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INSIDE

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Case Management for Refugees Can Be Challenging and Rewarding

They need a dose of advocacy with case management

Refugees resettled in the United States often have multiple medical and social-behavioral health needs that require case management. Although their numbers are small in any single community, their needs can be a challenge.

"There are so many issues involved with immigrant and refugee populations seeking healthcare," says **Marcia Carteret**, MEd, director of intercultural communications for the Colorado Children's Healthcare Access Program (CCHAP), and a senior instructor in the department of pediatrics at the University of Colorado School of Medicine in Denver.

Refugees' barriers to healthcare include cultural challenges in navigating the U.S. healthcare system, language barriers, poverty, and low health literacy, Carteret says. *(For more information, see story on cultural barriers, page 40.)*

"A large percentage of refugees are at risk because of the combination of these factors," she says.

About 70,000 refugees have settled in the United States annually in recent years, a small proportion of the more than 60 million refugees worldwide, according to a report by the U.S. Department of State. *(The report can be found at: http://bit.ly/2mp8EMa.)*

EXECUTIVE SUMMARY

Refugees settling in the United States have multiple health needs and problems that make case management important and challenging.

- The United States takes in about 70,000 refugees each year.
- Many of the people arriving here have complex medical issues, including children with special needs.
- Language, health literacy, and cultural barriers are big issues.

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The mostly women and children that arrive in the U.S. often have complex health needs, and they can benefit from case management.

"The big thing they need is advocacy," says **Paige Kolok**, MSSW, CSW, care specialist for Passport Health Plan in Louisville, KY. Kolok works mainly with refugee populations on Medicaid, which is available to refugees through the Affordable Care Act (ACA).

"The major thing I do is address barriers to healthcare," Kolok says. "This population struggles to address barriers themselves due to language and cultural understanding."

For example, Kolok meets with a refugee family with a high needs child. The child has hydrocephalus and other medical problems. The family has no car, no concept of health insurance, and does not speak English. They do not know the difference between a hospital and a doctor's office, let alone the differences between family doctors and specialists.

"Maybe they're talking about seeing their neurologist, and I'm talking about their primary care physician," Kolok says. "They have a complete unawareness of how things are done."

Since the child has a wheelchair and transportation is a big issue, it's very difficult to coordinate care for each provider appointment, she notes.

Case management for the family includes coordinating appointments and transportation that is covered by Medicaid, communicating with transportation to ensure they arrive at scheduled visits on time, and ensuring the various doctors are communicating with one another.

"You have their dental care, physical care, and have to think about mental health," Kolok says. "A lot of our refugee clients come from a very, very traumatic past, so you have to think about how we're going to address mental health when there are not enough psychologists and psychiatrists for even the English-speaking clients."

Another challenge is systemic. Refugees often come from parts of the world where English and Spanish are not taught. Most arrive from Africa, East Asia, and South Asia, and primary care providers do not have staff that can speak their language. While interpreter services are available, these are expensive and sometimes beyond a practitioner's budget, so they sometimes will turn down refugees as patients.

"Doctors who work in private practice are burdened with so many tasks and requirements that it's difficult for them to thrive and keep their doors open," Carteret says.

"It isn't that providers don't want to serve these immigrant-refugee patients, but the cost of a telephone interpretive service is prohibitive in the primary care setting," she adds. "Hospitals spend millions a year on it, and primary care physicians can't afford to do that."

From a case manager's perspective, this obstacle can be challenging. "When I call a doctor's office and they don't want to provide services because they don't want to pay for an interpreter, then part of my job is to educate in a way that shines light on an individual story, so they'll want to help that person," Kolok says.

Passport Health Plan pays for a telephone interpreter for Kolok's clients. The service quickly connects her with an interpreter for any language within minutes.

"Usually we have a three-way call with the client or the client is with me, and we put the interpreter on speakerphone, and it works great," she says. "That is the most cost-effective way."

While in-person interpreters are

ideal, they're difficult to find in many areas — especially in rural parts of the country, Kolok and Carteret say.

Even when an immigrant or refugee population grows in an area, finding providers from that community or who speak that population's first language is difficult.

"In the Denver area, we have a large Somali population, and there are not a lot of Somali physicians licensed and practicing in Colorado," Carteret says. "We don't have a lot of physicians who are from any of the ethnic minorities, and that's just the reality of where we are in terms of recruiting these people into our residencies and medical practices."

In recent months, Kolok has noticed another issue with her refugee clients: increased anxiety.

For instance, one of Kolok's clients is Muslim, and she wears the hijab — a head scarf. She confided in Kolok that she is thinking of not wearing her head covering anymore so people won't know that she's Muslim.

"That makes me very sad, and I find it heartbreaking that people feel like they can't wear what they want to wear because they might be targeted," Kolok says.

Fear of being singled out for harassment is one stressor.

"Most people in America are good-hearted people, and if they just knew the story of one refugee, then of course we'd let that person in our country," Kolok says. "What kind of person wouldn't open their arms? The problem is people don't know their stories; they know fear, and they lump all refugees with ISIS, when they couldn't be more wrong."

Another issue is that many of the refugees who have arrived within the past year were separated from members of their family.

"Maybe the mom and kids came over, and the husband is stuck — unable to join them," Kolok says.

This happened with one client, who has two special needs children. Her husband was not granted refugee status at the same time as the rest of his family. The woman was handling her role as a single parent taking care of children with difficult medical issues, but she thought her husband soon would join them. He had received a letter to move to the United States as a refugee. Then the travel ban was ordered in January, and the family's reunion was put into limbo, Kolok says.

> "A LOT OF OUR REFUGEE CLIENTS COME FROM A VERY, VERY TRAUMATIC PAST, SO YOU HAVE TO THINK ABOUT HOW WE'RE GOING TO ADDRESS MENTAL HEALTH WHEN THERE ARE NOT ENOUGH PSYCHOLOGISTS AND PSYCHIATRISTS FOR EVEN THE ENGLISH-SPEAKING CLIENTS."

Even when federal courts put a hold on the travel ban, the husband was unable to travel here. "Just because they lifted the ban doesn't mean everything is flowing like it was," she says.

"My client doesn't know if she'll ever see her husband again, and now, families are split with uncertain hope of being unified," she explains. "That's a great cause of stress, which we all know can severely affect physical wellness."

In another example, Carteret recalls the case of a family of refugees from Somalia. The mother and her five children, under age 10, were resettled in the U.S. The father was not approved at the same time. Two of their sons spent their entire lives growing up in refugee camps. The mother has no job skills, and she needed to spend all of her time taking care of her children. The travel ban, which includes Somalia, lessened the prospects of her husband joining them.

Divided refugee families also need more case management services because of the unfeasible logistics of managing all of their competing needs.

The single mother of two, for instance, cannot leave one of her children with anyone else because of the language barrier and the challenges of the girl's severe autism. So she has to bring the girl with her to every medical appointment for herself or her other child, Kolok says.

"Part of my job is to provide relief for the mom," she says. "I make sure I'm connecting with the mom on a regular basis, and when the daughter — who is a teenager — needs diapers, I have to coordinate with the doctor to get them prescribed."

Kolok also follows up to make sure the mother is on the bus to get her daughter therapy and to make sure all of the pieces are connected.

"The daughter needs dental care, but she won't sit still for a dentist, so I have to explain what their options are, and these are all of the pieces that no one else thinks about," she says. "I try to help her and her children to not fall through the cracks." ■

Case Managers Face Cultural Barriers When Working With Refugee Populations

Navigating healthcare causes confusion

Many support services are available to refugee populations. They receive more help than other immigrants, but they also usually need more help — particularly in the form of case management.

Refugees often have suffered through violence and atrocities, which affect their mental health. They also might lack housing that is both safe and affordable. They might be settled in neighborhoods with high crime rates and without grocery stores or playgrounds. They have seen American television and know enough to be scared of potential violence. They often cannot drive and have difficulty understanding public transportation.

All of these are issues for their mental and physical health, but the biggest challenge is cultural.

"There are organizations that can get refugees on track with where to go for healthcare, and some might take them to appointments," says **Marcia Carteret**, MEd, director of intercultural communications for the Colorado Children's Healthcare Access Program (CCHAP), and a senior instructor in the department of pediatrics at the University of Colorado School of Medicine in Denver.

Yet, there remain barriers outside of the logistics, access, and transportation, and the chief barrier among these is cultural. Refugees often do not have an experience framework that prepares them for America's complex healthcare system.

"They do not understand how our healthcare system works," Carteret says. "They have a lot of confusion around the different names and types of doctors and setting up appointments or even calling a doctor's office."

When a refugee who does not speak English or Spanish calls a doctor's office and is routed to a phone tree that tells them to press one or two, they have no idea how to reach someone who can help them, she adds.

Another cultural conflict involves the concept of time. For refugees from low-income nations, their entire sense of time and scheduling is based on a premise that they'll have to wait. If they make an appointment for 9 a.m. to see a doctor, that means — in their world view — that they'll have to wait until 4 p.m. or later to actually see the doctor. So they will miss their U.S. doctors' appointments because of this cultural confusion over what a clock time appointment really means, Carteret says.

"Basically, people's sense of time is very much culturally based," she says. "And our healthcare system is so time-focused with appointments that are 20 minutes apart, getting people in and out."

What they most need is education about how the American healthcare system works, Carteret says.

"They need to know that it is very clock-time focused," she says. "Case managers need to help them understand the idea of patient-centered care and patient engagement, a concept that is very foreign to people from other parts of the world."

Refugees might expect doctors to be authorities who tell them what to do, and they do not grasp that they need to speak up for themselves and ask questions, Carteret says.

Another issue is health literacy, which is an enormous part of the challenge with immigrant and refugee populations, she says.

"People have very different expectations of physicians and very different concepts of illness causation," she says. "In many parts of the world, there is no concept of chronic disease."

Carteret has watched medical

EXECUTIVE SUMMARY

When working with refugee populations, case managers should be aware of cultural differences that greatly affect how these patients view disease and the American healthcare system.

- Scheduled appointments can mean something entirely different to some refugees, so they might miss crucial doctor visits.
- The underlying cause of diseases also can vary based on a person's cultural understanding and background.
- The American obsession with news overload can contribute to an atmosphere of fear and distrust of refugees.

residents struggle to explain to parents and children about asthma and how the child has to take the medication even when the symptoms go away.

"Refugees think if the symptoms go away, the child is cured, so they quit the medication," she explains. "Then when the child has an asthma attack and ends up in the emergency room, the parents think it's an entirely new illness, and they don't make any connection with the medication because they don't understand chronic disease."

People who come from some parts of the world, such as Latin America, might believe in susto — a disease believed to be caused by acute fright.

When someone becomes suddenly ill, they might believe the person's disease is caused by a destabilizing event, such as witnessing a car accident, hearing a gun shot, or even seeing a barking dog.

"So they have a hard time communicating with a Western doctor, unless the doctor asks about susto," Carteret says. "There is a whole litany of these culture-bound illnesses."

There is another cultural issue that affects refugees, but also everyone else: media overload.

"We need to take a look at how people have an unprecedented access to media overload," Carteret says. "Whether it's Twitter or texting or whatever, it's not helping us become more capable of critical thinking about these important issues like immigration."

Refugees and immigrants suffer partly because of Americans' misinformation and confusion about the issues. Constant online news feeds contribute to this confusion, she says.

"Refugees are trying to gain a sense of themselves, trying to become new Americans in these times," Carteret adds. "I think there truly is a disconnect from the history of the founding of our country; we're all from immigrant backgrounds unless we're Native Americans." ■

When Hiring New Staff, Which is Priority: Experience or Passion?

Surprising manager response

Case management for decades has been a profession for very experienced nurses. These highly skilled and experienced workers paid their dues in the healthcare trenches, and now want to do something that uses their well-honed skills in a different way.

But what if a manager looked at the recruitment process a little sideways? What if the priority would be to find people who have good problem-solving skills, who demonstrate creative potential in case management, and who have an obvious passion for the work and the patient population, but whose job experience doesn't check all the boxes?

This is the approach one manager has taken, and it has proven successful.

"I've been in my role for almost three years, and I have had one person leave because I helped coach her to something more suited to her. But other than that one person, I've had no turnover in my department, and we have 36 employees," says **Honey Blankenship**, MSN, RN, CCM, CPN, manager of case management for the Health Network at Cincinnati Children's Hospital in Cincinnati.

Blankenship has prioritized having a diverse workforce, including hiring men and people from different backgrounds. But mostly, she looks for passion in job applicants.

"When I put out a job posting, there are plenty of people who can do the work, but finding someone who is passionate is difficult — it can't just be about the qualifications," Blankenship says.

For example, Blankenship needed a pediatric case manager to work with children on Medicaid. The population included kids living in very low socioeconomic-type environments. "So in interviewing for a social worker position, I interviewed a gentleman and asked what inspired him," she recalls. "He talked about his volunteer work with inner city youth and his passion for those kids."

At that very moment, Blankenship knew she would offer him the job.

"He was experienced as a social worker, but had not done any case management," she says. "But I think there are some things you can teach people, and there are some things inherently ingrained in people — like passion. So I find people who have those things ingrained."

If she had found someone whose resume was better suited for the position, she might have had a case manager who could do the work, check all the boxes, but not go above

and beyond.

"I wanted a person who would come in and really make a difference in people's lives," Blankenship says. "I always tell my team that I'd rather they made a difference in one person's life than say they talked to five people today."

Another person Blankenship hired was a nurse who had no experience as a case manager. But the nurse spent months at her child's bedside after the child had a traumatic brain injury (TBI). For the nurse, the experience taught her how important it is to have someone with parents, helping them navigate the healthcare world during their crisis.

Blankenship hired the nurse to be a case manager, a job where she could put her passion to use being that stabilizing, helpful resource to other parents whose children were sick or injured.

Have these two case managers hired for their passion worked out? "Absolutely," Blankenship says.

Some of the same unconventional approach has served Blankenship well when she works to motivate and retain staff.

"Retention should be a natural and fluid process, facilitated by understanding individual employees and what engages them," Blankenship says. "You can't have a blanket strategy for retention."

Some employees are motivated by competitive salaries or bonuses. Others might desire a flexible schedule or a connection to a motivating vision. Still others simply want bureaucratic barriers removed so they can be more effective in their work.

Blankenship learns what each employee needs to stay passionate and motivated by meeting in person with them. For new employees, these meetings are weekly. For seasoned employees, it might be once a month. She also has an open-door policy, so no one feels as if they have to wait to ask a question or raise a concern.

"I see myself more as a coach than a manager," she says. "I have these wonderful, passionate people, and I help them figure out what is their strength and how we can utilize them so they're leveraging their strengths with their work."

The one-on-one meetings might include questions about what the employee likes to do and how he or she prefers to be coached. Blankenship asks what their goals are and how they like to receive feedback.

"These are tailored toward people's individual preferences," Blankenship says. "I ask everyone what is going well and what they are struggling with. Sometimes they say they don't have anything going on, and we'll meet anyway and talk for half an hour."

When a manager asks an employee what's going well with their work, the manager can see the employee light up as he or she talks about some positive aspects to the job.

"Sometimes, we have more programmatic concerns that employees bring to my attention, and those help me as a manager to shape our program," she says.

The most important part of the regular meetings is how it can build a relationship and trust with the employee. "The engagement piece is important," Blankenship says.

She uses her nurse-honed intuition with staff.

"It's very common for me to go to an employee and say, 'Let's go take a walk,' after one of their peers told me that something was off with this person," she says. "By having that relationship and engagement, we could walk and work through something."

The whole idea of the meetings and walks is to catch small issues before they become big ones. Employees will continue to be productive and compassionate and passionate when managers take time to alleviate their concerns and misunderstandings, Blankenship notes.

For many people in today's workforce, flexibility on the job is a major issue, so Blankenship provides that when needed. For employees who prefer a 10-hour day, four days a week, she helps them make that schedule work. When employees have special circumstances that require flexibility, Blankenship works with them.

For example, she had an employee whose wife had a baby. Both the husband and wife worked for the hospital and had to split their parental leave, and he gave most of his to her. One week after his child's birth, he was back at the job, trying

EXECUTIVE SUMMARY

Hiring new case management staff might work best if managers think outside the box of maximum nursing experience.

- One manager looks more for passion for the work and patient population.
- A potential employee's life and leisure experiences can play an important role in whether the person would be a good fit for a job.
- Life experience also can be important, particularly if it affects a case manager's view of helping patients.

to handle both work and the late hours of an infant.

"I told him that if his daughter is up all night long and she finally falls asleep at 6 a.m., then he doesn't need to be at his desk at 8 a.m. He could get that extra hour of sleep and come in at 9 a.m.," Blankenship says. "It will make him more productive and just give him the reassurance that what's important to me is not that he's sitting at his desk at 8 a.m., but that he gets some rest."

In another example, an employee walked to Blankenship's desk and said she had "Fridayitis." Blankenship told her to go home. "If your brain is completely spent, then go home and rejuvenate and come back refreshed on Monday," she says. "This allows employees to know that the quality of their work is more important than the amount of minutes they sit at their chair."

Focusing more on productivity than clock-punching works, she says.

"Honestly, my employees always make up their time," Blankenship says. "I haven't had anybody who I think is taking advantage of the flexibility, and the more I support them, the better the job they do in supporting patients." ■

Enough Is Enough: OSHA to Issue Regulation on Violence

HCWs at hearing share disturbing accounts of patient attacks

Taking the first step in what is likely to be a protracted political struggle, OSHA recently announced it will promulgate a federal regulation to protect healthcare workers from a shocking epidemic of violence.

The decision came at a Jan. 10, 2017, public meeting in Washington, DC, at which the standard litany of assault rates and statistics was devastatingly humanized by first-person accounts of healthcare workers.

In the current political environment, any new regulation could face stiff resistance, but after hearing such stories it may be hard to argue pros and cons, as academic discussions give way to a growing sense of outrage.

"I've been bitten, kicked, punched, pushed, pinched, shoved, scratched, and spat upon," said **Lisa Tenney**, RN, of the Maryland Emergency Nurses Association. "I have been bullied and called very ugly names. I've had my life, the life of my unborn child, and of my other family members threatened, requiring security escort to my car."

Unfortunately, such stories are not uncommon.

"It is clear that workplace violence is a serious occupational hazard that presents a significant risk for healthcare and social assistance workers, and I believe that a standard protecting healthcare and social assistance workers against workplace violence is necessary," said **David Michaels**, PhD, MPH, the outgoing assistant secretary of labor for OSHA. "I am pleased to announce, as one of my last actions, that OSHA will grant [HCW/union] petitions and will commence rulemaking to address the hazards of workplace violence in the healthcare and social assistance industries."

OSHA issued a request for information[1] on Dec. 7, 2016, asking for comments and suggestions as to how to best proceed with violence prevention strategies in healthcare. The comment deadline is April 6, 2017.

OSHA was prompted to pursue rulemaking by a recent GAO watchdog report[2] that cited staggering levels of assaults in hospitals, with attacks resulting in lost work days "at least" five times higher than private sector industries overall. Efforts to use the OSHA General Duty Clause to enforce existing protections have been minimal and ineffective, the GAO found.

"The collapse of America's mental health system has resulted in emergency rooms and hospitals being filled with patients in need of scarce inpatient psychiatric facilities, outpatient psychiatric facilities, and especially medical psych beds and medical geriatric psych beds," Tenney said. "This has resulted in ER psych orders, frustrated patients and family members, and it has increased violence. We ask that the OSHA [regulations] be coordinated with and complimentary to any efforts being undertaken by other federal agencies who are addressing the mental health crisis. While it's important that workplaces internally mitigate violence, it's also important for us to get to the root cause of the

violence. As a nation, we need to have zero tolerance for anyone who hurts a healthcare worker, a patient, or a visitor."

While that level of violence is disturbing in any context, it actually represents an undercount because many assaults go unreported by healthcare workers.[3] The attacks are primarily made by patients or their family members, and healthcare workers that do not report incidents may fear reprisals or think that no action will be taken by administration. However, the grim prevailing dogma that violence "is just part of the job" is starting to be roundly rejected.

"We know that workplace violence could be dramatically reduced if employers respond to our concerns and develop comprehensive prevention plans to protect workers," said **Jean Ross**, RN, co-president of National Nurses United, the largest union of registered nurses in the country. "OSHA cannot stand by and watch one more injury, one more threat of violence, or one more death to healthcare workers that serve patients across this country. The well-being of nurses, healthcare workers, and their patients must be safeguarded, and it's past time for OSHA to mandate these protections."

Mental Anguish

The psychological effect of an assault may linger beyond the physical pain, becoming a traumatic echo that remains with the worker long after the incident.

"Aside from sustaining a physical injury, being a victim of assault from a patient is vastly different from any other type of healthcare-related injury," said **Erin Johnson**, RN, of the Massachusetts Nurses Association. "Workplace violence has a psychological component that vastly affects one's mental ability to feel safe and secure when returning to work, and it takes support from employers to regain these feelings."

An RN for seven years, Johnson was recently attacked while working on a child and adolescent inpatient psychiatric unit at Providence Behavioral Health Hospital.

"Working with children ranging from ages 5 to 12 years old, I am more likely to be hit or kicked than I would be if I were working with older adolescents or adults, due to the higher tendencies of their impulsive behaviors," she said. "Recently, I was a victim of workplace violence, and although my experience may not seem horrific, it is one of the many examples occurring across the country."

Two patients broke through a secure door and escaped the unit last Christmas Eve.

"As these patients were being safely returned, I was punched in the back twice and bit on the inner portion of my upper right arm," Johnson said. "After my shift ended, I cried for what felt like hours, because I was in such a state of shock. I felt hurt, frustrated, sad, and most of all, angry."

The frustration may be widely felt when healthcare worker advocates are faced with the long slog it will take to pass an OSHA regulation under an administration that is moving to deregulate federal government.

While the recent passage of a California law[4] to prevent violence in healthcare certainly adds momentum to enactment of a national standard, hospital ownership and healthcare administrators will certainly raise the issue of costs, staffing, and warn against stigmatizing patients by "criminalizing" them, said **Katherine Hughes**, RN, with the SEIU Nurse Alliance of California.

"I don't want to criminalize the patient," she said. "I'm a nurse. I've taken care of white supremacists. I've taken care of gang members. I've taken care of murderers. I've taken care of the homeless. I've taken care of the hospital CEO. I've taken care of someone's grandma. We were able to show [in California] that healthcare workers don't really care where people came from. We treat them all the same, most of us."

Hughes also takes exception to the common argument that violence is unpredictable and regulations cannot effectively prevent incidents.

"But you can predict it," she said. "You know patients coming out of anesthesia might act up. So, do some training for people in the recovery room on what those things might be, right? I think it's really important that we can show our employers that if we had a little bit more time and a little bit more staff, we might actually be able to prevent some of the stuff that they say is unpreventable."

Yet, as urgent as the problem is, the OSHA process to enact regulation takes years of hearings, stakeholder meetings, and various and sundry bureaucratic and political requirements.

"I think the GAO assessed that generally, it takes on average about seven years," said **Jordan Barab**, former deputy assistant secretary of labor at OSHA. "But again, it is a process. It will require constant vigilance on your part to move the process forward, and if the crowd here is any indication, I'm sure constant vigilance will not be a problem. I think the evidence is clear in terms of the significant risk that workplace violence poses, in terms of the cost that workplace violence imposes upon employers, and

particularly workers — not just in terms of money, but in terms of their physical and mental health."

Without Warning

While expressing disappointment at the projected timeline for OSHA regulation, **James Phillips**, MD, of the American College of Emergency Physicians, said there are some positive signs of progress and the medical community should not be discouraged.

"We can't just rely on our government representatives and our organizations in Washington to make those decisions for us," he said. "As not only victims and healthcare providers, but as the research experts and those of us who are affiliated with them, it's our job to develop consensus, expert guidelines to help guide hospitals and other facilities going forward."

Having published a recent review article[5] on violence in healthcare, Phillips said he was, in part, motivated by attacks by patients in his work in emergency medicine and surgery.

"I've had a patient convicted of felony assault against me," he says. "But even worse was the fact that during my surgical residency, I actually had an intoxicated patient intentionally spit hepatitis C-positive blood in my eyes. I had no idea it was a crime. It was witnessed by the police, who didn't make mention of it. My attending said nothing. I visited occupational health, getting tested for the next six months."

One reason healthcare workers are not prepared for occupational violence is that the threat is not emphasized in medical school, he added.

"There's no training in medical schools to tell you, 'Hey, you are about to enter into the most violent industry outside of law enforcement in the United States. Be prepared,'" Phillips said. "Never — not one time in four years of medical school, nine years of residency, and a year of fellowship. I'm not qualified to speak about nursing school, but I certainly can say that the vast majority, if not all, medical schools do not discuss workplace violence or what you're entering into." ■

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Hospitals Do Not Know Own Outcomes

Hospitals depend so much on outcomes data to determine quality, but one researcher says most hospitals don't even know their outcomes. That leads them to make critical decisions based on faulty information, says **Donald Fry**, MD, executive vice president for clinical outcomes management with MPA Healthcare Solutions in Chicago, and adjunct professor of surgery at Northwestern University Feinberg School of Medicine.

Fry's conclusion is an outgrowth of his recent research in the *Journal of Bone & Joint Surgery*, in which he found that risk-adjusted complication and readmission rates vary widely between hospitals where joint replacement surgery is performed. In addition, patients are twice as likely to suffer an adverse outcome after they are discharged than while they are still in the hospital.

Fry says the study results confirmed his belief that hospitals often don't know their own outcomes. In too many cases, he says, neither the hospital nor the surgeons know about deaths after discharge or readmissions to another hospital. In his recent research, inpatient major complications of care and deaths represented less than 50% of the adverse outcomes occurring across the entire continuum of care, Fry notes.

"The spectrum for adverse outcomes has to extend into the postoperative period. The era of ever-declining lengths of stay means that more complications of care are not recognized or declared until the patient is in the post-discharge period," he says. "Hospitals have very limited knowledge, if any, about 90-day post-discharge deaths that are not readmitted."

Hospitals could gain a better idea of true outcomes with a database holding encrypted patient identifiers so individuals could be followed after discharge for admissions to other hospitals, and for deaths, Fry suggests. If a state database is not possible, the problem might be addressed with a system in which hospitals in a community communicate with one another when patients are admitted to one facility after being treated in another, he suggests.

Medicare's move toward bundled payments makes it imperative for hospitals to obtain accurate outcomes data, he says.

"Hospitals have to know the results of their care because the hospitals and clinicians under bundled payments will sustain substantial financial penalties when their patients have excessive rates of readmission to the hospital," Fry says. "You can't fix a problem if you don't even know that it is happening."

Hospitals can unfairly benefit from the lack of true outcomes data, Fry notes, though it is not intentional. By not including some post-discharge data, the hospital's quality of care can seem higher than it is, he says.

"They're not being malicious; it's not some sinister plot to avoid the realities of your quality of care," Fry says. "But I do think it's a problem when you declare victory and there's still five minutes left in the first half. That is what exists with our current measurements of inpatient care."

There are multiple reasons that hospitals aren't working with valid outcomes data, says **Alan Cudney**, RN, MBA, a principal healthcare consultant with SAS, a consulting company based in Cary, NC. Lack of analytic maturity is a key reason, along with how data typically are compartmentalized, disorganized, and difficult to access, he says. Many healthcare organizations do not have a strategy for organizing and managing data, or subsequent analytics with that data, he says.

"The process of preparing data for cross-functional analytics is cumbersome and poorly managed, and the culture does not support, empower, and reward data exploration and collaboration to create real improvements in care and service," Cudney says. "There is a lack of appropriate analytic tools and a lack of modern analytic tools that can prepare data for analytics, as well as run complex modeling and queries."

> "THE ABILITY TO ANALYZE CARE AND OUTCOMES ACROSS THE CONTINUUM IS BECOMING A CAPABILITY THAT IS NECESSARY FOR SUCCESS AND EVEN LONG-TERM VIABILITY."

The selection of analytic tools often is based on localized needs and is not aligned with an enterprise strategy, he says. Siloed use of analytic tools makes it more difficult to perform complex analytics across the organization, he says.

"Value-based care is shifting the cost-benefit equation for leaders and clinicians at care delivery organizations. The ability to analyze care and outcomes across the continuum is becoming a capability that is necessary for success and even long-term viability," Cudney says.

Input Good Data

Outcome measures are only as good as the data available to compute them, says **George Dealy**, vice president of healthcare applications at Dimensional Insight, a data analytics company in Burlington, MA. However, with increased adoption of electronic health records (EHRs) and standardization of clinical and quality data, there's more opportunity than ever before to work with measurements that have the potential to help improve care, he says.

In the near term, healthcare providers should be able to refine their approaches and develop the associated competencies to work with the most useful and reliable measures that exist today, he says. As interoperability of healthcare information continues to improve, additional measures — such as those that require information from multiple health systems — will also become increasingly available and practical. Examples of these measures include those related to readmission rates and complications of care, which require information from multiple settings of care, potentially across several organizations, he says.

"Government entities are able to help. The example of the difficulty identifying deaths outside of care settings points to the fact that mortality information is not effectively shared as well as it could be," he says. "Both the federal government and state governments track this information closely and could potentially share it, assuming the appropriate level of confidentiality and privacy was adhered to." ■

The Joint Commission's Antibiotic Stewardship Now in Effect

Standard follows CMS, CDC strategies

Infection preventionists should be aware that with the turn of the new year, The Joint Commission's antibiotic stewardship standard is now in effect. The new Medication Management (MM) standard (MM.09.01.01) requires antimicrobial stewardship programs for hospitals, critical access hospitals, and nursing care centers.[1]

According to The Joint Commission, the new standard includes elements of performance as summarized below:

• make antimicrobial stewardship an organizational priority;

• form a multidisciplinary antimicrobial stewardship team that includes, if possible, an infection preventionist, a pharmacist, and a physician;

• educate healthcare workers on antibiotic resistance and stewardship practices,

• educate patients and families on appropriate use of antibiotics.

The Joint Commission is a deemed authority to enforce conditions of participation (CoP) for CMS, which issued a new proposed rule June 16, 2016, requiring antibiotic stewardship programs in hospitals to rein in drug-resistant bacteria and stop the rise of *Clostridium difficile* infections. The Joint Commission approach appears to be based on the CMS proposed requirements and the core practices for stewardship recommended by the CDC.

"The CDC estimates that, annually, at least 2 million illnesses and 23,000 deaths are caused by antibiotic-resistant bacteria in the United States alone," The Joint Commission stated in a background document.[2] "This standard will promote patient safety and quality of care, as well as align these accreditation programs with current recommendations from professional and scientific organizations. An antimicrobial stewardship standard is being developed for both the ambulatory and office-based surgery settings."

In a related development, The Joint Commission has revised and updated its National Patient Safety Goal on preventing catheter-associated urinary tract infections (CAUTIs). The goal, which now also applies to nursing homes, has been updated to include new elements of performance.

According to The Joint Commission, these include the following:

• educate healthcare workers on the proper use of indwelling urinary catheters, the risks of CAUTIs, and the importance of infection prevention;

• develop written criteria, using established evidence-based guidelines, for placement of an indwelling urinary catheter;

• follow your written catheter procedures and guidelines on insertion and maintenance of urinary catheters;

• measure and monitor CAUTI prevention processes, and in units and wards where a high volume of catheters are used.

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CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.

COMING IN FUTURE MONTHS

- Remote monitoring program keeps patients on track
- Health system's care transition reduces LOS, readmissions
- Update on MACRA and effect on case management
- New strategies to reduce 30-day readmission rates

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CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:
1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right, or log on to AHCMedia.com, then select My Account to take a post-test.

3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE QUESTIONS

1. **Which of the following is one of the biggest issues case managers might encounter in working with refugee populations?**

   a. Healthcare illiteracy
   b. Cultural differences
   c. Complex medical and mental health needs
   d. All of the above

2. **Some immigrants and refugees believe that diseases can be caused by acute fright. What word do they use to describe that?**

   a. Mal
   b. Phobia
   c. Susto
   d. None of the above

3. **According to Honey Blankenship, MSN, RN, CCM, CPN, which of the following is a good way to determine the best people to hire as case managers?**

   a. Ask job applicants which sport or other physical activity they most enjoy in their spare time.
   b. Ask job applicants what inspires them.
   c. Ask job applicants what they would like most about the job.
   d. None of the above

4. **Blankenship also has a theory about how to retain and motivate staff. What is it?**

   a. Provide the most competitive salary and bonus package.
   b. Give workers flexible schedules.
   c. Clear staff's way when it comes to bureaucratic challenges and rules.
   d. Find out which motivator works best for a particular worker and use that one.