CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

AHC Media
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JUNE 2017 Vol. 28, No. 6; p. 61-72

Case Managers Will Promote Their Profession on Capitol Hill

It might be time for Case Management Model Act

Every time there is a new Congress and a new president, there are big opportunities and challenges for educating lawmakers about the need to include professional case managers in important healthcare bills or regulations.

This year, that mission is especially important as Congress debates repealing and replacing the Affordable Care Act (ACA).

The Case Management Society of America (CMSA) will meet and talk to members of Congress during the upcoming CMSA Hill Day 2017, Sept. 13-14, on Capitol Hill in Washington, DC.

"Every time we visit Capitol Hill and our CMSA leadership and members meet with Congressional leaders, our goal is to educate policymakers first and foremost on who we are as professional case managers," says **Patricia Noonan**, RN, MBA, CCM, director of Network Care Management with Lahey Clinical Performance Network in Beverly, MA. Noonan is the chair of the CMSA public policy committee.

> "OUR GOAL IS TO EDUCATE POLICYMAKERS FIRST AND FOREMOST ON WHO WE ARE AS PROFESSIONAL CASE MANAGERS."

Congressional representatives might not be aware that case management is provided by an interprofessional team that can include lay navigators, community health workers, pharmacists, physicians, allied health professionals, and case managers, says **Cheri Lattimer**, RN, BSN, executive director of the National Transitions of Care Coalition (NTOCC) in Prescott, AZ. The NTOCC includes pharmacy professional organizations, case management, veterans affairs, hospitals, and other

Financial Disclosure: Author **Melinda Young**, Editor **Jill Drachenberg**, Editor **Dana Spector,** AHC Media Editorial Group Manager **Terrey L. Hatcher,** and Nurse Planner **Margaret Leonard** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

CASE MANAGEMENT ADVISOR™

Case Management Advisor™,
ISSN 1053-5500, is published monthly by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
Case Management Advisor
P.O. Box 74008694
Chicago, IL 60674-8694

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
Customer.Service@ahcmedia.com.
AHCMedia.com
Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

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SUBSCRIPTION PRICES:
Print: U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $419. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours or CMCC clock hours, $369. Outside U.S., add $30 per year, total prepaid in U.S. funds.

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Back issues: $75. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

ACCREDITATION: Relias Learning, LLC, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.25] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity has been approved by the Commission for Case Manager Certification for 1.5 clock hours. This activity is valid 24 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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transitions of care stakeholders.

"The challenge is that various professional organizations and academic leaders need to come to a consensus so we can share the same information with legislators," Lattimer says. "Consensus is needed on what are the services, who can deliver the services, and what do we actually mean when we say we're achieving outcomes."

From CMSA's perspective, Hill Day 2017 is a big opportunity to create a lasting effect.

"Our goal is to have 200 professional case managers attend our Capitol Hill day, so we can all deliver an important message to Congress that we are professional case managers, adding value to our healthcare system and to healthcare consumers," Noonan says.

"We are licensed, qualified healthcare professionals. We are guided by the standards of practice for case management. We are guided by our professional certifications," she adds. "That clearly, in and of itself, is an important message to deliver to congressional leaders that are thinking about developing or drafting new legislation that includes case management services."

Having CMSA members share their stories of how they are adding value to patients and clients is what resonates, Noonan adds.

CMSA recently updated its Standards of Practice for Case Management and supports the Case Management Model Act that promotes case management program standards. *(See story about Case Management Model Act, page 64.)*

The 2016 revised Standards of Practice for Case Management focus on recent changes in the healthcare industry, including minimizing the healthcare system's fragmentation and expanding and maximizing the contribution of the interprofessional collaborative healthcare team to plan care and services for patients. More information about the revised standards is available at: http://bit.ly/2q35bRU.

CMSA's chief message is that the organization is nonpartisan and would like any newly introduced healthcare legislation to include professional case managers in order to reach broader healthcare populations and to increase case management's contribution to quality care, safety, and outcomes, Noonan says.

"From the standpoint of both private insurance and healthcare reform, we all realize that the ability to be able to work with and manage this healthcare coordination is key," Lattimer says. "There is a tremendous amount of duplication of resources and, sometimes, not the best use of time and money in our healthcare system."

EXECUTIVE SUMMARY

Case managers and others will head to Capitol Hill to meet with lawmakers in September to explain how case management adds value to the healthcare delivery system.

- The first goal is to show policymakers who professional case managers are.
- The Case Management Society of America will focus on its Standards of Practice for Case Management and the Case Management Model Act.
- Another focus will be helping lawmakers understand the importance of case management in the care continuum — particularly as they debate any new healthcare legislation

The goal is a unified healthcare system in which teams work to support patients through the continuum of care, Lattimer adds.

"Over the years, many providers say the laws are made and they don't look at what they'll actually mean to patients and caregivers," Lattimer says. "We're trying to take a look at that."

Outreach and education are CMSA's chief objectives for 2017. The Case Management Model Act is one possibility.

"It would be helpful to hand [lawmakers] talking points on a case management model act to demonstrate how case management works and how it is structured, regardless of where case management happens," says **Chriss Wheeler**, RN, MSN, CCM, owner of Innovative Care Consultants in Independence, MO. Wheeler also is the vice-chair of the national CMSA public policy committee.

"I think our leaders are really looking for good information to be able to restructure whatever the ACA becomes," Wheeler says. "It gives me hope that Congress realizes we can't go back to what we were before, because we can't sustain it economically."

Congress changes every two years after all U.S. representatives and one-third of the Senate go through the election process. Any legislation that was left languishing in a committee right before the new Congress takes office is gone, and would have to be reintroduced. Advocacy groups like CMSA have about two years to meet with legislators to convince them of the importance of bills that address their concerns.

"Each time you go knock on their doors to build that relationship, you have a better opportunity to get things done," Wheeler says.

"Sometimes change comes very, very slowly. After research comes out, it takes 17 years to change that behavior to support the research," Wheeler says. "Our political world also takes time to bring things about."

CMSA stresses its nonpartisan nature and focuses on how case management helps patients.

"Since the ACA was enacted, we share the stories of how we are working with chronic and complex individuals and how we're making a difference each day," Noonan says. "The cost savings is significant, and we're playing a role in not only contributing to achieving national quality goals, but also in reducing inefficiencies and readmissions."

"SINCE THE ACA WAS ENACTED, WE SHARE THE STORIES OF HOW WE ARE WORKING WITH CHRONIC AND COMPLEX INDIVIDUALS AND HOW WE'RE MAKING A DIFFERENCE EACH DAY."

One of the challenges case managers face is that the regulations that provide funding for care management services do not define who is qualified to provide those services. Case managers need to be licensed professionals who can conduct an assessment independently.

So, while having coding now that pays for chronic care management services is a positive thing, it's not clear that organizations will put resources into professional case managers.

"In today's world, you can have non-licensed personnel do the work," Wheeler says. "When you look at most physician offices, they have medical assistants who finished nine-month certificate programs, and those are the folks doing medical case management."

What the coding lacks is an understanding that professional case management has better outcomes. CMSA's standards of practice define a professional case manager as someone who has at least a bachelor's degree and a professional license, or, in some states, a certificate. "The caveat is that, within your scope of practice and licensure, you have to be able to do an assessment independently," Wheeler says.

As healthcare evolves away from fee-for-service and toward population health goals and focus, there likely will be such a huge demand for case management that healthcare organizations will need to fill some of these jobs with case manager extenders. But those roles also need to be well-defined, she says.

"That's something our model act will do — defining the role of the professional case manager and defining what a non-clinical person does when helping to support the case management process," Wheeler explains.

For instance, case management extenders could arrange patients' transportation to medical appointments. But the chief oversight and organization should be the professional case manager's job.

"We have to make sure we are getting the professional case manager to assist," Wheeler says. "Your outcomes are going to be better. They just are." ■

Case Management Model Act Defines Case Management at the Federal Level

Act defines case management to lawmakers

The Case Management Society of America (CMSA) recently sent letters to U.S. representatives and senators, asking for their consideration of The Case Management Model Act. CMSA developed the original act in 2009.

The model act, according to an April 24, 2017, CMSA letter, addresses critical areas in case management and has received endorsements from a variety of healthcare organizations, including the National Association of Social Workers.

The purpose of the act is to define case management on the federal level, defining qualifications for case managers, scope of services, quality management programs, and case management functions.

CMSA published online a 14-page version of the act. It calls case management "a consumer-centric, collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes."

Case management is an effective way to mobilize resources to promote quality-based and cost-effective care for a variety of populations, the CMSA letter notes.

"We need to make sure that these services continue to be properly funded and expanded to reduce costs and improve clinical outcomes," the letter reads.

"Case management is one of the most effective solutions in healthcare and must become a fundamental pillar of healthcare reform, including promoting patient education, safety, and healthier outcomes," according to the CMSA letter. "Without federal support, we will not be able to harness the full power of case management strategies and interventions."

CMSA is currently updating the act. For more information about the Case Management Model Act, visit: http://bit.ly/2oucCED. ■

New Payer-provider Five-year Contract Pushes the Envelope on Care Coordination

Health system agrees to guarantee

Even as changes to a national healthcare framework have occupied public debate in 2017, there's evidence that the trend toward care continuity and keeping patients out of the hospital are here to stay. A new, five-year contract between two powerhouses in the healthcare arena suggests that the era of fee-for-service medical care will continue to evolve into a fee-for-value model.

Independence Blue Cross and the University of Pennsylvania Health System (UPHS) signed a contract, effective July 1, 2017, which will give the organizations shared accountability for quality and cost of care. UPHS has joined the Independence Facilitated Health Networks (FHN) model, which focuses on better care coordination.

The agreement is huge, as Independence spends $1.2 billion annually at University of Pennsylvania Health System facilities, says **Anthony V. Coletta**, MD, MBA, president of Facilitated Health Networks, Independence Blue Cross of Philadelphia.

"It's a big system with a huge number of patients," Coletta says. "We spend in the Philadelphia market $6.5 billion in healthcare every year, and Penn is a big piece of that."

With a large customer population, there's a need to lower costs and create a more efficient workforce, he notes.

The Facilitated Health Network model works to achieve this goal through its three pillars, including engage, enable, and empower, Coletta says. "'Engage' is economic — decreases the rates and puts in new value-based programs," he adds.

One example of this is the Independence-UPHS contract's focus on shared accountability. In

the agreement, UPHS will provide Independence members with a 30-day readmission guarantee on all inpatient services and surgeries.

What this means is that any time an Independence member is readmitted to a UPHS hospital within 30 days, the health system will cover their costs. "There is no cost to members or Independence," Coletta says.

"We consider this to be a bold statement that indicates they're stepping up to be increasingly accountable for both quality and cost," he adds. "It's the first [30-day readmission guarantee] in Philadelphia, and I suspect it's one of the first in the country."

The pillar of "enable" relates to data exchange. The new contract between Independence and UPHS will include a robust data exchange and care management platforms. Clinical data will be merged with claims data, Coletta says.

Data exchange makes it possible to perform risk stratification of health populations and manage them collaboratively. The data is in real time, enabling physicians to make better-informed decisions.

Data will include specialist and facility utilization, drug prescribing patterns, and potentially preventable ED visits.

"It allows you to identify the patients who have the most complicated needs on the care management side, and you can aggregate the claims to demonstrate who has the most chronic conditions," he explains.

The empowerment piece relates to enhanced, coordinated care management between the two organizations' care teams. An Independence clinical care transformation team will work with UPHS doctors. They'll help to manage cost efficiency by sharing reports that compare cost ranking from low to middle to high for frequently performed procedures.

Also, there will be care groups that include staff from both organizations to meet quarterly to share best practices.

"So instead of us being siloed, we'll increasingly engage the health system to get as close to a point of care in a coordinated way," Coletta explains.

For instance, each hospital has case managers working with Independence teams to find patients the right skilled nursing facility, where they can complete rehabilitation successfully and return home, he says.

"There are nurse navigators, who are care managers, out in practices, seeing these complicated patients when they're seeing their doctors, and establishing care management plans for these patients and helping them to implement those plans," Coletta says.

Another strategy involves enrolling the highest-risk patients in a house call program.

"We deploy people to their homes," Coletta says.

The house call program involves sending clinical practitioners to Independence members' homes. "There's a core group of clinicians: RNs, nurse practitioners, and physicians, supported by behavioral health social workers, and — we anticipate with the Penn agreement — community health workers, trained beyond a high school diploma, but not with a clinical degree," he says.

Ideally, the first encounter would involve a nurse case manager who assesses the patient's case and establishes a care plan, Coletta says.

The house call program is resource-intensive, but it can identify social determinants of health obstacles that otherwise would be difficult to spot.

For example, Coletta accompanied a non-Independence physician to a couple of Independence members' homes and found the experience to be fascinating.

They first visited a man who had congestive heart failure (CHF). He had several follow-up needs, including medication reconciliation and an appointment with a cardiologist. But he also was experiencing an exacerbation of his CHF.

"It was an hour-long visit, and most of what she did was what a doctor would need to do," Coletta says. "The other half could be done by a nurse care manager."

At the second visit, Coletta and the physician saw an elderly woman who had chronic obstructive

EXECUTIVE SUMMARY

Independence Blue Cross and the University of Pennsylvania Health System signed a five-year contract, effective July 1, 2017, to share accountability for quality and cost.

- Independence spends $1.2 billion annually at University of Pennsylvania Health System facilities.
- UPHS has agreed to provide Independence members with a 30-day readmission guarantee on all inpatient services and surgeries.
- Case management and care continuum services are expected to be a part of the change.

pulmonary disease (COPD), and lived alone. That visit took two hours.

"I sat and watched for an hour, seeing things that could have been done ahead of time," Coletta says. "The model is growing and scaling up, and it's very engaging to see that level of intensity in the home."

The patient lived in a home with very steep steps. She had a long oxygen tank, and she walked slowly up the stairs, trailing the tank's hoses between her legs. She was an apparent risk for falling and injuring herself, he says.

"She had six empty oxygen tanks in the corner, and she had mistaken her daily inhaler for her emergency inhaler and was confused, not taking her inhaler in the way it was prescribed," Coletta says. "This is emblematic of how critical these cases are."

The experience also reinforced the importance of having home visits. Seeing how the patient struggled with her oxygen tank on the stairs could lead to a physician or case manager suggesting a solution that would reduce her risk of falling. The physician was able to get the patient back on her maintenance inhaler, taking it correctly, which could prevent an ED visit.

"You have to deal with their social determinants, and — to me — the imperative is to figure out a way to scale that model up, linking the hospital work to the rehab facilities where they're often discharged, and from there to their homes," Coletta says. "Inside the engagement model, you invest in resources to keep people out of the hospital." ■

Case Management Contributes to Better Transitions, Reductions in LOS

When reviewing her health system's care transition, a manager of case management noticed a trend: The length of stay was heading in the right direction, but the readmission rates bounced up and down.

"Readmissions didn't have a steady decline. If it declined one year, it would go back up another year," says **Melanie Payawal**, RN, BSN, PHN, CCM, ACM, manager of inpatient case management for Sharp Rees-Stealy Medical Centers in San Diego.

Payawal was determined to do something about it.

"I am a case manager at heart," she says. "You see what's going on with the patients, talking to them, seeing what they're going through, and it hits you on a personal level. That was my motivation."

Payawal worried about readmissions from the patient's perspective, partly because she had seen her own grandmother bounced throughout a healthcare system in a different city before she died more than a year ago.

"When my grandmother was discharged, a lot of pieces did not fall into place," she recalls. "I had to do case management for my grandmother, who had multiple comorbidities and renal disease."

Seeing "frequent flyers" in her own patient population brought back those memories. "Oh, that patient is back in again. What's going on with that patient? Did we do anything for this patient besides put home health in place?"

There were gaps in too-slow referrals to ambulatory case management.

"I'd look at all these cases, and it was a little painful," Payawal says. "I did 75 case reviews with a very detailed look at the medical component."

Then Payawal asked for input from ambulatory case managers, a skilled nursing facility, home health, and others.

"I started looking at trends to see if I could capture anything," she says. "I also looked at avoidable days."

She found that many patients did not have follow-up appointments scheduled. Or, if the appointments

EXECUTIVE SUMMARY

One health system's care transition data showed improvements in length of stay, but less so in readmissions.

- Frequent flyer patients needed faster referrals and follow-up appointments.
- Changes made the process more effective and resulted in positive outcomes, including lowering the 30-day readmission rate from 12.9% in 2015 to 11.1% in the most recent data.
- Psychosocial issues can hinder a patient's progress and must be adequately addressed.

were scheduled, they were for 1.5 or two weeks later with their primary care provider. "That's too long," Payawal says.

"If we want to prevent a readmission, then they have to meet with the physician," she adds.

Payawal drilled down deeper into the data to see whether these patients had any symptoms after discharge that could be handled at the primary care provider level before they worsen and require a hospital stay.

What she saw was eye-opening. Patients had symptoms that could have been handled earlier in the ambulatory setting, but there was too little follow-up, so these symptoms were missed, she says.

"I knew if we didn't tie up that loop, we're not doing any service for the patient," Payawal says.

Another major finding was that several patients were delayed on discharges because of a lengthy MediCAL process. Patients were staying in the hospital for as long as months.

"We had to figure out a way to be more effective," she notes.

"We looked at patients who stayed in the hospital for eight or more days," Payawal explains. "Then we listed these patients in a report with their clinical information and other data, and we'd sit down and brainstorm to see if there was something we could do to help move the patient to the next level of care."

The result was a 10.63% decrease in length of stay between 2014 and 2015, and a continued improvement through 2016. It was 4.8 days in 2014; 4.29 days in 2015, and 4.27 days in 2016, Payawal says.

The 30-day readmission rate was 11.1% in the most recent quarterly data available. It had been 12.9% in 2015, she adds.

The following are ways the organization used data and case management to improve outcomes:

• **Obtain useful data.** Using Medicare Advantage patient data, Payawal had data analysts provide a monthly report. Reports listed bed days, readmission, and length of stay.

The report also provided some trend information based on diagnoses. "But that doesn't tell us the complete story of what goes on with patients," Payawal says.

To get a fuller picture, Payawal took the detailed readmission report and list of patient names to perform a case review on some patients.

THE RESULT WAS A 10.63% DECREASE IN LENGTH OF STAY BETWEEN 2014 AND 2015, AND A CONTINUED IMPROVEMENT THROUGH 2016.

"Readmission reports list the number of days between when they were readmitted, so it's a pretty comprehensive report," she says. "To focus my energies, I use data as a guide, compare it with previous data, and go in that direction."

• **Use data effectively.** "What I do with data is compare it to previous months to see if there is worsening of the numbers," Payawal says. "If it looks like it's getting worse from one month to another, I start focusing energy on that population."

For example, a trend might be if Payawal notices there was a patient readmitted within a 14-day window, and she learns that patients like this one are not getting to primary care provider appointments on a timely basis.

Next, Payawal reviewed call center data and met with the call center's leadership team to present her findings.

"I said, 'We need to have our patients seen within five to seven days because, typically, patients are readmitting before they even see their doctor,'" she says. "We trained the leadership team on how to input the information into the discharge paperwork, so when they talk with patients they could solidify a time and date and put it in the paperwork before the patient is discharged."

Payawal also asked the call center team to generate their own report to monitor their compliance.

• **Deal with psychosocial issues.** Psychosocial issues can impede a timely discharge and increase readmissions. Sometimes patients have no support at home. They live by themselves, and their families are uninvolved. When the patient has an acute event at the hospital and needs someone to care for him or her at home, there is no one, Payawal explains.

"So, we can't discharge the patient because of these social issues, and, unfortunately, we see that issue a lot in the hospital setting," she says.

Or, some patients may have to live with family members who weren't involved before. Now, those same family members will be making decisions on behalf of the patient, she says.

"We offer them as much resources as we can and offer them some choices regarding the next level, which could be assisted living, and we help them determine what they can afford," Payawal says.

For more information about Sharp Rees-Stealy Medical Centers' program and the risk assessment tool, contact Melanie.Payawal@sharp.com, or by phone: (858) 499-5564. ■

Study: Older Patients Vulnerable to Functional Decline Following ED Visit

New findings from a rigorously designed study suggest that older patients who visit the ED are at enhanced risk of disability for up to six months following the visit.[1]

Investigators evaluated what they refer to as the "burden of disability" in older persons during a six-month period after they were discharged from the ED, and they compared this group to a matched group of older persons who did not visit the ED, and an unmatched group of older patients who were hospitalized following an ED visit.

Investigators found that although an ED visit proved not as debilitating as a hospitalization on study participants, it was associated with statistically significant declines in functional status compared with the matched control group of participants who did not visit the ED. Researchers noted these outcomes reveal an opportunity to intervene and potentially mitigate functional declines in older patients who present to the ED for care.

The study is part of the Yale Precipitating Events Project, an ongoing investigation of older persons living in the community and initially nondisabled. Researchers are endeavoring to learn more about the epidemiology of disability as well as interventions that could be effective at maintaining or restoring function.

Researchers compared 754 patients who went to the ED without being hospitalized with a control group of 813 individuals of similar characteristics who did not visit the ED. They also studied a group of non-matched older patients who visited the ED and then were hospitalized. The average age of participants in both the ED-only and the control groups was 84 years.

Between 1998 and 2012, participants completed assessments every 18 months, and they were interviewed every month to gauge their functional status and to note any illnesses or injuries that prompted ED visits and/or hospitalizations.

At the beginning of the study, both groups exhibited similar functional abilities, with levels of disability ranging between 3 and 4 on a disability scale, where lower scores represented lower levels of disability. However, the group with participants who visited the ED scored an average of 14% higher than the control group participants on the disability scale during the six months following the ED visit. The group with participants who had ED visits followed by hospitalization demonstrated disability scores that were 17% higher than the ED visit-only group.

The most common reason for an ED visit and for an ED visit followed by hospitalization was musculoskeletal followed by a cardiac event. Gastrointestinal and infectious issues were the next most common reasons. The authors noted that further analysis of the cohort is studying whether some conditions that lead older adults to visit the ED are more predictive of subsequent functional decline than others.

William Fleischman, MD, a co-author of the study and clinical assistant professor of emergency medicine at the University of Maryland Medical Center in Baltimore, stresses that the reason for an ED visit and/or hospitalization likely is responsible for the increase in disability observed in the study, and notes that such patients probably could benefit from the kind of discharge planning that typically takes place in the inpatient setting. Further, he states there are things that EDs could do to prevent functional decline in older patients.

"The first step would be screening older ED patients to identify who may be at risk for functional decline. If an older patient is to be discharged from the ED, there are ACEP guidelines on steps that can help reduce the risk of functional decline," he says. "These include taking an active role in ensuring proper medical follow-up, arranging for home visits by a nurse and/or physical or occupational therapists, or arranging for appropriate equipment to be at home, such as a walker." *(For more information on the ACEP guidelines, visit: http://bit.ly/1fzmOix.)*

Fleischman observes that randomized studies from EDs in Canada and Australia have demonstrated that such interventions reduce the risk of functional decline.[2,3]

"[They showed] good promise for the two-step intervention process of performing a screening exam in the ED and then coordinating outpatient follow-up by comprehensive care teams," he says. "These interventions have been shown to reduce ED visits and readmissions, and may also reduce ICU admissions and improve a patient's quality of life.[4] I am not aware of a published cost-benefit analysis of these interventions, but there aren't many interventions in

medicine that can say they achieve [this much] in the older population."

Although the creation of geriatric-focused EDs in the United States may provide value in helping prevent functional decline, Fleischman is not aware of any published studies that have looked specifically at outcomes in this area. He also observes that the trend toward geriatric EDs is limited at this point.

"Only about 36 out of 5,000 U.S. EDs have dedicated geriatric EDs," he says. ■

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The Ethical Quandary of Moral Distress

Imagine you are nurse treating a cancer patient.

You are aware that the patient is suffering and no longer wants to be treated, yet family members push for continuing chemotherapy in hope of a cure. The patient continues treatment to appease this aim, suffering personal misery and giving rise to what nursing researchers term "moral distress" in the caregiver.

This condition is distinct from other emotional states caused by the pressures and obstacles that make healthcare such difficult work, explains **Cynda Hylton Rushton**, PhD, RN, FAAN, professor of clinical ethics in the Johns Hopkins Berman Institute of Bioethics and the School of Nursing, who participated in a symposium on the topic and was the lead author of a resulting paper.[1]

"Although it has overlapping characteristics, it is often distinguished from other emotional states by its focus on the moral or ethical aspects of the situation," says Rushton.

Rushton and colleagues outline a path to "moral resilience" for nurses and other healthcare workers feeling conflicted about a given situation and the inner desire "to do the right thing." Moral distress is more likely to occur as healthcare complexity increases, leading to ethically challenging scenarios that may contribute to burnout, they report.

Some of the building blocks for moral resilience cited in the paper include mindfulness meditation, ethics education, and organizational support. Thus, individual action within a broader framework of culture change is required.

"Addressing moral distress requires both individual and organizational strategies — neither is sufficient alone," Rushton says. "A misconception about moral resilience is that it suggests that one is ignoring or being complacent about the real and complex ethical issues that are present in our workplaces. On the contrary, skills such as mindfulness offer the foundational mental and emotional stability that is needed for conscientious clinicians to recognize and respond to threats or violations of personal and professional integrity. Without such stability, clinicians risk causing harm to themselves and others."

Clinicians also need to cultivate "moral efficacy" — the ability to recognize, deliberate, and act in ways that are aligned with their personal and professional ethical standards, Rushton notes.

"In order for moral distress to be addressed effectively, clinicians must practice in environments that support ethical practice [through] such structures as ethics committees, employee assistance programs, policies, and processes that support clinicians," she says.

This will require moving beyond "either/or thinking" and realizing there is some interplay between individual moral beliefs and the ethical mindset of their place of employment, she notes. ■

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Expect Zika Return, Reinforce HCW Safety

First cases appearing in Florida

Employee health professionals should prepare for the return of Zika virus, as the CDC expects the mosquito-borne infection threat to return to the U.S. as the warmer months arrive. That poses employee health challenges that boil down to the same essential message: prevent blood exposures, needlesticks, and alert employees who are pregnant or trying to become so.

Florida is already under fire, as state health officials reported the state had 29 cases as of March 20, 2017. The vast majority were in travelers returning from countries where Zika is spreading, but two cases were locally acquired via mosquitoes and two were of unknown origin. The state reported Zika infections in 13 pregnant women for 2017. All Florida county health departments now offer free Zika risk assessment and testing to pregnant women.

As this issue went to press, the CDC was advising pregnant women to consider postponing travel to Miami-Dade County.

"If you are pregnant and must travel or if you live or work in Miami-Dade County, protect yourself from mosquito bites by wearing insect repellent, long clothing, and limiting your time outdoors," the state health department advised. According to CDC guidance, providers should test all pregnant women who lived in, traveled to, or whose partner traveled to Miami-Dade County after Aug. 1, 2016.

"This is the first time a mosquito-borne disease has ever caused birth defects in humans," **Lyle R. Petersen**, MD, MPH, director of the CDC's Division of Vector-Borne Infectious Diseases, said at a recent two-day Zika summit at the CDC. "The last time an infectious pathogen — rubella virus — caused an epidemic of congenital defects was more than 50 years ago. … This is also the first mosquito-borne virus that has shown to be sexually transmitted in humans."

Again, though the primary threat is to pregnant women and unborn children, adherence to standard precautions and injection safety should block occupational transmission to workers if patients with Zika are hospitalized or treated in other healthcare settings.

The CDC recently reported Zika-affected pregnancies with birth defects in the U.S. were about 20 times higher than pregnancies occurring before the virus emerged as an epidemic in the Americas last year. "Defects and other early brain malformations, eye defects, and other central nervous system problems, were seen in about 3 of every 1,000 births in 2013-2014," the CDC reported.[1] "In 2016, the proportion of infants with these same types of birth defects born to women with Zika virus infection during pregnancy was about 6%, or nearly 60 of every 1,000 completed pregnancies with Zika infections."

The birth defects include microcephaly, with the critical risk period to the fetus occurring in the first trimester of pregnancy, Petersen said. The virus attacks the brain before the cranial plates of the skull are fully set, causing them to collapse to form the small head, he said.

The prevailing consensus is that most Zika infections are largely asymptomatic and inconsequential unless the infected person is pregnant or has had unprotected sex while the virus was circulating in the blood or persisting in a human reservoir like semen. Thus, we have seen the tragic birth defects, failed or terminated pregnancies, transmission to sexual partners both male and female, and Zika infection following a needlestick.

In addition, 2016 saw the strange case of a 73-year-old patient in the U.S. who apparently transmitted Zika to a visiting acquaintance — possibly through tears — before dying with an incredibly high level of circulating virus in the blood.[2] The secondary case developed symptomatic Zika infection, but subsequently recovered. It is possible that hormonal treatment for prostate cancer somehow accelerated viral replication in the index case, investigators concluded.

As employee health professionals are well aware, Zika is just the latest example of bloodborne threats to healthcare workers. This underscores the importance of using sharps designed to prevent injuries, the prompt reporting of any needlesticks, lacerations, and other exposure incidents to supervisors as soon as possible.

Healthcare workers should use standard precautions during patient care regardless of suspected or confirmed Zika infection status, NIOSH and OSHA recommend.[3] However, employers should consider enhanced precautions in situations where workers are at increased risk of exposure to Zika virus or other hazards.

"While there is no evidence of Zika transmission through

aerosol exposure, minimizing the aerosolization of blood or body fluids as much as possible during patient care or laboratory tasks may help prevent workers from being exposed to other pathogens," the agencies recommend. "Additional protections, including engineering controls to ensure containment of pathogens or enhanced PPE to prevent or reduce exposure, may be necessary during any aerosol-generating procedures or other such tasks."

ANA Trains for 'New Normal'

As emerging novel viruses seem to have become the "new normal" for employee health professionals, several research and training projects are being undertaken to shed light on how best to protect staff from infectious threats.

The healthcare system has certainly been tested by Ebola, Zika, and MERS, with a common finding that training and consistent, correct use of PPE is an ongoing concern.

The 2014-2015 Ebola outbreak spread to some 28,000 cases and caused more than 11,000 deaths. One of them was a patient admitted to a hospital in Dallas in October 2014. He died, but infected two nurses, who survived. There was considerable confusion about the case, and some initial speculation that the nurses must have had a break in infection control technique or PPE. While the exact route of transmission was never determined, a report by an expert investigative panel described a chaotic scene where any number of factors could have led to the occupational infections. Healthcare workers were confused and "lost confidence" trying to protect themselves with PPE guidelines that were in flux at that critical time, the panel concluded.

As a result of the Ebola outbreak, the American Nurses Association (ANA) has entered into training and resource collaborations with the CDC.

"The ANA has been involved in infection prevention and control for quite some time, ranging from antibiotic stewardships to preventing healthcare-associated infections, but after the Ebola outbreak we wanted a more formalized collaboration between ourselves and the CDC," says **Seun Ross**, DNP, MSN, CRNP-F, NP-C, NEA-BC, director of nursing practice and work environment at the ANA.

The nurse-patient relationship is arguably the most critical aspect of care delivery, and the ANA is particularly proud that nurses are consistently ranked as the most ethical of all professions.

"We have ranked No. 1 in that category for the past 15 years and that is a position we don't want to concede," Ross says. "We want to continue that trust [in nursing as an ethical profession]. We want to make sure that nurses are knowledgeable to handle anything that comes their way. Certainly, emerging infectious diseases are in that category and may involve at any time a different understanding of [infection control recommendations]. We want to do everything we can to minimize any concern or hesitation on the part of the nurse."

Thus, the ANA collaborated with the CDC to form the Nursing Infection Control Education (NICE) Network. The plan is to present CDC training materials at conferences and meetings of nursing specialty groups.

"The CDC is developing a basic training program and we are going to take it and gear it more toward nurses for ANA and some 20 other nursing associations," Ross says. "We will do it in collaboration with them at each of their conferences so we can reach a broader range of [nursing specialties]. After nursing school, once you get your first job, every hospital does basic infection control. With the NICE Network, we plan on teaching hand hygiene, PPE, fundamental principles, and prevention of infection transmission. We will use all of that as a baseline and expand on that and talk more about emerging infections."

In additional Ebola education efforts, the federal government has awarded $12 million over the next five years for training development at three hospitals that all cared for infected patients in their respective biocontainment units during the outbreak. The facilities participating in the collaborative training and education effort are Emory University in Atlanta; the University of Nebraska Medical Center in Lincoln; and Bellevue Hospital Center in New York City. Training will include rapid suspect or confirmed case identification and immediate isolation as well as appropriate donning and doffing of PPE. ■

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CE QUESTIONS

1. **The Case Management Society of America's 2016 revised Standards of Practice for Case Management focus on which of the following?**

   A. Minimizing the healthcare system's fragmentation and expanding the interprofessional collaborative healthcare team.
   B. Placing case management front and center of a new healthcare bill
   C. Ensuring that all case managers have either an RN or MSW
   D. All of the above

2. **What is the purpose of the Case Management Society of America's Case Management Model Act?**

   A. To define case management on the federal level
   B. To define qualifications for case managers
   C. To define scope of services, quality management program, and case management functions
   D. All of the above

3. **Which of the following is a chief benefit of having a house call program that sends physicians and other clinicians to elderly and chronically ill patients' homes?**

   A. The program can help patients set up their next appointment with a specialist.
   B. The program can provide isolated patients with much-needed social support.
   C. The program can identify social determinants of health obstacles that otherwise would be difficult to spot.
   D. None of the above

4. **When a health system is trying to improve its readmissions rate, data is needed. Which are some metrics that should be collected to produce the most useful information and analysis?**

   A. Patient demographics, self-funding rate, readmission rate
   B. Bed days, readmissions, length of stay
   C. Number of diagnoses, demographics
   D. None of the above