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INSIDE

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Nurses, Other HCWs Report High Levels of Sexual Harassment

Cases can result in major lawsuits

One out of four nurses reports sexual harassment on the job — and that is only one part of the physical violence and verbal bullying some nurses experience, studies show.[1]

Recent publicity about sexual harassment from celebrities and politicians has broadened public discussion of this problem and caused some organizations to improve their education and policies about sexual harassment.

Still, it's a big problem in healthcare, as recent lawsuits highlight. For example, one California woman filed 18 written complaints about sexual harassment by surgeons and medical staff when she worked as a cardiac surgery physician assistant at a hospital. She was fired a week after her last complaint. The woman reported being called a "stupid chick," being subjected to trashy sex talk, and being bullied — including a surgeon sticking her with a needle. A federal jury awarded her $125 million in punitive damages, a verdict that is being appealed by the hospital. *(Find more information at: http://abcn.ws/2APC8pD.)*

> "WE FOCUS ON THE FACT THAT THIS IS NOT A SEXUAL PROBLEM, BUT A POWER DYNAMIC, ABUSE OF POWER, AND THE SEXUAL DIMENSION IS THE WEAPON OF CHOICE."

Many case managers, whether they work in hospitals, primary care clinics, long-term care facilities, or other healthcare settings, may have seen or experienced sexual harassment, as well.

A first step in preventing the problem

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is to define it. *(See story on preventing sexual harassment, page 3.)*

"Sexual harassment ranges from extremes of sexual assault down to 'Did you get asked out on a date from someone you didn't want to go out with?'" says **Paul Spector**, PhD, distinguished professor in the department of psychology at the University of South Florida in Tampa.

"A lot of sexual banter goes on in the workplace, and sometimes it rises to the level of harassment," he says.

Generally, sexual harassment is unwanted behavior, a pattern of repeated behavior, and it creates a hostile work environment, Spector says.

"It flares up in the media every so often, going through cycles," he says. "We saw it with the Anita Hill hearing, but the behavior has been going on, and sexual harassment is part of a broader mistreatment pattern."

Sexual harassment that is unlawful and is subject to oversight by the Equal Employment Opportunity Commission (EEOC) must meet the following criteria:

- enduring the offensive conduct becomes a condition of continued employment;
- the conduct is severe or pervasive enough to create a hostile work environment that a reasonable person would consider intimidating, hostile, or abusive.

(For more on the EEOC's regulations on workplace harassment, visit: http://bit.ly/2By9Lh0.)

"The legal definition of sexual harassment is what we use in the workplace, although most people use layman terms, which are much broader and typically in the eye of the victim," says **M. Ann McFadyen**, PhD, an associate professor at The University of Texas at Arlington. McFadyen was a co-author of a paper on occupational sexual harassment, published in July 2017.[2]

Firing the accused employee often is the only recourse an organization can make, which is why so many news and entertainment companies quickly fired or severed ties with the stars accused of sexual harassment last fall.

Letting sexual harassment cases drag out can tarnish an organization's reputation, McFadyen says.

"Scientific evidence suggests that false claims are no more than 2% to 5%, so the vast majority of allegations have some degree of merit or substance to them," says **James Campbell Quick**, PhD, FAPA, distinguished university professor at The University of Texas

EXECUTIVE SUMMARY

For the past year, sexual harassment has made headlines, sometimes daily, as celebrities and politicians deal with accusations. Research shows that nurses and other healthcare workers also experience sexual harassment, abuse, and bullying on the job.

- One in four nurses reports workplace sexual harassment.
- Some recent lawsuits have found in favor of plaintiffs, leveling millions in punitive damages to healthcare providers.
- Sexual harassment can range from the extreme of sexual assault to an unwanted request for a date.

at Arlington. Quick co-authored the paper on sexual harassment.

"Ann and I focus on the fact that this is not a sexual problem, but a power dynamic [involving] abuse of power, and the sexual dimension is the weapon of choice," Quick says.

"What our study shows is that one of the biggest indicators of sexual harassment occurring is when you're in a male-dominated field," McFadyen says.

Studies show that male nurses also report sexual harassment, forced intimate touch, and others' attempts to have sex, Spector says.

A 2014 review of 136 articles about violence, bullying, and sexual harassment reported by nurses found that male nurses were affected, although the studies didn't indicate whether the alleged perpetrators were primarily male or female.[1]

If sexual harassment is thought of in terms of a power abuse, it makes sense that male nurses also would experience it. "In some cases, a person will use abuse to exert power over somebody, and in that case, it has nothing to do with sex," Spector says.

"I'm interested in the broader issue of mistreatment, and sexual harassment is a component of it," he says. "It can be very stressful to go to work and deal with this."

Bullying and sexual harassment also can contribute to medical errors, he adds.

Sexual harassment can lead to mental health problems in victims, says **Elizabeth Armstrong**, PhD, professor of sociology and organizational studies at the University of Michigan in Ann Arbor.

"Decades of research in psychology, sociology, and other fields indicate sexual harassment and sexual assault have really negative consequences in terms of depression, anxiety, and health issues," Armstrong says.

Major status inequalities can lead to workplace sexual harassment, and this likely is why nurses are vulnerable to it, she notes.

"The power differences are huge, and physicians may feel they have a certain amount of entitlement," Armstrong says. "One would think one of the reasons why nurses experience a lot of harassment is that in a feminized, lower status job in an organization that is very hierarchal, they are working directly with men who have a lot more power than they have in the organization."

This power differential also can affect how a healthcare organization handles sexual harassment complaints.

"If someone is a superstar, a doctor or surgeon, it can be difficult to say anything, and even if people do report the harassment to the organization, the organization might feel very reticent about pursuing or following up on the report," Armstrong says. ■

REFERENCES

1. Spector PE, Zhou ZE, Che XX. Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: a quantitative review. *Int J Nurs Stud*. 2014;51:72-84.
2. Quick JC, McFadyen MA. Sexual harassment: have we made any progress? *J Occup Heal Psych*. 2017;22(3):286-298.

Strategies for Preventing Workplace Sexual Harassment

Office climate matters

Healthcare organization leaders can do a great deal to prevent sexual harassment — or, at least, to stop it as soon as it occurs.

They first need to be aware that the organization's climate is very important.

"When an organization ignores sexual harassment, it has an impact on whether or not employees are exposed," says **Paul Spector**, PhD, distinguished professor in the department of psychology at the University of South Florida in Tampa.

"The more they pay attention and emphasize that everyone needs to be safe from this type of treatment and that if they are mistreated they'll be supported, the less impact it has on the employees who are harassed," he explains.

Employees who feel their workplace supports them will be more likely to go to the human resources department to file a complaint, Spector says.

"Organizations need to be concerned about getting sued, but they also need to be concerned about problems that occur that are not attributed to this, like increased medical errors and poor patient

treatment," he says. "A happy staff makes for happier customer service."

Spector and other researchers who have studied sexual harassment offer the following suggestions for how to prevent the problem:

• **Focus on prevention from the top down.** "Change the circumstances that are enabling the abuse to occur," says **Elizabeth Armstrong**, PhD, professor of sociology and organizational studies at the University of Michigan in Ann Arbor.

"Change the workplace culture and allocation of power to prevent harassment and abuse, rather than to expect victims to come forward and seek justice," she says.

"There's longstanding research about what's called 'second assault,'" Armstrong adds. "This is institutional betrayal, and that's when the survivors seek to have justice, and the process of trying to get that justice or to make the behavior stop to get some kind of remedy is as bad as the original assault, so the trauma is intensified."

• **Establish decisive policies and procedures when sexual harassment is reported.** Healthcare organizations should establish clear policies about what sexual harassment is and how it will be handled if reported. They can use definitions from the Equal Employment Opportunity Commission.

Reporting should be spelled out as to who receives the report and what the next steps will be. "When organizations have procedures in place that fairly and rapidly adjudicate claims and hold people accountable, the psychological and emotional outcome will be much better for survivors," Armstrong says.

> "COMPANIES NEED TO RECOGNIZE THEIR ROLE AND MAKE SURE THEY ENFORCE THEIR CODE OF CONDUCT AND MAKE IT CLEAR THIS WILL NOT GO UNPUNISHED."

"Organizations should take these reports seriously," she adds. "This doesn't mean they should believe every claim that is made, but an evenhanded, fair, transparent process that illustrates organizations' commitment is important."

In addition to establishing sexual harassment policies, organizations must have two or three channels through which employees can voice concerns, address issues, or file complaints, says **James Campbell Quick**, PhD, FAPA, distinguished professor at The University of Texas at Arlington.

"One channel is the HR department; a second is the legal system; a third is an organizational clinical psychologist," Quick says. "What's important about multiple channels is you don't want to have a system where one person or unit can block information from getting to the chief executive, who ultimately is the person who needs to know what's going on in the system."

Employees pay very close attention to how well an organization follows its own code of conduct. So, if the code of conduct says any employee who was named in a credible report of sexual harassment will be investigated and fired, then the employer should do exactly what the code states.

In the case of NBC morning talk show star Matt Lauer, NBC acted quickly to fire Lauer after the allegations because such conduct was clearly against the network's policy, says **M. Ann McFadyen**, PhD, an associate professor at The University of Texas at Arlington.

"Companies need to recognize their role and make sure they enforce their code of conduct and make it clear this will not go unpunished," she says.

• **Screen new employees for potential problems.** Screening potential employees for behavior that could lead to bullying or sexual harassment is not a science, but there can be warning signs for some potential predators.

For example, one sexual assault case involving a medical technician and a patient went to court, where

EXECUTIVE SUMMARY

Sexual harassment prevention starts with an organization's leadership paying attention and emphasizing the importance of workplace safety.

- There should be decisive policies and procedures for reporting sexual harassment and handling reported cases.
- Managers and staff need thorough sexual harassment training, including in-person classes with role-playing vignettes.
- Screening new employees for violence/bullying/harassment risk factors can help prevent some of the more severe cases.

it was discovered that the alleged perpetrator had prior arrests and risk factors, Quick says.

"If HR had carefully looked at his work history and arrest record, it wouldn't take long to see that this guy would fit into a 1% to 3% category of employees who will be high risk," Quick says.

Even closer supervision might have prevented the assault.

"In this particular case, he was given too much discretionary latitude, and that enabled him to get a patient to a place where he could victimize her without anyone seeing it," Quick says.

Healthcare organizations should hire professionals, such as psychologists, to identify high-risk employees and provide them with help, he adds.

• **Train managers and employees.** Employees and managers need comprehensive sexual harassment training. While some organizations conduct this training online, the more effective programs will include some interactive classroom components, McFadyen says.

"We've seen that electronic training is not as good as having training with vignettes and play-acting, where people can see what is sexual harassment," she explains.

• **Accept that times have changed.** Anyone who has watched the television show "Mad Men" with its casual acceptance of workplace smoking, drinking, and overt sexual assault can see that today's workplace is a far cry from 40 and 50 years ago.

The kind of sexual banter that might have gone uncommented upon a generation ago can cause employees distress.

"Back in the early 1980s, when I was in corporate banking, this was acceptable behavior and tolerated, and we all knew about it and dealt with it," McFadyen says.

"Women today, especially those who graduated five to 10 years ago, are much more highly sensitive in terms of comments they find harsh and mean," she adds. "The behavior tolerated then was wrong at the time, but nobody was coming forward."

Today, organizations are seeing a revolutionary change with dozens of prominent figures losing their jobs after public complaints of sexual assault or sexual harassment.

"Companies are being forced to deal with it more effectively than they have in the past," McFadyen says. ■

Community Finds Unique Ways to Bring Case Management to the Frontier

ED use decreased, care coordination improved

The nation recently has focused on rural areas experiencing opioid epidemics and struggling to regain employers during the major shift from manufacturing and mining to service industry jobs. One result is that the healthcare industry now can see the major health access problems faced by rural and frontier towns and communities.

Individuals in those areas tend to be older, have lower incomes, and lack public transportation. They also have limited healthcare resources, and few local social workers and counselors to deal with mental health issues, says **Pat Conway**, PhD, MSW, senior research scientist at Essentia Health in Duluth, MN.

"One problem is pain. There is no local resource or treatment for pain," Conway says.

These demographics and healthcare barriers are why researchers targeted the frontier/rural area of Ely, MN, to use case management strategies in improving patients' health and reducing barriers and costs.

Conway and other researchers recently published a paper on healthcare innovation in frontier communities. Their project used team facilitators to help patients with social-behavioral and resource issues. They found that the project increased care coordination for people with complex needs. ED use decreased following people's enrollment in care coordination.[1]

"There's a big push in healthcare to reduce unneeded emergency department use," Conway says. "Across the country, people with behavioral health disorders get their first level of care in the ED."

Programs like the team facilitation approach help to decrease ED visits, lower costs, and give patients a more appropriate way of handling their problems, Conway explains.

"Care facilitators intervene early, and whatever issues patients have, they can be kept safe without going to the ED," she adds.

"An important part of the

work we've done is to provide care facilitation through an individual who partners with community members and identifies their needs and goals, reduces barriers, and establishes supportive services," says **Heidi Favet**, CHW, community care team leader at Essentia Health–Ely Clinic in Ely, MN.

Sometimes, people in need of healthcare are labeled as noncompliant by providers. The case management approach is to learn what is going on with them to create barriers to their wellness and to help them improve their health and reduce ED visits, says **Jenny Uhrich Swanson**, MPA, behavioral health network director at Northern Lights Clubhouse, a program of Well Being Development in Ely. Swanson also is executive director of Well Being Development.

Swanson, Favet, and Conway explain how the program works:

• The community has a hub-and-spoke model of care coordination.

"There's a hub, which we have located at the clinic with Heidi, and that's where the referrals go," Swanson says.

"Say a doctor refers a patient for care facilitation," she explains. "That person is referred to Heidi, and she does an initial assessment and then decides where to host the person's care coordination."

There also are care coordinators in clinics. At Well Being Development, a care coordinator focuses on mental health. Other coordinators work with youth services and in schools.

With the hub model, patients can enter the program from any point in the community, Swanson says.

For instance, they can be referred to care coordination from the ED, a general practitioner, or even the local housing authority. They can self-refer. Or students, identified as having issues in school, can be referred by the school. Family members can call and ask for services for a loved one, she says.

• A community care team provides help.

"Building a community care team was a genesis project," Favet says. "Our hope was to build a safety net for community members, starting in 2011."

But even as the team connected services across the community, some people slipped through the cracks, she says.

"We started the care facilitation model to capture people," she explains. "As we grew to have care facilitators in more and more settings, we grew with the hub-and-spoke model."

Care facilitators meet regularly, encouraging cooperation between service agencies instead of competition, Conway says.

• Care facilitators address patient needs through care coordination.

Care facilitators address the health needs of their referred patients. They look at each person's health issues, transportation barriers, food, housing, and medicine, and assess whether there are any service gaps that can be addressed.

"They identify gaps in service and identify new ways of solving problems," Conway says.

Care facilitators use a standard workflow that begins with outreach, building connections with the clinic and community providers, and helping them to understand what the services are, Favet says.

They also provide warm handoffs to clinics and might even connect with patients in the ED. They assess care plans and patients' mental health status and social determinants of health.

"There's a comprehensive assessment of needs," Favet says. "The assessment is focused on personal goals and starts with what the individual sees as a highest priority and biggest concern."

"The care coordination workflow includes outreach, assessment, care planning, and intervention — where people are connected to services," she says. "The other step that is very important to our model is the follow-up step."

"We are very consistent with not just connecting someone to a therapist or giving them a phone number or sending them to a healthcare navigator," she adds. "We call back to see if it worked: Were there any barriers to getting to the

EXECUTIVE SUMMARY

A care coordination program that uses care facilitators has helped to improve care coordination and reduce ED use among a frontier, or very rural, population.

- The program targets people who have healthcare barriers, mental health issues, and social determinants of health that prevent them from maintaining optimal health.
- Local service organizations team up with grant- and Medicaid-funded providers to help people lead more stable and healthy lives.
- Care facilitators reach out to build connections with the clinic and community providers, and help people understand what the services are.

appointment? Did it work? Do you need a new therapist?"

Often, patients are referred to the program because of one glaring problem, Swanson says. "Often, when that's resolved, you find many other things behind it, and that's what the reassessment is."

• It's funded in a variety of ways.

State grants paid for the creation of community care teams, Swanson says. "That's where the first process started," she says.

"Initially, Medicaid was paying for care coordination," Favet says. "The lion's share of people were Medicaid recipients, but we didn't want to limit who received those services."

Since then, various community agencies, including those committed to helping people with healthcare, housing, and employment, have been involved, often using their own resources to help the program's patients. Those that can bill payers do so, but the others use different resources. For instance, Well Being Development pays for a care coordinator to work, long-term, with the care coordination efforts, Swanson says.

"After five years of this process, we've moved that care coordinator position from a grant-funded position to a clinic-funded position," Favet says.

Federal money also supports some of the facilitator roles.

"The plan was for the service to be reimbursable and sustainable long-term," Swanson says. "The issue we found was that small nonprofits could not be billable providers, and the service was only reimbursed for educating on diagnosis-based items, such as a new diabetes diagnosis."

It's a value to the community, so those involved look for alternative funding, including grants, she adds.

• Anecdotal and other evidence demonstrate program's benefits.

Aside from observing reduced ED visits and improved care coordination, it's difficult to measure the program's overall community effect, Favet notes.

"We're so small that showing any population health prevention level impact would be very difficult in a community our size," she says. "Our entire area is 12,000 people, spread out over nearly 100 miles."

The town of Ely has about 4,000 permanent residents.

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"We haven't undertaken a population health study because it's very difficult to show causation when there are so many things that happen simultaneously," Favet says.

However, there have been plenty of anecdotal examples of the program's success.

One person who connected with the program through Well Being Development suffered a bipolar condition and other chronic health conditions, Favet recalls.

"She had a low quality of life, living on a sofa in someone else's home, and she reported she didn't know what a good day looked like for her," she says.

Four years after care facilitation help, the woman is in college, has her own apartment, is involved in creative activities, and volunteers in the community.

"The most wonderful thing is to see her smiling," Favet says. "I think about how we helped an individual, who had struggled chronically and felt totally unsupported, meet her potential."

Another person, whose untreated diabetes led to repeated ED visits and hospitalizations, was helped with his housing situation. This led to more stable housing, and it gave the person the self-confidence necessary to improve his medication compliance, Favet says.

"Last spring, he was trained in a chronic disease self-management model, and so that's just another one of our many success stories," she adds.

One of the program's chief benefits is how it normalizes the importance of paying attention to the whole person, looking at depression, anxiety, and other issues, Conway says.

"This is a story that might happen across the country in rural areas if we can continue to focus on teams in the community and in the clinic, rather than just focusing on the individual and individual's diagnosis," Conway says. ■

REFERENCE

1. Conway P, Favet G, Hall L, et al. Rural health networks and care coordination: health care innovation in frontier communities to improve patient outcomes and reduce health care costs. *J HC for Poor & Underserved* 2015;27(4):91-115.

Antibiotic Stewardship Requires Hospitalwide Commitment

Hospitals can play an important role in addressing one of the most urgent public health problems today: the misuse and overuse of antimicrobials. An effective antibiotic stewardship program requires significant commitment from top executive levels down to the bedside.

Antimicrobial stewardship promotes the appropriate use of antibiotics and other antimicrobials. The goal is to reduce microbial resistance and simultaneously improve patient outcomes by decreasing the spread of infections caused by multidrug-resistant organisms, says **Linda Greene**, RN, MPS, CIC, FAPIC, president of the Association for Professionals in Infection Control and Epidemiology (APIC) in Arlington, VA, and manager of the infection prevention program at University of Rochester Highland Hospital in Rochester, NY.

Antibiotic resistance is a major public health threat. It is estimated that in the United States, antibiotic-resistant bacteria infect 2 million people annually, says **Katherine Fleming-Dutra**, MD, medical officer with the Office of Antibiotic Stewardship at the federal CDC in Atlanta. At least 23,000 people die as a result.

"Antibiotic use is a major driver of antibiotic resistance, and antibiotic stewardship is the effort to measure and improve antibiotic use. The goal of antibiotic stewardship is to combat antibiotic resistance and to improve healthcare quality and patient safety," Fleming-Dutra says. "Improving antibiotic use through antibiotic stewardship can lead to decreased antibiotic resistance and prevent avoidable antibiotic adverse events, such as allergic reactions and *Clostridium difficile* infections, [which are] sometimes deadly diarrheal infections. Effective antibiotic stewardship can also help decrease healthcare costs."

Antimicrobial-resistant organisms are associated with longer, more expensive hospital stays and poor outcomes, including increased risk of death. *(APIC offers a number of resources for antibiotic stewardship online at: http://bit.ly/2ylAyyV.)*

CDC and CMS Team Up

Improving antibiotic prescribing and use is part of the CDC's comprehensive approach to combat antibiotic resistance. The CDC also works closely with the Centers for Medicare & Medicaid Services (CMS) to promote the principles of antibiotic stewardship by providing direct technical assistance in hospitals nationwide to implement these programs within their acute care institutions.

For instance, as of September 2017, the Hospital Improvement Innovation Networks (HIINs) recruited more than 4,040 hospitals nationwide, working with them to improve the quality of care provided to patients. An essential element of their work is targeted at the implementation and strengthening of antibiotic stewardship programs based on the CDC's Core Elements for Hospital Antibiotic Stewardship Programs, Fleming-Dutra says.

"Technical assistance is provided to these hospitals at a local level through engagement with a wide array of clinical staff inclusive of quality improvement specialists, infection preventionists, and pharmacists, as well as hospital leadership to reduce overall patient harm," Fleming-Dutra says. "This includes directed assistance to reduce infections associated with antibiotic misuse and/or overuse, like *Clostridium difficile* and other multidrug-resistant organisms. The HIINs work to assist the hospitals in overcoming challenges by utilizing and spreading best practices that contribute to the achievement of the triple aim."

Hospitals Can Improve Stewardship

Infection control professionals have been promoting antibiotic stewardship for years, but hospitals have not always adopted it with the same passion, Greene says. Fleming-Dutra notes that the CDC recommends all acute care hospitals implement antibiotic stewardship programs in response to the urgent need to improve antibiotic use. CDC's Core Elements of Hospital Antibiotic Stewardship Programs outlines the components needed for an effective hospital antibiotic stewardship program.

That's where quality professionals can help, Greene says.

"This is a major initiative, but when you think about quality, costs, and potential threats in a potential hospital or healthcare organization, you have some very significant issues that compete for attention and resources," Greene says. "The proper and judicious use of antibiotics is an

issue that requires attention because it can affect patients and overall quality of care in far-reaching ways."

The current hospital quality assurance and performance improvement (QAPI) conditions of participation require that the hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for the QAPI program. Fleming-Dutra notes that the proposed infection control and antibiotic stewardship conditions of participation would require the hospital to:

- appoint a qualified infection control professional as the leader of the infection control program and a qualified medical professional as the leader of the antibiotic stewardship program;
- ensure that these leaders meet specific responsibilities for their respective programs;
- ensure that systems are in place and are operational for the tracking of all infection surveillance, prevention and control, and antibiotic use activities in order to demonstrate the implementation, success, and sustainability of such activities;
- ensure that all hospital-acquired infections and other infectious diseases identified by the infection prevention and control program as well as antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with hospital QAPI leadership.

The primary concern is that overuse of antibiotics encourages the mutation of drug-resistant organisms, the "superbugs" that can be hard to treat in any single patient and difficult to eradicate once they take hold in a hospital or unit.

"We also know that antibiotics are associated with severe diarrheal diseases like *Clostridium difficile*, which is a huge issue nationwide and which is part of public reporting," Greene says. "When you look at this from a quality and compliance perspective, especially with value-based purchasing and the data that is involved there, prevention of *C. difficile* is a very important concern."

> "WHEN YOU PUT ALL THOSE THINGS TOGETHER, IT IS A QUALITY AND PATIENT SAFETY ISSUE THAT IS EXTREMELY IMPORTANT."

The costs associated with antibiotic use also are of concern, she notes.

"When you put all those things together, it is a quality and patient safety issue that is extremely important," Greene says. "Unfortunately, over the years this concern has been effectively siloed. Pharmacy and infection control professionals have been working on this for years and there has been an effort to restrict some of the big-gun antibiotics so that they would be used only when truly necessary, requiring infectious disease approval in some cases. Other organizations have required a review of charts by infectious disease specialists to look for opportunities to discontinue or avoid antibiotics with some patients."

Those efforts have been ongoing for years now, but they often were loosely put together and did not cross all boundaries of a hospital, Greene says. The next step is to encourage hospitals to develop organizationwide programs rather than efforts residing only in infectious disease or infection control, she says.

The basis of antibiotic stewardship is providing the right dose of the right antibiotic at the right time, but Greene says that involves much more than just the pharmacist or physician writing the prescription.

"The bedside nurse, for instance, is a big part of that program, and people didn't really think about that recently," she says. "If I'm the first person assessing that patient and I don't get the right information regarding their history or allergies, that could make a difference in what the doctor orders. Or, if I'm not timing my antibiotics appropriately and I lose IV access, or if the nurse sends cultures when they're not necessary because there are no clinical symptoms, the bedside nurse can have a significant impact on antibiotic use."

Unnecessary cultures are a good example of how a well-meaning nurse or physician can increase the use of antibiotics with no benefit to the patient, Greene explains. Everyone has organisms living on the skin but not necessarily causing infection, but sending a culture to the microbiology lab can produce a report that tells the doctor the patient has a high concentration of staph. The doctor then prescribes an antibiotic, trying to be prudent and respond to admonitions about infection control.

"There are so many things that even the bedside nurse does that

have not been appreciated as an important part of this stewardship," Greene says. "A good antibiotic stewardship program ties all this together in the realization that this is not one person's role. It's everyone's role to make sure we are doing the best for patients from admissions through discharge."

A hospitalwide antimicrobial stewardship program will require leadership support from the C-suite on down, Greene says. There must be administrative support for appropriate laboratory staff, for instance, and there must be accountability across all parts of the organization.

There also must be a designated leader for the effort, Greene says. That usually will be a pharmacist or physician who champions the effort across all departments and who can be the focal point for questions and problems that may arise, she says.

That leader will be the one to push specific initiatives such as evaluating how often you order antibiotics or the adoption of an antibiotic timeout. This leader also will spearhead reporting, data tracking, and accountability.

"Quality professionals play an important role because they often are very influential in helping an organization set goals and come up with scorecards or quality goals," Greene says. "At my own organization and most others, there is someone from the quality improvement department on these antibiotic stewardship boards because they have that high-level view of the organization and know how to drive efforts toward a stated goal."

Education is another area in which quality professionals can play an important role, Greene says. This can be a particular concern with hospitals that see a lot of turnover with interns, residents, and other clinicians, she says. That is why it is important to have much of the antibiotic stewardship program hardwired into the system so that resources and policies are consistent as people come and go, Greene says.

The electronic medical record can be used to keep antibiotic stewardship consistent, with prompts and data entry requirements, for instance. Ongoing education also is key, Greene says.

Measure Outcomes With Antibiograms

Measuring progress and results is another area where quality professionals can contribute, Greene says. The CDC offers an antibiotic use module and an antibiotic resistance module that can be useful, but Greene notes that they require electronic data capture with an automated infection surveillance system.

"You can pull information out of those modules, like days of use and daily dosages — the things that will give you a good perspective," she says. "If you're using an inordinate amount of the medications intended only for the sickest patients, you might stop and look at that to figure out why. A key element of antibiotic stewardship is using the most narrow spectrum coverage that is effective. You don't want a 'gorilla-cillin' when a regular penicillin will do."

CDC recommends that hospitals track and report antibiotic use and outcomes, such as *C. diff* infections and antibiotic resistance, to measure the effect of interventions to improve antibiotic use, Fleming-Dutra says.

At the national level, CDC tracks antibiotic use and progress in implementation of antibiotic stewardship. *(More information can be found in CDC's* Antibiotic Use in the United States, 2017: Progress and Opportunities*, available online at: http://bit.ly/2husPnF.)*

Measuring outcomes is critical, particularly in the form of an antibiogram, a periodic summary of antimicrobial susceptibilities of local bacterial isolates submitted to the hospital's clinical microbiology laboratory.

Antibiograms are used to assess local susceptibility rates and in monitoring resistance trends over time within an institution, Greene explains. They also can be used to compare susceptibility rates across institutions and track resistance trends.

"The antibiogram tells you specifically about your institution's experience, such as your resistance to drug A from certain organisms, or your rates for diarrheal disease, whether they are going up or going down," Greene says.

Greene also recommends conducting a gap analysis with the following questions: Do I have someone responsible for antibiotic stewardship? Is leadership giving me the resources for this? Do I monitor in real-time, and measure outcomes?

"It is always good to know where you stand at the moment. If you're wondering whether you're really devoting the right effort to antibiotic stewardship, do that kind of gap analysis and see what you're currently doing and where you might put more emphasis," she says. "It's possible that you have much of this in place already, but it's just not organized under one umbrella and maybe you don't have one person who is bringing it all together and taking responsibility." ■

Evidence That Working 'Bare Below the Elbows' Protects Patients

Experimental evidence supporting the concept of healthcare workers working "bare below the elbows" to prevent transmission of pathogens to patients via long sleeves was presented in San Diego at the IDWeek 2017 conference.

A study using two mannequins and a surrogate DNA marker for *Clostridium difficile* showed that workers in long sleeves were more likely to contaminate a subsequent patient than workers wearing short sleeves.[1]

"During simulations of patient care, the sleeve cuff of the long-sleeve white coats frequently transferred the viral DNA marker," said **Amrita John**, MBBS, infectious disease epidemiologist at University Hospitals Cleveland Medical Center. "No transmission occurred when short sleeves were worn. During work rounds, the cuffs of physicians in long-sleeved white coats frequently contacted patients or environmental surfaces."

The healthcare system in the United Kingdom went to a bare-below-the-elbows policy in 2007. In 2014, the Society for Healthcare Epidemiology of America (SHEA) said the practice should be considered in the U.S. "based on biological plausibility and the low likelihood of harm."[2]

A sharp decline in *C. diff* infections in the U.K. after adoption of the policy led to John's interest in conducting the study.

"This [decline] has been attributed to a decrease in fluoroquinolone prescriptions," she said. "It's intriguing to me that it also happens to perfectly coincide with this new bare-below-the-elbows policy."

The findings have implications for healthcare worker dress in general, but the primary reaction has come from physicians accustomed to wearing the classic white coat.

"This policy has created a lot of angst among physicians," John said. She cited some of the online reactions to previous studies, including the following comments:

- "Just because they cultured some bacteria on a couple of white coats does not mean that these are vectors of disease transmission."
- "Another stupid checkbox for healthcare workers that makes no practical sense. Our skin have bacteria on them as well."

In the study, healthcare workers were randomly selected to wear either long-sleeved or short-sleeved white coats while examining a mannequin contaminated with cauliflower mosaic virus DNA, a surrogate pathogen. The workers would then remove their gloves, wash hands, and don new gloves before moving to another "patient" mannequin that was uncontaminated.

"In 25% of interactions when long-sleeved coats were worn, it was noted that the sleeve cuffs and wrists were found to be contaminated with the DNA markers after examining the first mannequin," she said. "No such contamination was noted with short-sleeved coats. It was then noted that in 15% of interactions when long-sleeved coats were worn, the environment of the second mannequin was contaminated with the DNA marker. Again, no contamination with the short sleeves. Finally, in 5% of interactions when long-sleeved coats were worn, the [second] mannequin was contaminated. Nothing with short sleeves."

A total of 34 healthcare workers participated in the study, which was supplemented by observational data of physicians wearing long-sleeved coats during clinical rounds.

"In 44% of their interactions between physicians and patients, the sleeves of their coats came into contact with either the patient or the patient environment," John said. "The environmental surfaces that were most frequently contacted by the sleeves include high-touch surfaces such as bed rails, beddings, and privacy curtains. These results provide support for the recommendation that healthcare personnel wear short sleeves to reduce the risk of pathogen transmission."

Enacting such a policy in the hospital setting is another matter, as John said it will take more data to move the needle on something involving traditional attire like the long-sleeved coat.

"[This study] has changed my personal preference," John said. "I now tend to roll up my coat sleeves above my elbows, but institutionally I would say we are not there yet. It would probably take some evidence in terms of larger studies or showing actual transmission in the clinical setting to convince people. I would say this is definitely some evidence pointing in that direction." ■

REFERENCES

1. John, A, Alhmidi H, Gonzalez-Orta M, et al. Bare Below the Elbows: A Randomized Trial to Determine if Wearing Short-Sleeved Coats Reduces the Risk for Pathogen Transmission. Abstract 996. IDWeek 2017, Oct. 4-8, 2017, San Diego.
2. Bearman G, Bryant K, Leekha S, et al. Healthcare personnel attire in non-operating-room settings. *Infect Control Hosp Epidemiol* 2014;35(2):107-121.

CASE MANAGEMENT ADVISOR™

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CE QUESTIONS

1. **Which is a federal government criterion for what constitutes sexual harassment?**

   a. Enduring the offensive conduct becomes a condition of continued employment.
   b. The conduct is severe or pervasive enough to create a hostile work environment that a reasonable person would consider intimidating, hostile, or abusive.
   c. Both a & b
   d. None of the above

2. **Which of the following is a best practice policy and procedure for reporting sexual harassment to the healthcare organization?**

   a. Spell out who receives the initial report.
   b. Establish clear policies on what steps will be taken after the report is made.
   c. Establish procedures to fairly adjudicate claims and hold people accountable.
   d. All of the above

3. **Which of the following is a potential benefit of providing case management to frontier/rural, underserved areas?**

   a. Case management services can help to reduce poverty and opioid addiction.
   b. Case management can help people with social determinants of health and decrease ED visits.
   c. Case management can bring in grants to build a new mental health facility or hospital in the area.
   d. None of the above

4. **Only female nurses report experiencing sexual harassment on the job.**

   a. True
   b. False

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.