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INSIDE

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For Older Patients, Loneliness Might Be Biggest Social Determinant of Health

Case managers can help change this

Loneliness and social exclusion can have a big impact on patients' health and quality of life, and it's a problem that is compounded by deteriorating health as people grow older.

Research shows that loneliness and social isolation, whether it is actual or only perceived, can be associated with increased risk for early death.[1,2]

"It's very clear from the data that people who are more isolated, whether from aging or from loss of family members, connections, and peers, have immune systems more at risk," says **Ellen Fink-Samnick**, MSW, ACSW, LCSW, CCM, CRP, principal with EFS Supervision Strategies in Burke, VA.

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Socially isolated patients do not function as well physically. They become sicker, and they may not follow through on health appointments, eating well, or taking their medications regularly, she says.

"Social exclusion has always been considered one of the determinants of health," says **Karen Nelson**, MSW, MBA, director of social work and case management at Stanford Healthcare in Palo Alto, CA.

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"Before, it was considered that people were excluded based on race, gender, or other characteristics," she says. "Now, we find people are not excluded based on those areas of diversity, but because society has changed fundamentally in the number of social connections it offers people naturally."

People rely more on technology and less on phone calls and in-person visits with friends and family. They have moved from communities where they participated in church and social activities to new places where they do not know anyone, Nelson explains.

"People are not connected with their neighbors in the same way, and they move frequently," she says. "This is a problem, especially with the elderly, because people are living longer but are so far from family connections, their children, and grandchildren."

Decades ago, people would stay in the community in which they were born. They would stay with their church family for decades, and those affiliations would give them an identity. Now they have to search actively for an identity, and social connections are not as abundant as they were, Nelson says.

"Grandparents would look forward to that family dinner every Sunday, and they had a purpose in life — even if they weren't working. They had natural connections," Nelson says.

With extended family weekly meals largely gone and more people living alone than ever before, social isolation is common, she adds.

"Just like we pay attention to obesity, smoking, and lack of exercise as risk factors, we need to pay attention to loneliness and social isolation as potential impacts that could impact life expectancies," Nelson says. "Socializing is good for your health."

While technology has contributed to social isolation, it also can enhance and enrich older adults' lives, one study shows.[3]

"Older adults are not naïve. They see the benefits of technology and are really satisfied with it," says **William J. Chopik**, PhD, assistant professor in the department of psychology at Michigan State University in East Lansing.

Chopik's study asked a large sample of older adults for their opinions about technology use.

"We found a lot of older adults were using technology for social purposes, and they were having better outcomes," he says. "They were healthier and happier. Reaching out with technology reduced loneliness, which can take a psychological and physical toll on people."

Using technology to combat

EXECUTIVE SUMMARY

Lonely, socially isolated people are at greater risk of early death. They also are more likely to suffer from health problems and a lower quality of life.

- Social isolation can lead to poor healthcare follow-up and sicker patients.
- Case managers should assess patients for social isolation, talk with them, and find solutions that could help them become more engaged in their homes and communities.
- Technology and social media can help to combat these issues.

social isolation has some inherent advantages. The older people surveyed said they liked how it saves them time and gives them flexibility in communication. Nine out of 10 said they were satisfied with technology, Chopik says.

Looking at technology a different way, it increasingly is being used to identify at-risk patients, but it is not as useful in identifying social isolation, Fink-Samnick says.

"If someone is landing in a hospital, then yes, someone should be assessing them to see if they live alone. This used to be a standard question," she says. "A lot of new electronic health records have included social determinants and psychosocial factors as part of the assessment."

But is this better than a case manager's in-person assessment? Probably not, Fink-Samnick notes. "Some preliminary work being done says, 'Sorry, but a basic assessment by a case manager or nurse, talking with a patient, is just as effective in determining social determinants of health."

Fink-Samnick, Nelson, and Chopik offer these suggestions for how case managers can help patients overcome loneliness and achieve social connections:

• Assess patients for social isolation and loneliness. Hearing and vision problems, disability, estranged family, language barriers, mental health and substance use issues, and living in a new community all can contribute to social isolation and loneliness, particularly among older adults.

Case managers can assess patients for those qualities, particularly when patients have other signs of health risks, such as frequent hospital and ED visits, Fink-Samnick says.

"Social determinants and psychosocial factors should be part of patients' assessment and risk stratification," Fink-Samnick says. "The challenge is there often is such reliance on electronic health records and technology, but for social determinants of health some preliminary work needs to be done."

This preliminary work might include a basic assessment in which the case manager speaks with the patient to determine whether he or she experiences social isolation, loneliness, and other social determinants of health to address.

• Identify barriers to social connection, including behavioral and physical health issues. "A high percentage of socially isolated patients have comorbid depression [and] anxiety and need a high level of intervention," Fink-Samnick says.

When behavioral and mental health issues affect a patient's feelings of social isolation, case managers can look for collaborative care programs for the patient.

"Look at what they need from a global perspective," Fink-Samnick says.

If a patient's isolation is caused by limited mobility, a case manager can encourage the patient to ask a family member or neighbor to visit him or her regularly, Nelson says.

"As people live longer, they are less likely to be able to drive, and if they live in a community without public transportation, then they will feel more isolated," Nelson explains. "So if people don't visit them, then they are very cut-off."

Hearing loss and vision problems also contribute to the problem. An older patient could be cognitively intact but still isolated from neighbors because of these physical impairments. A solution might be to encourage the patient to live in an assisted living home where there are communal meals and community activities, Nelson adds.

• Find community resources for patients. Find out what is available for patients in the community, Fink-Samnick says.

It is important for case managers to stay informed and know where there are food banks, respite care, Meals on Wheels, and other resources.

"Could they be referred to a coalition that does medication reconciliation and sends someone into the home?" Fink-Samnick asks.

In addition to agencies that visit people's homes, there are services that can take older people to healthcare appointments.

"About 50% of healthcare organizations have contracts with Uber Health or Lyft," Fink-Samnick says. "Some of the connections are being made by payers; they'd rather pay for transportation than have someone readmitted to the hospital."

"There are real benefits to patients being connected with support groups, which usually are run by social workers and psychologists," Nelson adds. "There are online support groups, and there are ones you can physically attend, and these are helpful to people experiencing social isolation."

Case managers also can help patients connect with volunteer opportunities and with senior centers, Nelson says.

Organizations like Stanford Healthcare also provide opportunities for social engagement. "We have an exercise program here, called Strong for Life, that is held a couple of times a week and it helps people reduce loneliness, increases stimulation, and brings a connection with others," Nelson explains.

In cases where patients truly are isolated because of depression or

other mental health issues, social workers can help by working with them to address their feelings of loss, depression, and loneliness, she adds.

• Reach out to families/ neighbors when appropriate. "Case managers and social workers can help families realize how they can provide meaningful support to a loved one," Nelson says.

One strategy is to ask the patient about the people listed as contacts on his or her chart.

"You have to be respectful of people's boundaries," she notes. "You need to engage them in a conversation so they can identify what might feel right for them, as there's not one solution that will solve the problem of loneliness for everyone."

Sometimes, the people on the patient's contact list will be good connections. They might be family members who were just unaware that the patient needed more in-person support or phone calls. The contacts might include neighbors who, with a little nudging, could stop by to see the patient weekly or daily. But this could be problematic if the patient is not comfortable with these connections.

"There's a difference between what we think of as loneliness and what patients perceive as loneliness," Nelson says. "A patient might have three daughters, and you can say they're connected with the patient, but you need to know a little more about the quality of that relationship. Does the patient feel that is a supportive relationship? Know when it's a real connection."

• Use technology also as way to connect. Some forms of technology can be too expensive for older patients, including smartphones and desktop computers. New technology also can be hard to learn.

But when patients have access to the internet and join online chat rooms and social media accounts, their quality of life can improve, Chopik says.

Case managers can help patients tailor social media use for their benefit. For instance, if a person's motivation for getting online is to connect with old friends or meet new people and keep track of existing relationships, social technology, like Facebook, can be useful, he says.

"I would suggest they join Facebook, see if they do enjoy it, especially if they have mobility limitations and are confined," Chopik says. "The great thing about technology is you can reach everyone all around the world and in your community." ■

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Care Coordination Team Helps Medically Complex Pediatric Cases

The national nursing shortage creates challenges and safety issues for Delaware families with medically complex children who require 24-hour care.

These children have ventilators, tracheostomies, feeding tubes, and IVs. They are cared for in the home environment, but often need eight or more hours of private-duty nursing assistance each day, says **Ellen McClary**, LCSW, CCM, manager of care coordination at Highmark Health Options in Wilmington, DE. Highmark Health Options handles Medicaid managed care cases.

"Due to the nursing shortage within home care specifically, a lot of times the nurses do not show up at the homes, or the agencies do not have the full staffing capacity to supply the hours the children need," McClary says. "This means the onus is on the families to fill those gaps."

Families are trained but are not as skilled as nurses. This gap in care can lead to safety issues. Also, parents often live with hourly, daily, endless stress — and having to forgo their sleep to fill in when the private-duty nurse does not show up at night can compound their stress and anxiety.

When Highmark Health Options approves a physician's request of a certain number of nursing hours for a pediatric patient, it is because those hours are necessary to ensure the child's health and safety, McClary says.

"If a child needs a nurse while they sleep, and that nurse doesn't show up, then the parent has to stay at the bedside all night to check the child's vital signs," she says.

This situation proved untenable for patients, so Highmark Health Options established a care coordination program in January 2017 to prevent gaps in nursing care.

The program's early results are promising. It has identified nursing care gaps earlier, resulting in fewer downshifts — occasions when nurses do not show up for their shift.[1]

"It takes time to get good data, and what we're trying to accomplish is to have fewer downshifts," McClary says. "We're being proactive — making sure issues are addressed earlier and have the right agencies and staffing onboard."

A two-person care coordination team — a social worker and a nurse care coordinator — assists for children with care needs that require at least eight hours of private nursing care per day. They meet jointly with families and collaborate in assessing cases and building care plans.

"They can engage with the health plan member and get on the phone and start problem-solving," McClary says. "We don't want to put any additional time constraints on the family, so we make sure they don't have to do separate visits with nurses and social workers and that they're visiting or calling together, as a team."

The nurse coordinator works with physicians and specialists to address all of the patients' health needs and to make sure all doctor appointments are kept. Social work care coordinators help families navigate the system and make referrals to community resources.

"These families are really complex and have special needs children, so they're in a state of stress all the time — 24 hours, seven days a week," McClary says. "So it's really important that we address all aspects of this family's needs and issues."

The team ensures the children have their special medications and that the family is seeing all necessary specialists. They also ensure all immunizations are up to date, that children can get to school as needed, and that the caregivers' needs are being addressed with community mental health services and respite care.

"We attend IEP [individualized education program] meetings with them and make sure they have all therapies in place," McClary says. "We're trying to do full care coordination across the continuum."

The care coordination team also makes sure nursing agencies are not missing scheduled shifts. If a nursing agency says it is short-staffed and may not be able to fill all needs, the team finds another agency to send nurses to patients' homes.

"Some members have two to three agencies coordinating those shifts to ensure every hour that's approved for is filled and staffed," McClary says.

When care coordination teams learn that a private duty nurse did not show up at the scheduled time, they call the agency and report the incident as part of a data collection effort. This gives the organization an opportunity to look for trends regarding missed shifts, she says.

"Our care coordinator calls the agency to ask what happened and to see whether this is an isolated incident or whether they foresee more staffing issues on this case," McClary says. "If the agency says they don't have the case fully staffed or they're having chronic staffing issues, then we have an opportunity to call additional agencies, make referrals, and see if we can get someone in there very quickly — filling in gaps."

One possible back-up plan for emergencies or unexpected nurse call-outs involves family or friends. "They might have friends or family they know would be willing to be trained in their child's care," McClary says. "We don't want the mom and dad to be the only ones providing care, without support."

So far, families of children with complex medical needs have embraced the care coordination program, she notes.

"They feel that they are getting good response from our care coordination team when an issue arises," she says. "We are discussing extending the model to other complex populations within our health plan, but this has not been implemented yet." ■

EXECUTIVE SUMMARY

A national nursing shortage has affected families of medically complex children in Delaware, leading a Medicaid managed care organization to focus on a care coordination team approach.

- Care coordination teams consist of a nurse care coordinator and a social worker.
- The team meets with patients and families and works to prevent private-duty nursing care gaps.
- When problems occur, the team quickly resolves them.

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Focus on Patients' Strengths as Injury Recovery and Prevention Strategy

Frailty increases chances of poor outcomes

Case managers working with workers' compensation clients or managing a population of older adult patients should keep in mind that strength is important for positive health outcomes.

"Strength is so important to maintaining health," says **Michelle Despres**, PT, CEAS II, vice president and national product leader at One Call Care Management in Jacksonville, FL. Despres has spoken about workplace trends at national conferences, including the 2018 Case Management Society of America (CMSA) national conference.

Don't Waste the Muscles

Data from the U.S. Bureau of Labor Statistics show that the percentage of the U.S. workforce that is age 55 and older has increased from 12% in 1990 to 19% in 2010 and is projected to reach 25% in 2020. Older workers injured on the job are slower to heal and out of work longer than younger workers with an injury, Despres notes.

"Our muscles waste away as a byproduct of age," she says. "Strength is a key component of our health, and it [muscle deterioration] cannot only be stopped with strengthening, but it can be reversed with strengthening."

Strengthening is more than exercise. It involves specific actions to improve strength and muscle mass, including slow eccentric exercises and then rapid concentric exercises, she explains.

When someone is injured, case managers should be proactive and ensure patients are seen by physicians and physical therapists very quickly. This is especially true for older workers, who have double the median number of lost work days post-injury as younger workers, she says.

> WHEN SOMEONE IS INJURED, CASE MANAGERS SHOULD BE PROACTIVE AND ENSURE PATIENTS ARE SEEN BY PHYSICIANS AND PHYSICAL THERAPISTS VERY QUICKLY.

"The more quickly someone gets in and gets moving, the better the outcomes," Despres says.

Another key to moving injured workers back to their jobs is to find out exactly what it was that they did in their day-to-day work. "Get their job descriptions, something that functionally describes the work," she says.

A generalized job description, such as one that says "must be good at customer service or be timely," does not tell a physical therapist or doctor what the expectations are for that injured worker, Despres adds.

Knowing the worker's job also can help explain and prevent injuries. For example, Despres worked with one injured loading dock worker who hurt his knee at work. When Despres asked him how he was injured, he replied that he jumped off the loading dock four times an hour.

She checked out his workplace and discovered he was accurate about jumping off the loading dock, but that there also were stairs he could have used.

"Sometimes, it just takes common sense," she says. "There are situations like that where people don't understand their job requirements, and they have some choice in the way they work."

Part of the injured worker's return-to-work plan involved always using the stairs and protecting his knee through proper work movement.

"Case managers can provide physical therapists with the job demands at the time of the worker's injury," Despres says.

Changes in Vision, Functioning Are Issues

When therapists and case managers lack important information about the injured worker's job habits and roles, someone needs to call the employer and ask for details.

"Ask how the injury occurred, and if it's something simple like the worker jumping off the loading dock, then it helps us understand," she says. "With our aging workers we need to be cognizant of all the other things involved, which could include arthritis that is exacerbated by work."

Medications and falls, a common injury type in older populations, also could be factors, she adds.

Despres lists the following points to consider in older workers and aging populations:

• **Vision changes and aging joints.** "If someone is sitting at a desk, using bifocals, the person might adjust the desk so the monitor and bifocals line up, or else the person's head would be tipped to the ceiling," Despres says. "Ergonomic changes can be helpful. One simple one is that if the bifocal is on the bottom, move the monitor down."

Older workers also are at greater risk of osteoporosis, which increases their fracture risk, and of arthritis.

• **Hydration.** "As we get older, hydration is an issue," she says. "People working in warm environments or warehouses that are not environmentally controlled, or when they wear respirators that can be hot, they might experience dizziness."

As people age, their vascular system also ages, causing blood pressure to rise and creating a less effective oxygen exchange and cardiovascular system, Despres notes.

Case managers working with employers can help them anticipate and prevent this issue by making sure workers are staying hydrated during hot and humid work conditions, she adds.

• **Adjust productivity.** Older workers might struggle with keeping up with productivity demands, so it might be best to adjust productivity requirements to prevent injuries, she says.

"Case managers can recognize patterns of injury," Despres notes. "They might say, 'You know, I'm seeing people over age 50 coming in with wrist injuries, so is there some way we can adjust their jobs?'"

Aging workers have a lot of experience and a good work ethic, so they are valuable as employees, despite a possibly slower pace, Despres says.

"Older employees might have the best ideas of how to do a job, and they might know how to alter tools or use a great technique," she adds. "You can learn a lot from aging employees."

• **Functional capacity evaluations.** This test can be peformed for anyone returning to work. It also can help case managers and employers determine what functions an employee can safely perform.

It is a four- to six-hour test that matches employees to suitable work based on how well they can perform activities like kneeling, squatting, reaching, and other physical actions, Despres says.

"If someone is injured and can't do the same job anymore, then you can match the person to another job, vocational rehab, or reassignment," she explains.

• **Work conditioning.** Work conditioning programs can get injured workers back to their jobs.

For example, a worker will see the physical therapist to treat a knee injury. The therapist will help the person work on strength and motion in the muscles surrounding the knee.

"Maybe the knee improves and the strength looks good, but the person doesn't have the ability to sustain work functions for eight to 10 hours a day," Despres says. "So the person will go to training that is tailored to him, including aerobic conditioning, functioning proficiency, and others."

A case manager discusses the injured worker's treatment plan with therapists and others involved in the patient's care. Sometimes, the case manager accompanies the patient to therapy or the doctor's appointment.

"The case manager finds out if there's a barrier to the person getting well and then comes up with a plan for that," Despres says.

• **Obesity.** Case managers working with employee populations, as well as other populations, must be aware of how obesity can affect health and recovery.

Obese workers have more musculoskeletal injuries, more claims requiring physical therapy, and have higher rates of claims, she says.

"Body mechanics is a big issue when someone becomes obese," Despres says. "We teach people to hold the load close, but someone who is obese has a mass in front of them and is carrying boxes 10 to 15 inches away from them." ■

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Better Management of Patients With Psychiatric Needs

With limited care options, patients with psychiatric emergencies often present to the nearest ED where they may wait for hours, if not days, for some sort of disposition. The ED may get backed up as beds become scarce, wait times will increase, and all involved will be left frustrated and resigned that this scenario will repeat.

It is happening in every region of the country. The call for solutions could not be more deafening as frontline providers struggle to manage a patient population that many providers misunderstand and some even fear.

That is why Boston-based Institute for Healthcare Improvement (IHI) has teamed up with Well Being Trust, a national organization focused on advancing mental, social, and spiritual health, to identify better approaches to the care of patients with behavioral health concerns in the emergency setting. IHI leaders established ED & UP, a learning community in which nine hospitals are working with expert faculty to test new ideas. Their goal is to better equip EDs and their community partners to meet the needs of patients with mental health concerns while also improving outcomes for patients and families.

Consider Costs, Impact

In an online presentation, IHI leaders recently discussed what they have learned thus far from the project. Leaders included steps that administrators can take now to improve the way their facilities manage patients who present with psychological problems.

Scott Zeller, MD, the vice president of acute psychiatry at Vituity, is one of the faculty members working with ED & UP to formulate and test improvements. He noted that the dearth of mental health resources is contributing to the problem. "Even if [patients with psychiatric needs] are fortunate enough to have a psychiatrist or a clinician that they work with, they might call them up when they are having a difficult time and hear a voicemail that says 'If you are having a psychiatric emergency, please hang up and dial 911, or go to your nearest ED,'" he explained.

> "BOARDING IN AND OF ITSELF CAN LAST A LONG, LONG TIME. IT USUALLY AVERAGES BETWEEN EIGHT AND 34 HOURS FOR SOMEONE WHO IS BOARDING IN A REGULAR ED."

However, Zeller noted that the nearest ED often is ill-equipped to work with such patients. These patients wait three times longer to be seen than patients with traditional medical concerns. "The staff in the ED spends tons of time trying to help these folks out and get them the kind of treatment and dispositions they need. This interferes with their ability to care for other ED patients," he said.

It also is important to consider financial implications. Psychiatric patients in the ED can cost hospitals more than $100 per hour in lost billing. The overall costs to the hospital are even greater, Zeller noted. "Each time a hospital boards a patient ... if you put everything together, [it costs] about $2,300," he explained.

While the expense is high, the effect on a psychiatric patient who is boarded is far from optimal. Typically, such patients are just waiting for either a psychiatric evaluation or a psychiatric disposition, Zeller said. "Sometimes, these folks are [stationed] with a sitter in very close confines. Sometimes, they are strapped to a gurney in a hallway. Sometimes, they are in restraints. Many times, this is all going on without any kind of intervention or treatment," he observed. "It can be very disruptive and very unpleasant for people having a psychiatric crisis. Sometimes, as a result, their symptoms get worse."

Unfortunately, more of these types of patients are coming to the ED. Zeller noted that there has been a 55% increase in psychiatric patients visiting EDs in the past decade. In the same period, there has been a 414% increase in patients arriving for suicidal ideation.

"Boarding in and of itself can last a long, long time. It usually averages between eight and 34 hours for someone who is boarding in a regular ED. Sometimes, it can last for days and even weeks," Zeller said.

Employ Training, Innovations

What is the solution to such bottlenecks? There have been numerous calls in recent years for more inpatient psychiatric beds. However, Zeller argued that would be an unusual approach, as it would not be the default option for any other medical condition.

"If you come in with chest pain, high blood pressure, or an asthma attack, we are going to address that in the ED. We are going to find out what is going on, start treatment, and hopefully stabilize you in the ED and get you back home," he said.

"But for some reason, in far too many EDs, the default treatment — if a person is having psychiatric symptoms — is to find him a psychiatric bed."

Hospitalization for every patient with psychiatric symptoms is not a workable or affordable option, Zeller lamented.

"Even if we had tons of psychiatric hospital beds, we would use them all up if we were doing that," he explained. "If you are at a place where the default treatment is hospitalization ... I can guarantee you that those psychiatric hospitals are having a lot of unreimbursed one- to two-day admissions where the insurers are coming back from Medicare and Medicaid saying that these persons didn't really need to be hospitalized."

Further, Zeller added that such a policy is disruptive for the patient and bad for the ED.

"It is just not a good situation for anybody," he said.

Rather than looking for places to send all patients who present with psychiatric concerns, a better approach is to address the issues in the ED just like emergency personnel address most other medical problems, Zeller argued.

"What we found in our research is that the great majority of psychiatric emergencies can be stabilized in less than 24 hours in an emergency level of care," he explained.

In fact, Zeller noted there are simple steps that EDs can take almost immediately to improve management of these patients. For instance, he recommended better training for emergency staff in behavioral health best practices so that personnel understand that psychiatric emergencies are, in fact, medical emergencies.

"These are people who are experiencing painful conditions that need our assistance," he said. "If we can intervene appropriately, we are going to have phenomenal improvement and great outcomes."

Zeller added that one focus of this training should be on eliminating the idea that people with psychiatric emergencies need to be treated in a coercive way, either with restraints or forced medication.

"Those things really draw out and create a lot of the boarding," he said. "Once you put someone in restraints, or you have involuntarily medicated them, it is a lot more unlikely that your exit resources — psychiatric facilities — are going to be interested in taking them."

Another innovation that can help EDs accelerate appropriate treatment to patients with psychiatric concerns is on-demand telepsychiatry, which has been initiated in many areas, Zeller noted.

"There is nowhere near enough psychiatrists to drive over to your site. We may be able to have psychiatrists come and see your patient almost immediately over high-definition video conferencing," he said, noting there have been some good outcomes reported from such interventions.

Busier EDs that see four or more psychiatric patients a day might want to consider creating an emergency psychiatric assessment, treatment, and healing unit (also known as an emPATH unit), Zeller suggested.

"It is basically a separate section of the ED, or an adjacent section ... that is just for emergency psychiatric patients who otherwise might have been boarding in the ED," Zeller explained. "It is a much more home-like, supportive setting with experienced psychiatric personnel to work with these folks for up to 24 hours."

Instead of gurneys, patients sit in recliners. Patients can move about in an emPATH unit freely, Zeller explained.

"We are seeing amazing results with these units, not the least of which is that physical restraints and involuntary meds occur in less than 1% of patients," he added.

Address Upstream Levers

Initiative leaders understand that improvements in the care of patients with mental health concerns require work in the ED, explained **Mara Laderman**, MSPH, a director at IHI and the content lead for the organization's work in behavioral health. But, she added, leaders also know that improvements are needed in some of the levers upstream that are driving patients to the ED.

"We have developed a change package that is focused on the theory that we will have greater impact by intervening at multiple points ... than we can in working on isolated parts of the system," she shared.

Robin Henderson, PsyD, the clinical liaison to Well Being Trust and the chief executive of behavioral health for Providence Medical Group in Portland, OR, noted that emergency personnel typically respond quite differently to psychiatric trauma than physical trauma.

"Normally, when we are looking at someone coming in to the ED with a minor trauma like a broken arm or a broken finger, we will take them back and let them stay in their own clothes. We may let them have a family member with them. They keep things like their cellphone and their wedding ring," she explained. "But when we have someone coming in and they are hearing voices, or they may be actively psychotic, we will take those things that are a comfort to them ... we don't understand the unintended consequences of our best intentions."

Sometimes, such practices stem from an unfortunate event in the past that resulted in serious consequences, Henderson explained. For example, she recalled working in one ED that was the site of a suicide four years earlier. "They created an entire series of activities for every psychiatric patient who presented based on that one aberrant event," she said. "It changed their entire culture."

Henderson explained this kind of thinking and practice stems from a hospital culture where everybody is always looking to fix defects. For example, instead of acknowledging that a practice is working well 97% of the time, hospital staff will focus on the tiny percentage of times things did not go well, she observed.

"When we apply that same thinking to a trauma-informed culture, what we create are environments that are very based on fear, the false evidence that appears to be real as opposed to basic facts," Henderson offered. "And 97% of the time, when a psychiatric patient presents to an ED, there won't be violence, there won't be harm to staff, and there won't be a self-harm incident. Yet, we have created cultures, processes, and policies around the 3% of the time that [something bad will happen]."

To address this disconnect, Henderson advised ED leaders to review their policies to see what can be done to ensure that they are based on what actually happens in the ED with psychiatric patients as opposed to what might happen. She also suggested clinicians re-evaluate their own perspectives. For example, instead of wondering what is wrong with a patient, think in terms of what happened to the patient or what matters to the patient, she said. These changes regarding thoughts, questions, and attitudes are the building blocks of a trauma-informed culture within an ED, Henderson added.

Facilitate Access to Expertise

Vera Feuer, MD, the director of pediatric emergency psychiatry and behavioral health urgent care at Cohen Children's Medical Center in New Hyde Park, NY, one of the participating hospitals in the ED & UP program, noted that on average, U.S. children are hospitalized more frequently for psychiatric issues than for medical problems.

"In most of the country, kids get seen either by adult emergency medicine providers or psychiatrists. Only a few places have pediatric psychiatric expertise present," she explained.

This frequently results in adult-level concerns about safety, which leads to overuse of inpatient resources. Another problem, according to Feuer, is that kids are sent to EDs often purely because there is no outpatient alternative available. "Let's say a child draws a picture of a person hanging from a tree [at school], and nobody is sure what that means. The child might end up in the ED for a suicide assessment. [He or she] might be right next to a child who is there for a very different and much more serious reason," Feuer explained. "In pediatrics, in many ways, the solution ... is providing access to expertise quickly in an ambulatory setting for those kids who don't necessarily need the ED, but require an assessment."

To address this problem, Cohen Children's Medical Center is developing an urgent care program that is staffed by a child psychiatrist.

"It allows immediate access to expertise that is often needed when schools or therapists have concerns about kids, and [those kids] need to see a physician," Feuer said. "It helps to avoid revisits to the ED. If there are issues that come up for the kids that we see in the ED, we have them come to urgent care for follow-up. If they are not in care and need the transitional space, it can also help avoid an inpatient stay or serve as an alternative."

As part of the ED & UP collaborative, Feuer explained that the hospital is working to better educate patients, families, and hospital staff on how to manage things like agitation and other psychiatric issues while minimizing the use of coercion and medication. Also, Cohen Children's Medical Center is collaborating with primary care physicians, schools, and community partners to establish streamlined referrals and provide more overall wraparound care for families. ■

Texas-sized Mumps Outbreak Includes Nine HCWs

Investigation and follow-up is labor-intensive

A large outbreak of mumps last year in Texas included nine healthcare workers, many of whom were apparently infected in the community.

The outbreak was very disruptive, as healthcare workers with no proof of immunity had to be furloughed, and one occupational case was acquired by a phlebotomist.

"This was a nurse who was born before 1957, but had no documented immunity," said **Thi Dang**, MPH, CHES, CIC, a state health investigator who worked to educate workers and prevent mumps spread in healthcare facilities. "She collected specimens from suspected cases and did not consistently wear a mask."

The 2016-2017 mumps outbreak in Texas was the largest in 20 years, Dang recently reported in Minneapolis at the annual conference of the Association for Professionals in Infection Control and Epidemiology (APIC).

"We had nine mumps cases who worked in healthcare, including in acute care, a community clinic, EMS/fire, a skilled nursing facility, and a state-supported living center," Dang said. "The point is that even if you don't have cases in your hospital, they could be coming in from the community because your staff live in the community."

From 2011 to 2015, annual mumps cases in the state ranged from 13 to 68 people. Dang usually only sees nine mumps cases annually in the large rural public health district she covers.

"From October 2016 to May 2017 in Texas, we had 490 cases with 12 outbreaks," she said. "In our region, we had 387 cases with seven outbreaks."

In her health district, the situation became like "outbreaks within outbreaks." For example, the phlebotomist who acquired mumps in a hospital exposed 34 patients before the diagnosis was made, she said.

"We monitored those 34 patients, and two of them went into long-term care, so we monitored them there as well," she said.

A childhood disease now largely eliminated through vaccination, mumps can result in outbreaks in susceptible populations much as is seen with measles. With both viruses, clinicians who rarely see a case may miss the diagnosis, compounding subsequent follow-up of exposures. Mumps is a paramyxovirus that usually causes parotitis, the classic swelling in the salivary glands. It also can present with a low-grade fever, malaise, and headache.

"It spreads through mucous or droplets from an infected person, usually through a cough or a sneeze," Dang said. "The incubation period for mumps is anywhere between 12 and 25 days. However, we typically see signs around 16 to 18 days following an exposure."

Within the wide variety of healthcare facilities in her health district, Dang said many staff knew little about mumps, and proof of immunity often was lacking. During the outbreak, mumps education signs and procedure masks were placed at entrances and in waiting areas.

"The staff at these facilities were educated on the signs and symptoms of mumps and how to properly mask patients," she said. "We made sure they were separating people with potential mumps from the rest of the population in a waiting area or in the actual hospital."

Anyone in the community diagnosed with mumps was excluded from work or school until five days after onset of parotitis. "It was really difficult to get immunization history for these patients, for children as well as adults," Dang said.

The mumps message was somewhat complicated by flu season, which calls for respiratory etiquette to prevent spread in waiting areas and within facilities.

"It was difficult to get people focused on looking for parotitis and to still emphasize and follow respiratory etiquette," she said. "They had to tie in the [saliva] swabbing with the rest of the regular respiratory precautions that people were looking for. That was actually a big learning curve."

Much like community members, healthcare workers with active mumps were excluded from work until five days after onset of parotitis.

"Every facility I talked to, I asked them to check for documented immunity [of staff]," she said. "Documentation was two doses of MMR [measles, mumps, and rubella vaccine], physician documentation of disease, or positive titers. Birth before 1957 was not accepted as evidence of immunity."

Healthcare workers with documented immunity — even if they did not wear a mask and were exposed to a mumps case — were not recommended for exclusion from work, she said. ■

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CE QUESTIONS

1. **Which of the following are barriers to a patient's social connections?**
   a. Behavioral and physical health issues
   b. Disabilities and lack of reliable transportation
   c. Moving away from families and home communities
   d. All of the above

2. **Which are barriers to older patients achieving social connection through social technology?**
   a. Technology is designed solely for young people.
   b. Technology can be too expensive and difficult to learn.
   c. Social technology can accentuate their isolation.
   d. None of the above

3. **What was a major problem for medically complex children and families that a care coordination team at Highmark Health Options worked to resolve?**
   a. Private-duty nurses sometimes failed to show up for their shifts in the families' homes.
   b. The children were continually rehospitalized.
   c. Families had difficulty learning how to use the complex medical equipment.
   d. People failed to have the children vaccinated, and some died as a result.

4. **Which of the following is vital to maintaining health, especially as people age, according to Michelle Despres, PT, CEAS II?**
   a. Owning pets
   b. Running marathons or half-marathons
   c. Working at manual labor jobs
   d. Maintaining strength and preventing muscle wasting

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.