. It instructs patients that their fast-acting insulin is married to the meal and is not to be used every four hours, Brown says.

"This seemed to work when bolus insulin was first added, but we still needed something for when a patient was already on a set dose of bolus insulin," she says.

The solution was a corrective chart that patients could use to add or subtract to their set mealtime dose, according to their pre-meal blood glucose level. "Initially, orders were written that patients may use the PRN mealtime chart or the corrective chart," Brown says.

"The RNs learned to look at patterns and the basal-bolus ratio," she adds. "This was taken into account when writing the protocol."

One of the more interesting periods was when the protocol was suspended briefly as it was being adjusted, and case managers found they missed it, says **Freta L. Leddige**, BSN, RN, nurse manager for home telehealth at Mann-Grandstaff VA Medical Center.

"We stopped it for a short time and we nearly went crazy," Leddige says. ■

Mann-Grandstaff VA Medical Center's Insulin Adjustment Protocol

Focus is on specifics

Nurses at Mann-Grandstaff VA Medical Center of Spokane, WA, shared their insulin adjustment protocol for RN case managers with *Case Management Advisor*. The protocol is as follows:

Guidelines for adjusting insulin:

i. Assess patient for correct insulin administration, exercise, eating habits, symptoms of hypoglycemia or hyperglycemia, self-management knowledge (treating hypoglycemia, sick day management).

ii. Look at individual glycemic goal.

iii. Adjust one insulin type at a time, unless balancing basal-bolus ratio.

iv. If starting insulin for the first time, titrate basal insulin until fasting glucose is less than 150 mg/dl, insulin dose reaches the number of units equivalent to 50% of patient's weight in kilograms, or if any hypoglycemic event occurs. At that time, consider the addition of bolus insulin.

v. Goal for total daily insulin is 50% basal and 50% bolus, per patient agreement.

• If basal dose of insulin is greater than 50% of total daily dose (TDD) of insulin, may lower basal dose by 10% and add this amount to daily bolus dose. Consult provider if a larger adjustment is indicated.

• If total bolus dose of insulin is greater than 50% of total daily dose (TDD) of insulin, may lower total bolus dose by 10% and add this amount to daily basal dose. Consult provider if a larger adjustment is indicated.

vi. Titrate insulin dose to correct low glucose readings first. Consult provider if insulin dose needs to be lowered more than protocol allows.

vii. Adjustment of bolus insulin is to take into account what the patient is currently taking, i.e., prescribed dose of bolus insulin plus any additional units taken per correction chart.

viii. When increasing dose of bolus insulin, may split amount over three meals.

ix. If average fasting glucose is lower than bedtime glucose by 40 points or more (without having had a bedtime snack), may lower the basal insulin dose by 10%.

x. Check A1c to determine if at individual glycemic goal as appropriate.

xi. If A1c does not correlate with blood glucose readings, get 2 hour post-meal readings.

Advice for adjusting basal insulin:

(if not explained by unusual diet, exercise, or misuse of insulin)

• Adjusting basal insulin:

- If average glucose is greater than 300 for 3 days, may increase insulin by 10 units.

- If average glucose is 250 to 299 for 3 days, may increase insulin by 8 units.

- If average glucose is 200 to 249 for 3 days, may increase insulin by 6 units.

- If average glucose is 140 to 199 for 3 days, may increase insulin by 4 units.

- If average glucose is 120 to 139 for 3 days, may increase insulin by 2 units.

Hypoglycemia:

- If individual glucose reading between 60 and 70, may decrease

insulin dose by 2 units daily;

- If individual glucose reading less than 60, may decrease insulin dose by 4 units daily;

- If patient has two or more glucose readings of less than 70, may decrease total dose of basal insulin by 10%.

• Adjusting bolus (mealtime) insulin:

- If average glucose is greater than 300 for 3 days, may increase insulin by 10 units;

- If average glucose is 250 to 299 for 3 days, may increase insulin by 8 units;

- If average glucose is 200 to 249 for 3 days, may increase insulin by 6 units;

- If average glucose is 140 to 200, for 3 days, may increase insulin by 4 units;

- If average glucose is 120 to 139, for 3 days, may increase insulin by 2 units.

Hypoglycemia:

- If individual glucose reading between 60 and 70, may decrease insulin dose by 2 units daily;

- If individual glucose reading less than 60, may decrease insulin dose by 4 units daily;

- If patient has two or more glucose readings of less than 70, may decrease total dose of basal insulin by 10%. ■

Best Practices, Investments Needed to Communicate Effectively with LEP Patients

In May, the Department of Health and Human Services' (HHS) Office of Civil Rights issued a final rule that bans hospitals that receive federal funds from discriminating against transgender people, the disabled, and people with limited English proficiency (LEP). *(More information about this rule is available at: http://bit.ly/1YCYEbl.)* In issuing the rule, HHS Secretary Sylvia Burwell noted that it was a key step toward realizing equity within the healthcare system.

Among other things, the rule clarifies what accommodations hospitals must make to meet the needs of LEP patients, specifying, for example, what makes an interpreter qualified. In fact, meeting the needs of LEP patients has long been an issue of concern for The Joint Commission (TJC). In May 2015, TJC issued a report noting that 20% of the U.S. population speaks a language other than English at home, and that approximately 25 million people, or 8.6% of the population, can be defined as LEP. Further, the report noted that by 2021, roughly half of all newly insured people in the United States will be minorities who are less likely to speak English. *(More information is available at: http://bit.ly/2aMdfjF.)*

What makes these data points noteworthy is the reality that LEP patients are at higher risk for adverse events than patients who are fluent in English. There is evidence that a growing number of hospitals are beginning to realize that the kind of investments needed to accommodate LEP patients may pale in comparison to the tab for maintaining the status quo.

Experts agree that there is plenty of room for improvement in the way hospitals endeavor to meet the needs of LEP patients. **Joseph Betancourt**, MD, MPH, director of the Disparities Solutions Center at Massachusetts General Hospital in Boston, explains that one of the biggest challenges is that many hospitals across the country don't have even a basic foundation in place for communicating with LEP patients.

"There still are many hospitals that don't have a dedicated interpreter service or, quite frankly, a real plan to effectively manage language barriers in healthcare delivery," he says.

These hospitals still rely on family members of patients to act as interpreters, or hospital workers who may have some knowledge of the patient's native tongue, but no proper training in medical interpreting, Betancourt notes.

"If we go to the next level, we do have some hospitals that have invested in dedicated interpreter services and who do have telephonic vendors in place, but their ability to use them effectively is hampered by the fact that they really haven't built the systems, nor have they trained their caregivers on how to use these services efficiently," he says.

For example, Betancourt notes that a provider may be well aware that the hospital has a dedicated interpreter service, but pressed for time, he or she wil nix the idea of waiting for an interpreter to come down, and just press forward. In fact, this is a particularly common scenario in the fast-paced emergency setting.

"The ED is a real cauldron for difficulties in these areas. There is no doubt that individuals in the ED are working in a high-stress, high-risk environment," Betancourt explains.

"These individuals need to move fast and need to get people triaged, so if the [interpreting] system isn't built to support the emergency service in a timely fashion, it just won't be used."

Consider Potential for Errors

However, providers should understand that shortcuts of this nature can produce severe consequences. **Glenn Flores**, MD, the distinguished chair of health policy research at the Medica Research Institute in Minnetonka, MN, describes the case of a six-month-old infant who presented to the ED with vomiting and diarrhea.

"The triage history given by the mother was interpreted by the boy's 12-year-old sister, and no medical interpreter was requested. The sister stated that the patient had four dirty diapers and three episodes of vomiting that day," Flores explains.[1]

The boy was triaged to a non-urgent level of care where the documentation stated that he had vomited seven times that day with no diarrhea.

"The boy was discharged shortly thereafter with a diagnosis of vomiting and with instructions only in English for rehydration solution by mouth," Flores notes. "Three days later, the boy returned to the ED in severe distress with new onset of bloody stools. He was admitted to the hospital and died six hours later from septic shock."

In another case, a 12-year-old paraplegic female presented to a children's hospital ED with shortness of breath, fever, a urinary tract infection, and tachycardia. She spoke minimal English, and her mother only spoke Spanish, Flores explains.

"An interpreter was not available until three hours after [the patient's] initial presentation. Neither telephone nor video interpretation was considered by staff," he says.[2]

Flores explains that it took 90 minutes for the medical staff to figure out that the patient recently had traveled to Mexico, where she had been diagnosed with a renal abscess. He notes that 30 minutes after the interpreter's arrival, the patient went into cardiac arrest. She died 23 minutes later.

"The autopsy revealed bilateral septic pulmonary emboli, a left leg thrombosis and sepsis as causes of death," Flores says.

These are just two cases, but Flores contends that they are emblematic of what can happen when effective interpretation services are not available or leveraged when LEP patients present for care.

"Substantial scientific evidence documents that optimal communication, patient satisfaction, outcomes, resource utilization, clinical research quality, and patient safety occur when LEP patients have access to adequate language services," he says.

Flores stresses that using ad hoc interpreters — whether they are family members, people in the waiting room, untrained ED staff, or even a primary caregiver who has limited English proficiency — is no substitute for using a trained medical interpreter. Further, he warns about the overconfidence that some healthcare providers have regarding their own fluency in the patient's primary language.

One other shortcut providers must avoid: using Google Translate for medical interpretation.

"Google Translate can be grossly inaccurate in medical encounters, placing patients at significant risk for harm," Flores warns. "Google Translate specifically states that it should not be used in safety-critical circumstances. It should never be used to replace a trained, professional medical interpreter."

Address Post-discharge Care

Communicating effectively with LEP patients extends beyond interactions that take place while such patients are in the hospital. They also need to understand written instructions, an area ripe for improvement, according to Betancourt.

"It is a particularly huge issue because on top of the fact that there are probably not the best systems in place to support LEP patients, we have a real dearth of patient materials in different languages," he says. "So these individuals are getting some level of instruction with the help of an interpreter [while they are in the ED], but then if they have any questions, they are really in a tough spot. They have no one to call. They don't really have a good navigator in place."

In fact, Betancourt and colleagues highlighted this issue in a report they completed for the Agency for Healthcare Research and Quality, in which they identified several high-risk scenarios in which language barriers posed a significant risk of a medical error. *(The entire report is available at: http://bit.ly/OcrakX.)*

"ED care was one of those high-risk scenarios because people are leaving with instructions that they often don't understand ... and that can lead to a whole series of errors," Betancourt says.

Some hospital systems are creating multilingual call lines or other innovative solutions so that LEP patients can access the help they need in a language they understand when they have questions about their

care post-discharge, but the need for such solutions is only growing with the increasing diversity of the U.S. population.

Betancourt notes that an increasing number of hospitals are getting the message.

"There is greater attention on issues related to patient safety, and the research clearly tells us that minorities and patients with LEP suffer more medical errors with greater clinical consequences than their white counterparts," Betancourt explains. "So if you are a hospital and you care about patient safety, you need to turn your attention to those issues."

Another force pushing hospitals to improve in this area is the move toward value-based purchasing, which places a premium on caring for patients who frequently utilize the system or are high-cost, Betancourt says.

"What we understand about these patients is that they are quite vulnerable, and language barriers can play a very significant role," he explains. "If you are getting paid on a value-based contract whereby you are compensated on your care of a group of patients with heart failure or a group of patients with diabetes ... then it really behooves you to make investments to address language barriers to avoid absorbing costs that come from patients misunderstanding."

Letting this issue slide has other financial ramifications as well, Betancourt warns.

For example, he describes the case of an LEP patient who presents to the ED with head pain, and there is no interpreter on site who can translate the patient's story.

"The provider will just send the patient to get a CT scan because he or she needs information," Betancourt explains. "Think about the cost to the healthcare system for that unnecessary CT scan when, in fact, an interpreter, for a fraction of the cost, could have allowed that ED physician to do his or her job, get a really good history, and figure out that the issue was sinusitis and not a subarachnoid hemorrhage."

Flores suggests ED administrators and providers push for all states to provide third-party reimbursements for interpreter services for LEP patients.

"Currently, only 12 states and Washington, DC, do so, but it is relatively simple to achieve," he explains. "The state legislature just has to approve interpreter services being a covered service under Medicaid. By not doing so, states are missing out on millions of dollars of federal Medicaid/CHIP [Children's Health Insurance Program] matching funds that could be flowing to them."

To find out whether your own ED is communicating effectively with LEP patients, Flores directs ED managers to complete a two-step process. Managers should consistently collect and record in the electronic medical record (EMR) whether patients speak a language other than English at home. If yes, then record what that language is and how well the person speaks English: very well, well, not well, or not at all.

"Any response other than 'very well' classifies this person as LEP," Flores notes, explaining that these questions come straight from the U.S. Census Bureau. "Monitor relevant outcomes for LEP patients, including wait time in the ED, time spent in the ED, hospital admission rates, medical errors, patient safety events, and mortality rates."

How might ED clinicians take steps to improve LEP communications in their own work settings? It's a challenge without supportive healthcare systems, Betancourt acknowledges.

"I would say the best thing ED physicians can do is advocate in their own systems to support interpreter services and ways to manage language barriers," he says.

Emergency leaders also should consider implementing a host of best practices that can ensure that communications with LEP patients are optimal, Flores explains. He suggests the following steps:

- Collect English proficiency data on all patients, using the simple questions from the U.S. Census Bureau described above.
- Record LEP data as a permanent and prominent part of the EMR.
- Provide trained, professional medical interpreters or bilingual providers to all LEP patients and families.
- Post multilingual signage throughout the ED, imaging, and lab departments and other areas frequented by emergency patients.
- Provide professionally translated prescriptions, discharge instructions, and any other handouts in a patient's primary language, and review these materials with the patient with the assistance of a medical interpreter.
- Identify ED clinicians and staff who speak languages other than English, test their proficiency in these languages, and provide additional training to those who are not fluent.
- Create a database of all bilingual providers and staff to be used as a resource for LEP patients and families.
- Refer LEP patients and families to resources that can help them learn English. ■

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GAO Report Takes OSHA to Task on Healthcare Violence

The Occupational Safety and Health Administration (OSHA) has ineffective enforcement programs for issuing citations and following up warnings for workplace violence in healthcare, the U.S. General Accountability Office (GAO) reports.[1]

While the number of inspections involving workplace violence in healthcare facilities has increased, a relatively small percentage of these inspections resulted in general duty clause citations related to workplace violence, the government watchdog group found. From 1991 through October 2014, OSHA issued 18 general duty clause citations to healthcare employers for failing to address workplace violence. Seventeen of these citations were issued from 2010 through 2014. These citations were issued in about 5% of the 344 workplace violence inspections of healthcare employers that were conducted from 1991 to April 2015, the GAO reported.

The GAO recommended that OSHA provide additional information to assist inspectors in developing citations, develop a policy for following up on hazard alert letters concerning workplace violence hazards in healthcare facilities, and assess its current efforts. OSHA agreed with GAO's recommendations and stated that it would take action to address them, including considering whether a separate standard is needed on workplace violence in healthcare.

As has been previously reported, healthcare workers suffer much higher rates of violent injuries than the overall work sector. According to the GAO, in 2011 nonfatal workplace violence injuries in healthcare were an estimated 40,000 incidents.

"The full extent of the problem and associated costs is unknown," the GAO noted in the report.

That's due in part to the fact that such injuries are not always reported by healthcare workers. OSHA has increased its education and enforcement efforts to help employers address workplace violence in healthcare facilities, but GAO identified the several areas for improvement.

While OSHA does not have a standard on preventing workplace violence, the agency can use its general duty clause to protect workers from violence. The GAO reported, however, that OSHA regional offices lack specific criteria to enforce violence prevention under the general duty clause. Specific examples of issues that have been or could be cited are needed, the GAO recommended.

OSHA inspectors can also issue warnings about violence prevention, but employers can essentially ignore these "hazard alert letters," and OSHA does not follow up to see if corrective actions were taken. As a result, identified hazards may persist, the GAO found.

"OSHA has not fully assessed the results of its efforts to address workplace violence in healthcare facilities," the GAO concluded. "Without assessing these results, OSHA will not be in a position to know whether its efforts are effective or if additional action may be needed to address this hazard."

In response to the report, OSHA said it agreed with GAO recommendations and is taking action. The agency is in the process of revising its enforcement directive and developing a training course to further assist inspectors, OSHA stated in letter that is included in the GAO report. OSHA also plans to include standardized procedures for following up on hazard alert letters in the revised enforcement directive. OSHA stated that it intends to find a cost-effective way to gauge its enforcement efforts to determine whether additional measures, such as developing a workplace violence prevention standard for healthcare workers, are necessary. In addition, OSHA stated that the agency is reviewing past inspections that resulted in citations or hazard alert letters to determine what measures may improve the process, the GAO reported. ■

REFERENCE

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CE QUESTIONS

1. When patients have social safety needs that affect their health, what's a thorough and efficient solution for meeting those needs, according to Pamme Taylor?

A. Start a database of various nonprofit and service organizations in an area that provide help with housing, transportation, food, and other needs.
B. Advise the patient's caregiver to resolve the issue.
C. Call a hotline to ask for help.
D. None of the above.

2. In collecting information for a social services database to meet patients' gaps, which of the following types of services would not be included?

A. Transportation
B. Housing
C. Library
D. Food

3. According to Nancy Brown, MSN, ARNP, ANP-BC, which of the following is a step included in an insulin adjustment note template?

A. Patient is instructed on changing the basal insulin dose and prandial insulin dose.
B. Nurse reviews individual glycemic goal, signs/symptoms of hypo/hyperglycemia, treatment, and prevention of low blood sugars.
C. Patient agrees with and verbalizes understanding of above plan and offers no questions or concerns.
D. All of the above.

4. Why doesn't The Joint Commission allow range orders in a protocol, such as the insulin adjustment protocol?

A. Because of the potential for errors or adverse outcomes.
B. Because ranges are too imprecise.
C. Because it's against federal regulations.
D. All of the above.