CASE MANAGEMENT ADVISOR™

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INSIDE



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# Know Older, Medically Complex Patients' Wishes

*Consider addressing end-of-life issues*

As the population of people who are age 65 or older expands, case managers continue to see increasingly older people with serious and multiple chronic illnesses. Healthcare for this population poses numerous challenges, but it also suggests an opportunity for case managers to address advance directive and end-of-life questions and needs.

Baby boomers turning 65 will continue for close to two decades, says **Linda Keilman**, DNP, GNP-BC, an assistant professor and gerontological nurse practitioner at Michigan State University's College of Nursing in East Lansing.

"The U.S.' fastest-growing population is its oldest one," she says.

Along with the gray wave is the health industry's increase in numbers of older Americans with multiple chronic conditions. The big question will be how to care

## EXECUTIVE SUMMARY

Case managers are seeing increasing numbers of older, sicker patients as the baby boomers enter the post-70 age. Challenges of caring for this population include learning how to broach the subject of end-of-life care when patients are particularly frail and ill.

- Patients with chronic illnesses can be grouped into categories of active and healthy, medically challenging, and nearing the end of life.
- Case managers should try to have conversations with physicians and patients about end-of-life issues.
- They can ask patients if they've thought about their feelings toward feeding tubes and respirators.

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for these patients, as there are too few young healthcare professionals interested in specializing in gerontology, Keilman says.

"How do we get more people interested?" she says. "Caring for older adults, in my opinion, is a blessing, and it started for me because I had two sets of great-grandparents and a lot of great-aunts and uncles that we saw on a regular basis."

Keilman's nearly three-decade interest in working with seniors grew from a love of healthy older people, but continued as she saw older relatives die.

"We had a lot of deaths in the family, and my parents taught us that this was a natural process of living," Keilman says.

By contrast, American society exhibits an anti-aging philosophy with commercials geared toward hiding the signs of aging and a focus on the culture of youth. "In this country, nobody wants to age," she says. *(See story on end-of-life discussions, page 136.)*

American culture also has issues with addressing death, as evidenced by the "death panels" speeches and protests during discussions of the Affordable Care Act.

"We are all going to die, and 'death' is a word that we don't like to use in our society," says **Mary Mareck**, MSW, a geriatric consultant and founder of Mareck Family & Geriatric Services in Lansing, MI. Mareck also wrote a 25-page end-of-life book, titled, *Planning for End-of-Life: A Resource Guide*.

"We will face chronic or life-threatening diagnoses, and we'll have to make decisions about what are our own wishes as a person, patient," Mareck says.

Case managers, whether they work in hospitals or community settings, are often involved when people face complicated and traumatic medical crises, she notes.

Although case managers have to be cautious with their time in order to handle their caseloads, it's still important to take the time to understand a patient's wishes about medical power of attorney, suggests Mareck.

"This outlines who is your advocate if something happens to you, but it may or may not list the limits on care that you would like," she says.

Mareck has written suggested questions that nurses and case managers can go over with patients to get an idea about what they might like to happen if their medical condition worsens. *(See questions for healthcare providers, page 138.)*

Case managers can help patients think about what types of medical interventions they would like if they're ever unable to speak for themselves. "Would they want to be on a ventilator?" Mareck says. "Would they want to have a feeding tube, and under what conditions?"

Multiple types of chronic illnesses can complicate care management where patients have different levels of health and medical need.

"I divide people into three different groups," says **Mark D. Ensberg**, MD, an associate professor of family medicine in the division of geriatrics at Michigan State University. "One group is rigorous and relatively healthy, one is medically complex, and there's a third group that is toward the end of life, where consideration should be given to palliative care or hospice. The middle group is the one that's often in transition."

For example, an elderly patient might have diabetes. Many of the diabetes guidelines were designed for vigorous and relatively healthy people who have the one chronic illness diagnosis of diabetes, he notes.

"If the patient has memory

problems or frailty, or if there is depression or other issues, you can't always follow the guidelines initially, but have to evaluate the patient and address the memory problems or frailty," Ensberg says. "You should increase support or look at the living situation before you can fine-tune the diabetes, but if they have multiple other issues going on, they could be at the end of life."

According to Ensberg, in assessing which of the three groups fits best for a particular patient, healthcare professionals could refer to the following five important observations:

- observations about cognition, memory, and ability to learn new things,
- physical strength and endurance, whether there are any falls or how the patient gets around their home,
- psychosocial behavioral issues such as anxiety, and whether the patient has social support and someone to rely on,
- spiritual support and whether the patient has a church that can provide support and help to the patient, and
- understanding what the patient's home environment is like.

"You're kind of looking for a fit between how they're functioning in their home and the support they have," Ensberg explains.

Looking at these categories and how they apply to patients is part of the role of case managers, and they can address advance directives as a part of this process, Ensberg says.

"It's absolutely important to address advance directives," he says. "Physicians are very busy, and discussions like these take a lot of time."

Medicare now pays physicians, with two new billing codes, to provide patients with end-of-life counseling — a change that went into effect at the beginning of 2016. But Ensberg says he suspects this additional reimbursement will not necessarily lead to a large increase in physicians having these discussions with patients. Case managers who bring up advance care planning with their patients could suggest patients discuss these issues with their physicians. "It is always easier if the patient comes with questions or wants to address it," Ensberg says.

"If there could be communication between case managers and physicians prior to these discussions, it's tremendous," Ensberg says.

As it's often the physician who poses an obstacle to these discussions, Ensberg suggests that case managers work with the physician's office nurses, who can help start communication between doctors and case managers.

When a case manager meets with a physician to discuss a case in which the patient is at the end of life, the case manager might ask the doctor how much the patient knows about his or her condition, Mareck suggests.

Case managers also might review advance care planning with patients, clarifying their decisions. For instance, a case manager could note to a patient, "You named your oldest son to be your power of attorney. Have you discussed with him your limits on care? Have you discussed how you will want to die? If you have a stroke and can no longer walk or swallow, do you know if you want to have a feeding tube?" she says.

When case managers or nurses or nurse practitioners discuss advance care planning with patients, they might want to use the SPIKES method, Ensberg says. *(See SPIKES method in a nutshell, page 137.)*

One way for case managers to think about addressing end-of-life issues is that they can bring these up to give their patients an opportunity to steer their own medical care.

"I think patients often don't feel like they have a voice in the medical decision process," Mareck says. "When a person comes in with a white coat on and says, 'This is what I think we have to do,' they just go along with it."

Case managers, alternatively, have an opportunity to empower patients and to say to their doctors, "Wait a minute — I want to talk to you about this," she says.

Having these conversations and empowering patients is particularly important for older patients with advanced diseases because the healthcare system is riddled with interventions that impair patients' quality of life with very little benefits.

"We are seeing people in their late 80s on dialysis," Mareck says. "It's very difficult and does not improve the quality of life; all it is doing is postponing death, and patients are not dying on their own terms, so it's important that the patient and their advocate have a voice."

It's not about assisted suicide — it's about asking patients what they want, she adds.

"We're saying, 'Do you want to go on dialysis until your daughter's wedding at Christmas?'" she says. "That's a different issue, and you have to think about the different values you have and how you want to die and where you want to die." ■

# Approaching End of Life Holistically and Peacefully

*'It's a 1,000-piece puzzle'*

Case managers who work with older adults likely have observed that the more frail and complicated their medical issues become, the more vulnerable they become. One disease might be a challenge, but multiple health problems can be a medical tsunami.

"Some of the people we take care of have 12 to 15 chronic conditions," notes **Linda Keilman**, DNP, GNP-BC, an assistant professor and gerontological nurse practitioner at Michigan State University's College of Nursing in East Lansing.

"The way I explain it to young college students is that looking at older adults, especially in geriatrics and gerontology, is a 1,000-piece puzzle that needs to be put together," Keilman says. "There are no straight edges and no picture to look at to try to determine where to start, so you have to approach the individual piece by piece, step by step."

## Know the Story

These steps often lead to an end-of-life discussion. Keilman offers the following suggestions for how to approach the topic with frail, older patients:

**• Know the person's story.** "When we know someone's story, we try to think of whom they were when they were a younger, more vibrant person with hopes and dreams of the future," Keilman says. "What did they encounter, where do they live, and who were they?"

The story is very important to provide historical perspective to the person's life and background.

"It gives us insight into who the person is in relation to a cohort of individuals," she says. "This is what is missing in healthcare because we don't really have time, like a reporter, to get the story, to get the facts."

Knowing the patient's story is to take a strength-based approach to patient care, Keilman says.

"When we think of individuals ages 85 and older, these are the individuals who fought in World War II, and the women left at home worked in factories," she explains. "They had a whole different way of life, living through the Great Depression."

For the baby boomer generation that is just turning 70 and heading into their elderly years, their experiences include the Vietnam War, a time of free sex and love, sit-ins, and civil rights marches, as well as *Roe v. Wade*, she says.

"Older people are closer to death than birth, but they still have a good journey where they are," Keilman says. "My goal is to have that person be comfortable and pain-free and symptom-free."

**• Learn how a patient understands his/her disease.** "Part of what a case manager can do is to provide education and re-education," Keilman says. "I call it intentional listening where you listen to the patient and family, trying to pick up red flags or emotions."

A strategy for doing this is to say, "I heard you say," or "Let me just talk to you about dementia and how those medications your loved one is on work," she suggests.

"Approach it in segments and allow the person to think about it for a while," she adds. "Then the next time you see them, you can say, 'You know we talked about dementia and its progression and how the medications are not a cure."

These conversations are a process and no difficult conversations can occur in one visit, Keilman notes.

"The nice thing would be able to have a conversational journey," she says.

**• Nurture a therapeutic relationship with the patient.** Case


## EXECUTIVE SUMMARY

Patients with multiple chronic illnesses often are frail and could benefit from case management that includes addressing end-of-life care.

- Case managers should ask patients about their stories to learn more about whom they are and their generational culture.
- It's important to know what patients understand and don't understand about their illnesses.
- Nurturing a relationship with patients can include simple things like asking about their dogs or cats.

managers, generally, have a more therapeutic relationship with their patients. They're a familiar voice, even if it's only for a phone call, Keilman says.

"Patients won't talk to their physicians as much as they'll talk to their case managers," she adds. "I ask them what's on their bucket list; what are the things they want to accomplish."

These unfinished tasks usually are small things, such as a granddaughter's wedding or graduation, seeing a first grandchild, or waiting for a visit from a loved one or friend, Keilman says.

Sometimes healthcare providers are afraid to ask patients these questions because they think the patient might ask for a cure or have different expectations than what their medical condition would suggest. But if the patient asks about a cure, there's nothing wrong with that, even if it's not achievable, she says.

The key is to be comfortable with one's own feelings about death and dying. Once a case manager has that comfort level, it's possible to ask patients how they envision the end of their lives and what cultural issues are important to them, Keilman says.

Another way to nurture a therapeutic relationship with patients is to ask them about their loved ones, including their furry companions, she suggests.

"Make sure you're introduced to their pets at a home visit," she says. "Then write down in the paperwork the name of their pet and when you call the patient later, ask about their pet and how it's doing. That makes a person happy."

• **Help patients develop their legacies.** Another question that case managers can ask patients is about what they want their legacy to be.

"That's an opportunity to help people at the end of their lives to make amends," Keilman says. "A lot of times there are old wounds where people don't talk to one another, and this is an opportunity to bring people together."

For instance, patients could be encouraged to talk into a tape recorder or write down some words and then, if they would like or if the person they are talking to is deceased, destroy them and let them go, she suggests.

Also, there are rituals that help people deal with life changes, and case managers can help patients find community and spiritual resources that would help them engage in a ritual.

"Case managers are fabulous at finding resources," Keilman says. "They don't have to be experts, but just knowing that we're holistic human beings with cultural, spiritual, and other understandings of these dimensions is important." ■

# How SPIKES Method Works, in a Nutshell

*Developed for delivering bad news*

The SPIKES method was designed as a six-step protocol for delivering bad news and was published in *The Oncologist* 16 years ago. It also can work for approaching end-of-life discussions with patients whose frailty and multiple chronic illnesses suggest it's time to discuss palliative care or even referral to hospice care.

Here's how SPIKES works:

• **Step 1: S – Setting up:** "The SPIKES method has to be in the right setting, where people are comfortable and can hear what you say," says **Mark D. Ensberg**, MD, an associate professor of family medicine in the division of geriatrics at Michigan State University in East Lansing.

• **Step 2: P – Perception:** "You should get a sense for where the person is at and how they see their situation," Ensberg says. "Sometimes that can be quite different from the way the healthcare provider looks at it."

• **Step 3: I – Invitation:** Ask patients what they're looking for or what they want to know, he says.

• **Step 4: K – Knowledge:** Let people know where they are medically and what that means for them and their future. "At that point you can talk about end-of-life issues and options, the quality of life versus quantity of life, and what we can cure and fix and how much should be for comfort," Ensberg says.

• **Step 5: E – Emotions:** It's challenging, but it's also important to respond to patients' emotions. "Sometimes people are more ready to discuss end-of-life issues than at other times," he says.

• **Step 6: S – Strategy/Support:** "Provide support and information that's necessary and arrange for a follow-up," Ensberg says.

For more information, visit: http://bit.ly/1LfJfae. ■

# Suggested Questions Case Managers Can Ask Older, Very Ill Patients

*Open the way for discussions*

Healthcare providers, including case managers, can bring up end-of-life issues with their most frail and ill patients by approaching it in a Q&A format.

For instance, **Mary Mareck**, MSW, a geriatric consultant and founder of Mareck Family & Geriatric Services in Lansing, MI, developed the following list of questions that can lead into a discussion of advance directives:

- What is my diagnosis, and how does it relate to other medical conditions I have?
- What are the treatment recommendations?
- What are the side effects, long- and short-term?
- Where, when, and how will the treatment take place?
- Will treatment lead to a longer or more comfortable life?
- What are the risks and benefits of the treatment? If it is not successful, what will be the next step?
- Does the cost justify the outcome?
- What if I change my mind because the side effects do not support the benefits of the treatment?
- If we want more information before making a decision, where can we get it? Second opinion?
- If I do not want the treatment, what will happen, how much time will I have, and what will that time be like?
- If my goal is to die peacefully — not in a hospital, but with my family — where does this treatment fit? Does it match my goals?
- Is hospice something to consider at this time? ■

# Case Managers Help Mentally Ill Youth with Transition Challenges

*Research shows rise in hospitalized youth*

Children and youths with mental health needs often have additional challenges, including an increased risk of hospitalization or ending up in the juvenile justice system. They also have difficulty transitioning and aging into adult mental health services.

About two out of three children and adolescents arrested each year have a mental health disorder, according to the National Conference of State Legislatures. Also, short-term inpatient psychiatric stays began to increase for youth in the mid-1990s, while older adult inpatient psychiatric stays declined in the same time period (1996-2007).[1]

A case management-type of behavioral health intervention can keep youth with mental health issues from being lost to the prison system or otherwise unable to live independent lives.

One such model is the work done under the OnTrackNY program in New York. The program specifically targets youth who are at that point of transitioning into adulthood, when they could flounder and be lost without professional guidance.

"We work with young adults, from 14 to 25, who are struggling with their first episode of psychosis," says **Stephen Smith**, PhD, a licensed clinical psychologist with MHA of Westchester in Tarrytown, NY.

"We have a targeted early intervention program to get them in after their first hospitalization."

One of the program's chief goals is to help youth enroll in school or find a job, and it has an 80% success rate in doing so, Smith says.

The case management-style program includes psychoeducation, therapy services, family services, medication management with a psychiatrist, and a focus on helping youth achieve their goals, including finding jobs, returning to school, and improving their grades, Smith says.

The program is called OnTrackNY and it is an evidence-based team approach to providing recovery-oriented treatment to youths with emerging schizophrenia

and/or symptoms including hallucinations, disorganized thinking, and unusual thoughts and beliefs.

"Seventy-five percent of our patients come from the hospital," Smith says. "We see those from the hospital while they're there, and we help them transition [as adults] to us rather than to an outpatient facility."

Once these patients are discharged, MHA contacts them and provides them with a place to stay for at least two years as part of the transitional housing Apartment Treatment Program. The organization's services are paid by Medicaid, and there are multiple locations, he explains.

The program also includes walk-in clinics, bilingual and mobile behavioral health services, support services led by peers, and home-based therapy options.

"Psychosis is one of those disorders that's not well understood," Smith says. "The go-to intervention has always been medication and hospitalization; years ago, a lot of these kids would have been on a direct pipeline to the hospital and more coercive, chemical-based interventions."

Research shows that if youth with mental health challenges are provided with interventions early on, their entire life trajectory can change, Smith explains.

Previously, a psychosis diagnosis would usually result in multiple hospitalizations and a downward spiral.

"If you do it in the right way and present a more collaborative and warm environment, then you can get them to tap into their strengths at a time when they need it the most," he says. "A lot of times these kids are considering college and are developing their identity when they have a psychotic break that causes a collapse as their whole world is turned upside down."

Smith provides this case study example: One student came to the program after her parents' separation led to her first psychotic break. "She had strong convictions about the government tracking her phone and her social media, and it was mixed in with depression and suicidal thoughts," Smith says.

With psychosis, the patient went to the hospital as her life spiraled out of control.

"We set her up with a psychiatrist and different services," Smith says. "We worked with her, starting small and focusing on her goals and how she could feel better about herself."

One of the program's strengths is that employees are trained to treat mental health in a non-stigmatizing way. For instance, staff addressed the young woman's psychosis, but did so in a way that did not suggest she was sick. This lead to a lessening of the psychosis symptoms, leaving other issues that could be dealt with through a case management-type of approach.

"After a few months, she was able to hold a job for a while, and then she began to travel," Smith says. "She can process what's going on now and has her desires and dreams."

The patient even began to look at online dating sites and has successfully started to live her life again, he adds.

Some of the program's biggest effects occur within the first few days post-discharge from the hospital, Smith says.

The youth meet with a psychologist within that first week and also meet with a psychiatrist to establish their medications. Then they meet with a nurse and social support services to help the youth return to work or school.

"Our program is an evidence-based practice," he says. "We look for individuals with a first onset of symptoms; by the time they start hearing voices, we want to make sure they have been seen and have received treatment within two years."

An initial assessment is about understanding the cause of the psychosis. It could be substance-related, mood-related, or schizophrenia. Then the program's staff educate the patients about how the program works and how its approach is recovery-oriented, Smith says.

"We engage in shared decision-making, where they are the ones at the head of the table," he explains. "The decisions go through them; we have a hand in guiding them, but never do anything without their

## EXECUTIVE SUMMARY

Case managers can help youth with mental illnesses transition into adult mental health services.

- A case management-style program in New York works with youth, ages 14-25, helping them return to school or work after a psychotic episode.
- Called OnTrackNY, the program is evidence-based and includes psychoeducation, therapy services, family services, medication management, and a focus on helping youth meet their goals.
- The program aims to reverse the trend of a mental health diagnosis leading to multiple hospitalizations and a downward spiral.

approval."

After the initial assessment and meetings with professionals, patients attend weekly or bi-weekly individual therapy sessions. There's also a social skills group available, and they're encouraged to attend that. Dialectical behavioral therapy (DBT) is available for people with personality challenges, including intense emotional responses and interpersonal difficulties, Smith says.

"We help them with psychosis, social skills, interpersonal relationship issues, primarily with someone who is trained in cognitive behavioral therapy [CBT]," Smith says. "We use that approach to help them deal with their symptoms and also to provide case management; it's 80% clinical and 20% case management."

The case management part helps patients find housing and transportation and provides social services, including help with school and jobs.

"We have someone who helps the person with interviewing and advocates on their behalf," Smith says. "If they can't help them with homework, we also have a tutor who can help the person." ■

## REFERENCE

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# Improving Care Coordination for Substance Abuse Patients

There has been significant discussion in recent years about the importance of providing a "warm handoff" to patients who present to the ED with substance abuse problems. The concept of immediately linking these patients with help for their addictions rather than merely giving them a list of phone numbers is widely acknowledged as a best practice, not only for its potential effect on outcomes, but also because it can make a dent on repeat visits to the ED.

However, some EDs are going a step beyond warm handoffs by embedding addiction counselors in the emergency setting, and in some cases even beginning treatment for an addiction in the ED. The approach takes some of the burden off busy emergency providers by providing them with immediate assistance for patients who present with complex addiction problems. Further, some EDs have found the chances for recovery are far greater when trained addiction specialists are on hand to guide patients toward positive change.

## Engage with Patients

Administrators of the San Mateo County Behavioral Health and Recovery Services (BHRS) in San Mateo, CA, recognized the potential for offering on-site assistance to high-risk, high-need patients presenting with alcohol use disorders in 2013, launching a pilot to test the efficacy of a comprehensive approach, explains **Clara Boyden**, a program manager at BHRS.

"We really wanted to expand access to other treatments like medications and do more engagement with case management to help people get better," she explains. "Through this pilot, we served 10 to 15 patients with really good outcomes, so we were able to work with our local health plan and proposed a much larger program that would build on this pilot; part of our proposal [involved having] staff embedded in our ED [at San Mateo Medical Center]."

The resulting Integrated Medication Assisted Treatment (IMAT) program began in 2015, and includes placing a behavioral health alcohol and drug services case manager on site in the ED at San Mateo Medical Center ED and Psychiatric ED around 18 hours a day, seven days a week. Case managers also are available at satellite primary care clinics and in the field to visit treatment centers and jails. **Roberto Donlucas** is an addiction counselor and case manager stationed in the ED as part of the IMAT program.

"There is a lot of collaboration going on between BHRS and the medical staff in the ED, and it is really focused on client-centered care," he explains.

When patients report during triage that they consume large quantities of alcohol, the IMAT case management specialist on duty is alerted.

"I read the information on their charts and try to get as much background information about the clients as possible before engaging with them," Donlucas notes. "Once the nurse speaks with them and does their triage and assessment, that is when I meet with [the patients] at the bedside."

Often, these patients are acutely intoxicated or incoherent, so it is difficult to engage in free-flowing conversation, Donlucas observes, but he will address their immediate needs, which often include housing.

"We offer a linkage to detox where they can receive withdrawal management services, and then once they are a little bit sober, then we follow up," he says. "We do screening assessments, and then we introduce them to the option of perhaps utilizing IMAT as a way of reducing their alcohol consumption."

In addition to IMAT, services offered through the program include basic primary care, peer coaching and support, an 18-hour sobering station, inpatient detox, and transportation assistance so patients can get to their appointments. The program is paid for by the local Medi-Cal health plan.

To date, the program has been available only for patients with alcohol use problems, but plans are in progress to expand the approach to include patients who present with opiate addiction issues.

"We have been having preliminary discussions with the ED and one of our providers from our pain clinic," explains **Matthew Boyle**, CPRP, a program analyst with the IMAT team. "It will be phase two of our IMAT program, and we are hoping that early next year we will have that program in place."

Key to the success of phase two will be putting all the necessary pieces in place to sustain the program.

"We have been working to build the infrastructure to be able to support the work that would need to happen with opioid disorders, especially the expansion of access to medications such as Suboxone," Boyden observes. "At the end of the day, our goal is to have people able to transition back into primary care where they can continue receiving ongoing medication support, if that is what is needed."

The ED providers and administrators have shown a willingness to start the conversation about potentially beginning treatment for opiate addiction in the emergency setting, Boyle says.

"The next step is to get that buy-in because we then need to shift [the patients] over to primary care, and our primary care system at this point in time is just beginning the conversation as well," he says. "We have a community-based organization that could temporarily perhaps partner with the ED and hold these people, and continue providing medication, but ultimately we want to transition these clients back into our regular primary care clinics."

"AT THE END OF THE DAY, OUR GOAL IS TO HAVE PEOPLE ABLE TO TRANSITION BACK INTO PRIMARY CARE WHERE THEY CAN CONTINUE RECEIVING ONGOING MEDICATION SUPPORT, IF THAT IS WHAT IS NEEDED."

## Expand Existing Services

The model already in place to assist patients who present to the ED with alcohol use problems also should work well for patients presenting with opiate use problems, Boyden suggests.

"We feel good about the model and the partnership, and we just need to adapt it for opiates and other substances," she says. "There would probably need to be some changes."

Until phase two of the IMAT program is rolled out, patients who present to the ED with opiate use problems are offered referrals to treatment. However, Boyden is eager to add engagement and potentially ED-based inductions to IMAT, where appropriate.

"When you look at the issue of substance use disorder, so many people who meet the diagnostic criteria are not wanting to go to treatment," Boyden says, noting one reason for such resistance is that many programs are abstinence-based. "[Patients] may reject the idea of full abstinence, but they may be interested in addressing their substance use and changing it," she says. "They may not want to stop [altogether], but they may want to cut down and control it better, and that is the place I think where we can start working with them and change that relationship, connect them with medications that can help address cravings, help them find stability through housing, and help them address other things that are important to them."

Supportive leadership has been hugely beneficial to pushing the IMAT approach forward, Boyden adds.

"The quality of the partnership [between BHRS and San Mateo Medical Center] has been phenomenal, and it is helping our ED folks see the change that is happening to individuals who have worked with our team," she says. "It is really the quality of the partnership and the feedback on people who have

improved that have started to change ... perspectives and bring hope for healing and recovery back to some of our most disillusioned and frustrated staff who are kind of in the trenches in the ED."

Placing an assigned case manager in the ED who offers a program and links to resources makes a big difference, according to Boyle.

"We have been really well received, and it has been an honor to partner with [emergency personnel] and be embedded there," he says.

In fact, Donlucas notes that emergency providers keep asking him when the IMAT team is going to expand services to patients with opiate addictions.

"The general consensus here is that there is a vested interest from direct service providers in the ED all the way up to leadership staff to address this national epidemic," he says. "So we are working on it behind the scenes. We are really trying to lay out the foundation so that we can properly treat this population."

## Target Gaps in Care

With the help of a $120,000 gift from the Tigger House Foundation, Riverview Medical Center in Red Bank, NJ, also is in the process of deploying addiction counselors in the ED to work with patients who have a primary substance abuse issue.

"Patients who come in depressed and have problems with alcohol or opiates ... are handled pretty well by our system and by the mental health system in general, but where the real deficit has been is if the patient is coming in with a primary substance use issue and no comorbid psychiatric issues," explains **Ramon Solhkhah**, MD, the chairman of psychiatry at Jersey Shore University Medical Center in Neptune, NJ, and corporate medical director at Meridian Behavioral Health, both part of the Hackensack Meridian Health System. "So that is really what the addiction counselor's role is going to be: working with those patients and helping them get into treatment, and providing families with support and education."

The plan is for the addiction counselors to be on site in the ED seven days a week, primarily during a late afternoon/early evening shift.

> "WE ARE WORKING ON IT BEHIND THE SCENES. WE ARE REALLY TRYING TO LAY OUT THE FOUNDATION SO THAT WE CAN PROPERLY TREAT THIS POPULATION."

They also will be available to provide consults to patients who have been admitted to the hospital on medical or surgical floors, and to spend some time running groups and providing education to patients who have been admitted to the hospital's inpatient psychiatric unit.

The intervention is just a pilot project at one hospital out of 11 adult hospitals and two children's hospitals in the Hackensack Meridian Health System at this point, but Solhkhah notes that administrators are hoping that with proof of concept, they will be able to expand the ED-based addiction counselors across the system. There certainly is a huge need in the region, he says.

"Substance use disorders are a huge problem for us here in central New Jersey. We are sort of the epicenter in the country for the prescription opiate and heroin problem," Solhkhah notes. "We are in between the ports at Newark and Philadelphia, so we've got, unfortunately, very pure drugs that tend to come into the country right through us, so that tends to lead to a lot of opiate problems for us."

To date, psychiatric clinicians have been taking on the patients who present with primary substance abuse problems, but this has not been their main focus.

"The real elegance of this new program is we will have people who are specially trained in techniques like motivational interviewing and are able to work with patients where they are and engage them in treatment," Solhkhah says. "We think that is a specialized skill set. We have been doing it as well as we can, and maybe better than most, but we still think that isn't really the level of care that our patients deserve."

Solhkhah suggests the addiction counselors are part of an effort to make the coordination of care between the ED, the inpatient units, and outpatient providers as seamless as possible.

"We are certainly embracing that concept on the mental health side. Our [mental health] patients often times need [this coordination] even more than the other medical specialties," Solhkhah explains. "Mental health providers across the country are in short supply, let alone those who are trained in addiction; there can be long waiting lists to get people into treatment, so every little bit that we can do and engage the community to help us with supporting these sorts of endeavors, we are very grateful for." ■

# Safety Huddles Produce Results If They Are Controlled and Monitored

Leaders at Bassett Medical Center in Cooperstown, NY, worried in 2014 that its culture of safety could be improved, particularly the length of time it took to resolve known safety issues. When a review of data revealed a decline in staff reporting actual and near-miss events, the vice president for patient safety and performance improvement called for the development of a safety huddle policy.

After a year of regular safety huddles, reporting of incidents has increased 51%, and participants reported more than 1,500 issues of concern.

Safety huddles were known to the leaders and staff at Bassett, but they had a reputation as one of those ideas that caused people to get excited initially but then lose interest, says **Ronette Wiley**, RN, MHSA, CPPS, vice president of performance improvement at the hospital.

"We heard from a number of people that safety huddles were useful until they fizzled out," she says. "One of the things that made ours successful was that we developed monitoring and tracking tools to help hold people accountable. We also had a great champion for the safety huddles in our CEO, who tries to attend every safety huddle."

The team designed a daily leadership safety huddle to promote awareness of issues within the previous 24 hours plus any issues that may arise in the next 24 hours. Leaders from 31 departments meet at 8 a.m. each day, which means that they must round on their units or otherwise contact their staff to be aware of any developments or concerns. There was some initial concern about that requirement being too onerous, so Wiley asked members to commit to only a 30-day trial period with the possibility of altering the time or frequency.

At the end of the 30 days, huddle participants reported that the meeting was ingrained in their workdays and should remain unchanged. Some members did ask for a call-in number so they could attend by phone, but that request was denied.

"We felt that was detrimental to the important face-to-face connection," Wiley says. "We also wanted to resist our natural tendency to multitask as we're driving or looking at something better on the computer."

Some departments were added to the original huddle team as the first year continued. The team leaders added the human resources and biomedical departments to the huddles when they realized that those departments often were copied or consulted on issues that arose.

Wiley says the following are the key rules for making their safety huddles successful:

- Arrive on time.
- Plan ahead, and appoint a substitute if you cannot attend. Participants will sign in at each huddle so that attendance can be monitored.
- Give yourself enough time to meet with staff before the huddle so that you are well informed.
- Be prepared to present your information in a clear and concise way.
- Stick to the facts. If there is nothing to report, the participant will state that fact, and the huddle moves on to the next person.
- Do not discuss issues and potential solutions. The huddle is intended only to make others aware of issues; problem-solving happens in a different venue.

In addition, Wiley says the success of the safety huddles can be attributed to the visibility of the CEO and senior administrative and medical staff at the daily huddles. It also is important to recognize participation, so each month Overlake presents each safety huddle participant with a small gift and a message of thanks. Anyone responsible for a "good catch" or providing outstanding care receives a signed certificate of appreciation.

Supervisors also bring staff members to the huddle to recognize them for doing something especially noteworthy.

Incident and event reporting increased 51% during the first year that huddles were implemented, and near-miss reports increased 86%. There were several concrete improvements from information reported at the safety huddles, Wiley says.

"One example is what we call 'code grays,' which is patient behavior escalating toward violence," she says. "Last year we had a significant uptick that we learned about in the safety huddles, and after instituting a more robust de-escalation program, we're now seeing a 60% reduction in those incidents." ■

## COMING IN FUTURE MONTHS

- Case management programs use new technology to better track patients' ADLs
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# CE QUESTIONS

**1. Which of the following is a good observation to make in assessing where a patient is on the continuum from mostly healthy and robust to medically challenging to end-of-life, according to Mark D. Ensberg, MD?**

A. Observations about their cognition, their memory, and their ability to learn new things.
B. Physical strength and endurance.
C. Psychosocial behavioral issues, like anxiety and whether the patient has social support and someone to rely on.
D. All of the above.

**2. The SPIKES method, which can be used for addressing end-of-life issues with patients, was designed as a six-step protocol for delivering bad news and was published in *The Oncologist* 16 years ago. Which of the following includes the correct words that constitute the acronym SPIKES?**

A. S = Setting; P = Problem; I = Insight; K = Knowledge; E = Empathy; S = Support
B. S = Self-awareness; P = Persistence; I = Intuition; K = Knowing; E = Escalation; S = Service
C. S = Setting; P = Perception; I = Invitation; K = Knowledge; E = Emotions; S = Strategy/Support
D. None of the above

**3. Mary Mareck, MSW, developed a list of questions that can lead into a discussion of advance directives. Which of the following is not on her list?**

A. What is my diagnosis, and how does it relate to other medical conditions I have?
B. What are the side effects, long- and short-term?
C. Would you like us to refer you to hospice care today?
D. Will treatment lead to a longer or more comfortable life?

**4. An evidence-based program, called OnTrackNY, provides recovery-oriented treatment to youths with emerging schizophrenia and/or psychotic symptoms. Which of the following is the program's chief goals for the youth?**

A. To help youths and their families deal with the social implications of psychosis.
B. To help youth enroll in school or find a job.
C. To keep mentally ill youth out of prisons.
D. None of the above.

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