CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

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Program for Navajo Diabetes Population Uses Case Management Techniques

Program stresses cultural care

A health center that works with a Navajo population in Arizona faced challenges in improving care for people who struggle to overcome cultural and economic barriers to care. The center's solution combines case management with cultural integration in medical care.

Chinle Comprehensive Health Care Facility in Chinle, AZ, started a program to provide quality, low-cost healthcare to diabetes patients. This population includes people who lack basic living standards, such as clean water and electricity.

> "IF A PATIENT DOESN'T FEEL COMFORTABLE BECAUSE OF CULTURAL BELIEFS, THEN WE FIND A WAY TO GET THE PATIENT THE BEST CARE AND INTEGRATE WESTERN CULTURE ALONG WITH NAVAJO CULTURE."

"That's where the Navajo Baa Hózhó Program came from," says **Ruth Finley**, RN, BSN, outpatient department nurse improvement specialist at Chinle Comprehensive Health Care. Each patient receives a Baa Hózhó card with a phone number that patients can call weekdays from 7 a.m. to 6 p.m.

After implementing the program, the Chinle area's ED visits per 100 adult patients began to decline from a peak rate of 60 per 100 patients per year in December 2015 to a rate of about 35 per 100 patients per year in August 2017, according to the health center's internal data.

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"We wanted to work with high-risk, high-cost patients and mainly try to keep them out of the emergency room," Finley says. "Many of our patients use the ER if they have something wrong. They don't see primary care providers."

Patients sometimes live in the mountains without electricity or running water, Finley says. "There are grandmas and grandpas who are herding sheep," she says. "They heat their homes with wood."

Most families will take care of their elders, but a few people do not have anyone helping them, she adds. "Transportation is a huge issue because of the remoteness and not having reliable services," Finley says. "We don't have paved roads everywhere, and we have a food desert here."

The nearest Walmart is more than an hour away. Junk food is readily available, but produce is expensive. It is difficult to convince diabetic patients to not eat high-calorie, cheap food that lacks nutritional value, she adds.

It also is difficult to find nurses to work in such a remote area. This is why the health center employs health coaches, including people who are part of the Navajo community. The health center also has hired diabetic health coaches; now, these coaches are part of the Baa Hózhó program.

"Baa Hózhó is a Navajo term that means 'happy' or 'balance,'" says **Krista Haven**, MSN, RN, CDE, diabetes nurse improvement specialist at Chinle Service Unit Diabetes Program and diabetes case manager at Navajo Baa Hózhó Program.

The program is a patient-centered care plan. This means that if the Navajo patients need help that is outside of Western medicine, they receive it. *(See story on how program works, page 135.)*

"If a patient doesn't feel comfortable because of cultural beliefs, then we find a way to get the patient the best care and integrate Western culture along with Navajo culture," Haven says. "We have Navajo medicine in the clinic, including Navajo medicine men, who do prayers, chants, and ceremonies."

For example, if a patient presents to the ED because of a snake bite, the ED staff will treat the injury and hold a ceremony for the patient. They also will cleanse the ED by burning sage to clear the room of negativity, Haven says. "The perspective that patients have is different from Western thinking, and you have to allow for cultural

EXECUTIVE SUMMARY

An Arizona health center that works with a Navajo population started a diabetes case management program to help patients stay out of the ED and hospital.

- It is called the Navajo Baa Hózhó Program, Navajo words that mean "happy" and "balanced."
- Many patients are low income and live in remote areas where they lack running water and electricity.
- The program includes Navajo medicine men who can perform ceremonies related to patients' medical treatment.

barriers and consideration if you are giving care to patients," she adds.

Cultural considerations are important to many patients. One success story involved a patient with a necrotic foot. Doctors told him that it needed to be amputated. The patient refused the surgery when he learned that he would not be allowed to take the amputated limb home to bury, per his cultural/spiritual tradition, Finley recalls.

"Our case manager and health coach got on the phone with him and talked about how this is a life-threatening situation," she adds. "They worked it out that he could be transferred back to Chinle to have the operation, and he was able to go home and do his ceremony to bury the amputated foot. He's been doing wonderful since then."

In the Navajo culture, healthcare professionals also must be sensitive to how they give information to patients, Haven says. "I wouldn't go into a room after a Navajo patient's A1c results are back and tell her, 'I'm sorry, ma'am, you have diabetes,'" Haven says. "That would be taboo because you just cursed the person."

Instead, healthcare professionals should present the results in a third-person narrative format, like telling a story. "Say, 'Sorry, we were able to read your blood results, and some of the readings were high. Some people we know, who had high readings, were able to start on medication. Would you also like to have that medication?'" Haven explains. "Or say, 'We worked with someone else who had high sugars like you do, and they had a diagnosis of diabetes, and we gave them a medication to bring down their sugars. Can we do for you what we did for them?'"

The patient might ask to go home and think about it. Sometimes, they will return and say their aunt or grandmother told them to not take the medication. The care provider will say, "Can you bring them in so we can talk with them?" she adds.

"Sometimes it takes several visits to be able to give the patient that diagnosis, and sometimes they just take a long time to think about it," Haven says. "You have to explain what you're doing because they think about every aspect of the disease."

Health coaches also help with the language barrier. All of them speak Navajo. "When sitting and talking with patients, we have them speak Navajo," Finley says. "About 25% of our population lists English as a second language." Patients often do not understand what their doctor tells them, so the health coach can sit with a patient after the doctor's visit and explain what was said.

Since health coaches live in the Chinle community, they also provide consistency in patients' healthcare experience. This builds trust, Finley notes. "Our providers come here for three to four years, and then leave," she says. "Our population does not trust the health system."

Now that patients can call their health coach and the health coach stays long-term, there is more stability and trust, she adds. ■

Navajo Case Management Program Combines Cultural, Patient-Centered Care

Focus is on patients with diabetes

The best way to improve the health of high-risk patients might require case management that is sensitive to the population's particular cultural, religious, and socioeconomic needs.

Chinle Comprehensive Health Care Facility in Chinle, AZ, created a program that employs culturally sensitive care management staff. Health coaches meet with patients to help them make their first doctor appointments and to navigate them through the healthcare system, says **Ruth Finley**, RN, BSN, outpatient department nurse improvement specialist at Chinle Comprehensive Health Care.

As part of the Navajo Baa Hózhó program, health coaches visit patients at home, as needed. They also might speak fluent Navajo, says **Krista Haven**, MSN, RN, CDE, diabetes nurse improvement specialist at Chinle Service Unit Diabetes Program and diabetes case manager at Navajo Baa Hózhó Program.

Finley and Haven explain how the program works:

• **Enroll patients.** Providers refer patients to the Navajo Baa Hózhó program. The healthcare facility uses a screening tool. "Care managers get information from the electronic health record [EHR], and they also interview the patient and family," Finley says.

The risk screening tool is from the Northern Arizona Healthcare system, she notes. "The health system gave us this tool because we reached out

to them, asking what we could do to help with transitions from hospital to home and then to the primary care clinic," she explains. "They had this screening tool, which is based on the BOOST tool, and we adopted it for our population."

Project Better Outcomes by Optimizing Safe Transitions (BOOST) uses the 8 Ps:

- Problems with medications;
- Psychological;
- Principal diagnosis;
- Physical limitations;
- Poor health literacy;
- Patient support;
- Prior hospitalization;
- Palliative care.

(For more information on Project BOOST, visit: http://bit.ly/32Uwe56.)

• **Assess patient.** Case managers meet with the patient and perform the first assessment, Finley says.

Case managers also use the Patient Activation Measure (PAM) and the EuroQol tool to assess functional status and to see how patients feel about their own health.

The EuroQol Group, in 1987, developed a standardized non-disease-specific instrument that is used to measure health-related quality of life. *(Read more at: www.euroqol.org.)*

PAM was first described in a study published in 2004. PAM is used to measure how actively patients are participating and engaged in their own healthcare. *(More information is available at: http://bit.ly/2EUBuLT.)*

PAM was developed in four stages:

- Stage 1: Conceptually defining activation, using a literature review and consultation with experts and focus groups;
- Stage 2: Generating, refining, and testing a large item pool, building on the domains identified in stage 1;
- Stage 3: Extending the measure's range as needed and testing whether the measure could be used with respondents without chronic illness;
- Stage 4: Using a national probability sample to assess the performance of the measure across different subsamples in the population.

"These tools help with determining patients' functional status and determining how people feel about their health," Finley says.

> "IT'S EQUITABLE CARE, BUT WE CANNOT GIVE THE SAME CARE TO EVERYONE AND HAVE IT BE THE BEST CARE FOR EVERYONE."

Patients review PAM statements and check the boxes of how strongly they agree or disagree with the statement. Sample PAM statements include:

- I am the person responsible for taking care of my health;
- I can tell my doctor about my worries, even when he or she does not ask;
- I understand my health problems and what causes them;
- I can figure out ways to fix new problems with my health.

PAM is a 100-point scale, which makes it easy to compare a patient's status from week to week. "We look back and say, 'You were a 70 last week; why do you feel your health has gone down?'" Finley says. "With PAM, patients sit and complete it themselves. It's more of self-assessment."

• **Set SMART goals.** "We have patients set a SMART goal," Haven says.

SMART stands for Specific, Measurable, Achievable, Relevant, and Timebound. *(Information on SMART is available at: http://bit.ly/34bMejp.)*

This approach works better than the traditional strategy of giving patients orders and expecting them to follow these without any consideration for the patient's ability to understand, cultural issues, and motivational level.

"SMART goals are more collaborative than dictating orders to a patient," Haven says. "This is how we get a patient on board and write a care plan that is based on the patient's needs and wants."

For instance, if a patient wants to make a doctor's appointment, then case managers ask the patient to write down this goal. If the patient has heart failure concerns, he or she is asked to check weight at the same time each day, she explains.

"Then, we ask them, 'Do you have a scale?' And if they don't have one, we ask them and a family member, 'Do you have a way to get a scale?' If there is no way for them to purchase a scale, we help them get one," Haven says.

Health coaches help patients make their appointments and serve as assistants to case managers, Finley says.

Based on patients' PAM and EuroQol scores, the team helps them set SMART goals. These are target behaviors and changes set at each visit.

"They say, 'I want to try to walk more,'" Finley says. "We set a goal for the next two weeks, saying, 'I'll walk two minutes a day.'" The goals are written down, and the health coach calls patients to check on their progress.

• **Embrace cultural awareness.** The Navajo Baa Hózhó program strives for balance in patients' medical care and lives.

"Everything about the culture is balance, and there's a kinship way of life," Haven says. "If you have something wrong physically, it might be related to your eating too much or not exercising. Everything has a balance."

Patients might wonder what they did to cause their illness. A balanced healthcare culture will offer patient populations the opportunity to engage in culturally appropriate activities that enhance health, such as huge community walks and marathons, she adds.

The program has a diabetes grief group for patients who have undergone amputations because of their high glucose levels.

Case managers and health coaches spend a lot of time with patients who experience substance use, psychological, and family/social issues that make their diabetes diagnosis especially difficult, Haven says. "We spend a lot of time with those patients, offering them our resources and outside resources, as well," she says.

Nearly one-third of the population served in the diabetes program do not have running water or electricity. Some patients have to go to a community house to fill water jugs for bathing and to water their animals, Haven explains.

Case managers ask patients if they have electricity because they are supposed to keep their insulin cool. When Haven asked one woman this question, she replied that she keeps her insulin in a box that she buries in the ground to keep it cool.

"When we give Baa Hózhó care, we don't give it equally," she says. "It's equitable care, but we cannot give the same care to everyone and have it be the best care for everyone."

The goal is for case managers and health coaches to get to know their patients, understand their needs, and tailor care based on each patient's needs and wants, she adds. ■

Connected Care Management Model Helps Rehab Patients

Care transition coordinators help patients

A connected care management program for stroke and other inpatient rehabilitation patients could work for all at-risk patients as they transition from inpatient acute care to rehabilitation care, home health, and the community.

"The care transitions program is designed for any patient leaving the inpatient setting and transitioning home to home health and hospice," says **Kristi Wimberly**, PT, director of care transitions at Encompass Health, Home Health & Hospice in Dallas. "We have certain things we do for more complex transitions. Our gold standard is bedside transitional care assessment."

Many patients who have suffered a stroke and need rehabilitation to learn to walk, talk, swallow, and take care of their activities of daily living (ADLs) will stay in inpatient rehabilitation hospitals.

Inpatient rehab provides a high level of medical oversight with three hours of therapy, five days a week, and meeting with a rehabilitation physician at least three times a week, says **Elissa Charbonneau**, DO, MS, chief medical officer at Encompass Health in Birmingham, AL.

"In 2016, the American Heart Association and the American Stroke Association published revised guidelines that said people who had a stroke are best served in inpatient rehabilitation hospitals rather than skilled nursing facilities," Charbonneau says. "The guidance added to our commitment for patients who have had a stroke."

Once patients have received comprehensive inpatient rehab services, they usually will need some follow-up care in the community. Encompass Health works with home health and hospice providers, including the company's own, to help provide warm hand-offs and smooth care transitions to the community. "We're in a unique position to collaborate and work together to make sure patients are followed throughout the care continuum," Charbonneau says.

"It's very exciting for case managers because they're very important, and this is an area where doing good case management to keep patients out of the hospital is extremely rewarding," she adds. "They can't do it alone; it takes a team, and everyone needs to be committed to it."

The first step is to evaluate

patients to ensure they are placed in the right setting for post-acute care, Charbonneau says.

"We have clinical transition coordinators who follow patients once they come into the inpatient rehab hospital, and they are the primary communication persons once patients are discharged to the home health side," she explains. "This is helpful because the coordinators are integrated into the weekly team conferences we hold for all patients."

The inpatient rehab team conferences discuss patients' progress in reaching discharge goals. Attending these meetings helps transition coordinators learn what is needed to ensure a safe and seamless discharge.

"They can arrange to have a nurse come out on the day of discharge to assess patients and make sure they are OK and understand the medicine," Charbonneau says. "It's a continuum of care, rather than the patient leaves one place and there's no [provider] communication, which is when people fall through the cracks."

At the first meeting with patients, the care transition coordinator will say "I'm a nurse, a care transition coordinator, and I'm here to assist with your transition to care," Wimberly says.

"Everything we find goes into our medical record so operational and clinical partners can see what we've learned during that transitional visit," she explains. "They can anticipate barriers and be prepared for high-risk patients."

In addition to care coordination notes, there is a clinical snapshot attached to patients' medical records. Clinicians must review it before seeing the medical records, Wimberly notes.

"It has information about caregivers and diet. If the patient is a stroke patient, there are swallowing precautions, a note on whether a swallow study was completed, communication about language barriers, transfer techniques, precautions they might be under, and anticoagulation medication following a stroke," she explains.

The goal is to complete a care visit within 24 hours of discharge and to provide follow-up for 48 hours, ensuring everything has gone smoothly with the transition, Wimberly says.

"If the start of care is delayed, or if there is a very high-risk transition with potential barriers, we may be involved a little bit longer," she adds.

The home health program includes care transition coordinators — nurses and therapists housed in the inpatient facility. Care transition coordinators collaborate with all providers to gain the most accurate picture of patients' progression toward goals and to assess patients prior to discharge, Wimberly says.

"All transitions happen at the discharging facility, which collaborates with the care team to get the most accurate picture and an assessment of patients prior to discharge," she says. "We review the medical record clearly, speaking to the care team and working with a multidisciplinary team of pharmacists, respiratory therapy, a wound nurse, depending on what that patient needs."

Risk stratification helps the team identify high-risk patients and potential barriers, including psychosocial and environmental factors, Wimberly says. *(See story on risk stratification, page 139.)*

"If we identify potential barriers, we work with case managers and social workers prior to discharge," Wimberly says. "We make recommendations on our end when we identify risk factors, and we have a social worker added to the care plan." If patients need transportation or Meals on Wheels, the case management team makes it happen.

Care transition coordinators work with patients and their families to review the medical record and start preliminary medication reconciliation, looking for errors and changes made to patients' home medication regimen, she adds.

"We make sure patients understand the medications they are taking and any changes made to their prescriptions," Wimberly says. "When we find medication errors, like something that wasn't discontinued but should have been prescribed for only the hospital stay, we address those prior to discharge."

Care transition coordinators also help patients address care barriers, such as transportation to the pharmacy, financial burdens, cognition problems, and visual impairments.

"All of these things play into a patient's ability to adhere to the medication regimen," Wimberly says. "We also collaborate with the patient and specialist to make sure all follow-up appointments are scheduled."

Coordinators send discharge summaries to community providers prior to the first visit. They work to connect patients to their doctor within three to five days after discharge. Prior to the care transition program, patients might not have seen their provider for four to six weeks, due to scheduling obstacles, she adds.

"We let doctors know the patient was hospitalized and has a high risk for readmission, and we are able to get the patient scheduled for a visit a little quicker," Wimberly says.

Coordinators can use checklists to help with handoffs. For instance, when patients are discharged with

heart failure or a deep wound, case managers will need to go a little deeper into the transition to ensure they do not experience recurring medical emergencies. "We can do a complex checklist," Wimberly says. "Sometimes, it requires a live handoff, where we pick up the phone and give reports."

Case managers ensure the patient's plan of care will continue during the transition and that community providers receive all discharge summaries, medication lists, and medical records, she adds. "We work with community physicians to make sure we have everything in place to deliver care in the home setting," she says.

Encompass Health's focus on care management is designed to produce the best outcomes for stroke patients and other patients, Charbonneau says. "This model helps patients reach their maximum potential," Charbonneau says. "We make sure they have appointments, transportation, and all of those case management-related things that help them carry over to the next place." ■

Health System's Risk Analytics Find Patients in Most Need

Risk tool prevents readmissions

Artificial intelligence and case management can help patients stay out of the hospital. An inpatient rehabilitation hospital system uses risk stratification data from electronic health records (EHRs) to identify patients with declining health who might need to be sent to an acute care hospital.

The data also can help organizations target resources to cases where case management and care transition services provide the most efficient and cost-effect benefits.

"An exciting thing we are doing on the inpatient side is the predictive analytical model," says **Elissa Charbonneau**, DO, MS, chief medical officer at Encompass Health in Birmingham, AL, which provides inpatient rehabilitation care, home health, and hospice services.

The model uses an algorithm in an EHR. It ranks patients according to their risk and need to be transferred to an acute care hospital, she says. "There is an alert on the electronic health record, and we're now piloting a similar program for patients after they leave our hospital," Charbonneau adds. "We can assess their risk after they are home."

The risk stratification tool, named ReACT (Readmissions Acute Care Transfer) is used by all Encompass Health hospitals, says **Dina Walker**, RN, MSN, ACM, RN-BC, national director of case management, Encompass Health in Birmingham, AL. The purpose of the tool is for the hospital to react to changes in patients' conditions as timely as possible.

"We're trying to track and determine abnormal medical signs and symptoms, suggesting the patient is getting worse in some way," Walker explains. "It helps us assess the patient and intervene before the patient has to go back to the acute care hospital."

The algorithm checks for changes in various clinical areas, including:

- Vital signs;
- Appetite;
- Skin condition;
- Ability to participate in therapy;
- Fatigue.

A change for the worse in any of the metrics that ReACT monitors would suggest the hospital needs to thoroughly assess the patient and see what might be going wrong, Walker says.

Encompass Health can collect cutting-edge patient data because the health system is large and has been collecting EHR metrics for about nine years, Charbonneau says.

"We want the model to predict — not just for inpatients, but also look at after they are discharged, so we can look at what makes them a higher risk," Charbonneau adds.

The data might point to a patient who needs help accessing medication or whose lab work indicates a higher risk. "Maybe the patient is not eating well or is missing therapy," Charbonneau says. "Those are statistically significant predictors that [suggest they might end up] back in the hospital."

Risk stratification tools can be embedded in health records, looking for trends continuously. "The algorithm runs in the background of the electronic health record," Charbonneau explains. "Doctors and nurses can see the information as it happens. They can see when a patient's risk goes from low to high or from high to very high."

These changes will trigger an alert message to the doctor and nurse, telling them the patient's risk has

increased, she says. "It gives us the ability to stratify patients according to their risk of going back to an acute care hospital," she adds. "They are labeled as low, high, or very high risk, using the colors green, yellow, and red."

Encompass Health plans to expand the tool and use it in the outpatient setting, Charbonneau adds. "There will be different data points, but we've come up with an algorithm to look at these patients as they leave the hospital, and we're currently piloting it," she says.

The new algorithm is called Readmission Prediction Model. Its purpose is to determine the probability that a patient will be readmitted to an acute care hospital after he or she is discharged from the inpatient rehabilitation hospital, Walker says.

This tool examines a variety of metrics, including:

- Combination of diagnoses, including cardiac arrhythmia and heart failure;
- Use of diuretics;
- Blood glucose treatment;
- Lab results;
- Signs of infection;
- Changes in vital signs over three days;
- Therapist assessments;
- Decline in appetite;
- Skin condition changes.

"It tells us the probability of someone being readmitted to the hospital," Walker says. "We can foresee something happening down the road and implement an intervention to address it."

Case managers could contribute to the risk stratification data by adding information about patients' social determinants of health, including their access to nutritious food, transportation, community resources, and healthcare facilities near their homes, she explains.

"Case managers are learning to assess the things the predictive algorithm hasn't learned yet," Walker says. "We're hoping documentation by case managers for those other types of things will inform the algorithm, so we'll have a complete picture of the patient's readmission risk." ■

Hospital Improves Acute Care for Elders With Dedicated Unit

A Massachusetts-based health system is reporting positive results from an initiative designed to improve care for geriatric patients and increase the use of advance care planning.

Baystate Health's Acute Care for Elders (ACE) model of care is a designated unit that includes staff trained on mobility, rationalizing, medication, early discharge planning, and early recognition and treatment of dementia, according to **Maura J. Brennan**, MD, division chief for geriatrics and palliative care with Baystate Health.

The ACE model of care first emerged in the 1990s.[1] As defined by the author of one study, an ACE unit "includes principles of a prepared environment that encourages safe patient self-care, a set of clinical guidelines for bedside care by nurses and other health professionals to prevent patient disability and restore self-care lost by the acute illness, and planning for transitions of care and medical care. By applying a structured process, an interdisciplinary team completes a geriatric assessment, follows clinical guidelines, and initiates plans for care transitions in concert with the patient and family."[2]

ACE is a medical acute care unit. There are not different levels of service; beds and services are billed as acute care. End-of-life beds on the unit are not hospice beds; rather, they are used for patients who are expected to die before discharge who were previously scattered over the hospital.

The Baystate Health ACE program began when Brennan was conducting grand rounds and reviewed a paper on the success of such programs. The vice chair of medicine asked why Baystate was not running such a program if they were so successful.

Brennan received enthusiastic support from the hospital's quality department, which recruited and trained a team. Quality improvement staff also provided "basic quality 101 training" to Brennan's entire division, she says.

"Everyone from the secretarial staff up to me learned what a run chart and a PDSA cycle are," Brennan says. "We began a pilot on a medical unit where we used typical ACE criteria on about eight patients. A member of our group was from decision support and finance. He became very enthusiastic about participating in meaningful change rather than just crunching numbers somewhere."

Initial funding for the program included some modest support from a Health Resources & Services Administration grant, philanthropy, the hospital, and the medical practices group. (Today, the program largely is baked into operations.)

Over 18 months, the hospital studied length of stay, costs, use of restraints, falls, and other criteria, showing enough improvement to win the hospital president's annual safety award. That led to enough support that the pilot project was expanded to become a full ACE unit, despite budgetary restraints. The unit includes 34 beds, with additional space dedicated to patients at the end of life.

One of the biggest challenges is to keep patients mobile, Brennan says. The staff tried walking patients regularly, but Brennan found the staff members were too busy with their primary duties to regularly mobilize patients. Volunteers helped walk patients until leaders became concerned that home care and post-acute rehab services were affected by patients not moving around enough while in the hospital.

"That prompted a hospitalwide interest in improving mobilization. That allowed us to get approval for patient mobility technicians," Brennan explains. "We're now tracking and recording distances in ways that we hadn't before. It seems like mobility shouldn't be so challenging but it was one of the toughest nuts to crack." Part of the impetus for improving mobility hospitalwide was that Baystate is an accountable care organization and shares the risk of post-acute costs. That makes it easier to address issues that affect more than one silo in the hospital, Brennan explains.

After the first year, ACE unit patients' length of stay was almost one full day shorter than other patients, and there were measurable gains in patient safety. Complication and delirium rates decreased by 30% to 50%, and falls were reduced by 50%.

Use of restraints was virtually eliminated, and 17% more patients returned home rather than discharging to another facility. More than 500 medication changes resulted from the ACE team's recommendations. Approximately 60 nurses and 50 physicians were trained in the ACE program.[3] The ACE unit also leads other departments in patient satisfaction scores.

A team approach is necessary to see good results from the ACE unit, Brennan says. However, one should not assume everyone's idea of teamwork is the same.

"We talk about teamwork a lot in healthcare but I think it's not always seen the same way as we see it in geriatrics. You might have a physician who thinks teamwork is the doctor making the calls and everyone else doing as he says," Brennan says. "Truly grasping teamwork and building processes in which everyone is equally valued and can see their successes is important."

Hospital quality leaders interested in establishing an ACE unit should remember that it requires a genuine interdisciplinary approach. Care is provided in a less hierarchical way, with a focus on the need to treat basic geriatric and palliative care needs while also addressing medical concerns. "It's a classic quality improvement win because it is an example of eliminating the quality waste," Brennan says. "If you get rid of the unnecessary drugs, eliminate falls and restraints, you're improving the care of the patient, and you're also going to save money. You can do better by doing the right thing, which was surprising to a number of people who thought this was going to be more expensive." ■

REFERENCES

1. Palmer RM, Landefeld CS, Kresevic D, Kowal J. A medical unit for the acute care of the elderly. *J Am Geriatr Soc* 1994;42:545-552.
2. Palmer RM. The acute care for elders unit model of care. *Geriatrics* (Basel) 2018;3. pii: E59. doi: 10.3390/geriatrics3030059.
3. Baystate Health. Acute Care for Elders (ACE) unit & program. Available at: http://bit.ly/2lwmbT2. Accessed Nov. 5, 2019.

Nurse Suicides Finally Coming to Light

Overcoming the historic dearth of data on a critical issue, the authors of a new study reported that nurses are at higher risk of suicide than the general population.

Researchers reported[1] that female nurse suicide rates in the United States were significantly higher than for women in general, with a rate of 11.9 per 100,000 nurses, compared to 7.5 suicides per 100,000 women in the population. Male nurse suicides are even higher, with a rate of 39.8 per 100,000, compared to 28.2 per 100,000 men in general, says lead author **Judy E. Davidson**, DNP, RN, FCCM, FAAN, nurse scientist at University of California, San Diego (UCSD).

"We had a series of [nurse] suicides here in San Diego that piqued my interest in the topic," she explains. "I went to the literature and found out there was nothing. The data I could find about nurses in the U.S. were over 20 years old. But all of that old data were speaking to the point that nurses were probably at higher risk. For some reason, we had just let this research question go silent."

The ongoing research is difficult due to the lack of a national database that links cause of death by occupation and gender. Davidson is working with the National Council of State Boards of Nursing to collect as much detail as possible to continue her research.

"If I had my druthers and a magic wand, I would ask each state to report gender with their licensure workforce data at the end of every year," she says. "Every state reports how many actively licensed [nurses] they have every year. If we had the gender data to go with it, we could do a much better job."

The findings already have resulted in significant national action, with the American Nurses Association (ANA) forming a task force to specifically look at nurse suicide. Davidson was in discussions with ANA leadership on preventing nurse suicide when nurse members brought up that issue for discussion at the group's annual conference in April.

"They have asked us to collaborate with them on a task force that [started] in the fall to look at suicide prevention in nursing," she says.

When asked for comment, the ANA sent the following statement: "Whether it's due to demanding shift work or the stress associated with providing care on the frontlines of nearly every clinical setting, we know that depression and anxiety are common complaints among nurses," the ANA stated. "UCSD researchers' investigation of nurse suicide provides much needed and timely insights into this critical issue."

Physician suicide has been studied closer, and it is estimated that as many as 400 doctors commit suicide annually, she reports. However, the current incidence of nurse suicide in the United States has been largely undocumented, a situation Davidson first addressed in a pilot study.[2] In a recently published follow-up paper, the researchers drew data for 2014 nurse suicides from the CDC's National Violent Death Reporting System (NVDRS). The data set included all suicides reported by medical examiners from 18 states for that year. There were 14,774 suicides in the 18 states, including 205 nurses, the researchers found.

Davidson and colleagues confirmed that their pilot study data suggested nurses are at risk for suicide and experience higher rates than the general public. A larger NVDRS data analysis that will include 40 states is underway.

"We are fairly confident that what we are seeing is real," she says. "We are finishing up a longitudinal analysis. The data should be released soon — 12 years of CDC data from 2005 to 2016."

HEAR Suicide Prevention

Originally formed to address physician suicide risk, the UCSD Healer Education Assessment and Referral (HEAR) program has been expanded to include nurses.[3] The program should be considered nationally by other institutions, she says. The program includes proactive measures like contacting clinicians to offer voluntary mental health screening.

"They can remain completely anonymous through this encrypted system that is managed through the American Foundation for Suicide Prevention," Davidson says. "We found that usually only people who are moderate to high risk answer the survey. They know they have a problem and have been waiting for someone to reach out."

Counseling is available by phone without providing identification. Referrals can be made to counseling outside the geographic area to avoid recognition by colleagues or friends.

"We have had no physician suicides since that program was put in place, and we have had hundreds of clinicians accept referrals for the mental health that they needed," she says. "Three years ago, we started this same program for nurses. We just extended the program and tested it, and lo and behold, we are having the same results."

The chief of nursing sends a letter asking nurses to undergo the screening as a matter of self-care. The healthcare system employs two full-time counselors in the HEAR program.

"This year, we had 40 nurses accept referrals for mental health treatment that had expressed suicidality," Davidson said. "In the meantime, the therapists don't drop them in a hole — they don't say, 'Your appointment is in six weeks.' They continue counseling them until they go to their appointment, which is the beauty of the program."

It was the recognition and response to physician suicide risk that ultimately opened the door for nursing, she adds. "It's because of physician suicide [awareness] that here at UCSD we were able to develop the first nurse suicide prevention program in the country," Davidson said.

The suicide data reveal that nurses are more likely than the general public to have sought mental health treatment.

"They are seeking treatment, but it may be inadequate if their depression was so bad that it led to suicide," she says. "It may be undertreatment, intermittent treatment, or not the right treatment. In any case, they have had more mental health access than the general population and they still completed suicide. That is a problem

that needs investigation before more nurses die."

The key difference in the HEAR program may be that someone is reaching out to the nurses and offering counseling, she adds. "We nurses are stoic as people. 'Buck up and take it; the work is hard,' is the way we have always been trained," she says. "[We are] getting past that, changing the culture and getting nurses to reach out and get the treatment that they need when they really need it. This proactive approach is working, and our culture here is shifting."

Crisis Debriefings

The hospital also offers "crisis debriefings" that may include group therapy with a clinical team that has been emotionally affected by a disturbing event. "It helps them process their feelings and emotions on what it was like to have a patient die, hit us, or throw things at us," she says.

Such interventions are common in some other professions, but nurses traditionally have been expected to weather a crisis in the name of patient safety. "Why haven't we done this all along? We are exposed to negativity all the time," Davidson says. "The horrific things you witness, the connections to people who die."

Even with a system designed to ensure anonymity, it is difficult for some nurses feeling suicidal to come forward. To self-medicate, they may develop substance abuse disorders with alcohol or drugs.

"They felt the stigma against mental health treatment was too great, and they didn't get the help they needed psychologically," Davidson says. "They turned to drugs or alcohol for their existential pain and suffering. It may be work issues or home issues, and it gets out of hand. They never get the help they need. They try to hide it, but eventually it creeps into their work and they are found out, or they get a DUI."

Once these work or legal consequences arise, a nurse's license to practice may be in jeopardy. "My personal recommendation is that we need to do more about making the nursing response to nurse substance-use disorder nonpunitive," she says. "We need to develop systems like the physicians have in place to caringly refer affected nurses into treatment, without losing their license, so that they can come back into the workforce once they are rehabilitated. Substance use disorder is a disease, and needs to be treated like one."

Lethal Knowledge

In the 2014 CDC data, pharmacologic poisoning was the most common method of suicide among nurses. However, nurses were more likely to use drugs at home than divert them from work to commit suicide.

"That signals to me — and we won't know until we analyze the data from the longitudinal study — that the reason is usually not about access to drugs at work," she says. "Instead, it may be because of an understanding of how to kill yourself with drugs. It's the knowledge of how to use drugs in a lethal manner."

The suicide prevention project reveals that nurse-reported stressors are roughly equal between work and home. "But the stressors from work are all modifiable," she says. "Things like orienting your staff completely and thoroughly, making sure they feel welcome in the environment, and not alone when they move from another state or another organization. Loneliness and feeling separated are big risks."

Nurse bullying, which has almost been viewed as a rite of passage in a culture that "eats its young," can inflict psychological harm. "That can lead to depression, and depression can lead to suicide," she says. "We need to actively address the bullying in our environment. Some of the bullying is from work compression. If people feel like rats in a cage, spinning the wheel and getting nowhere, they will act like rats in a cage."

Other modifiable factors in healthcare include reactionary rules and policies that were enacted in haste but become entrenched. Some practices that began with a single physician preference, warning from the health department, or a warning from an accreditation agency are never revisited, becoming sacred cows that add layers of unnecessary work.

"On any given day, we are overregulated as a profession, with policies and rules that don't have evidence behind them," she said. "Doing that hard work of stripping out these [unneeded] policies is a suicide prevention technique." ■

REFERENCES

1. Davidson JE, Proudfoot J, Zisook S, et al. Nurse suicide in the United States: Analysis of the Center for Disease Control 2014 National Violent Death Reporting System dataset. *Arch Psych Nurs* 2019. doi: https://doi.org/10.1016/j.apnu.2019.04.006.
2. Davidson J, Mendis J, Stuck AR. Nurse Suicide: Breaking the Silence. National Academy of Medicine. Discussion Paper. Jan. 8, 2018. Available at: https://bit.ly/2FyMCvX.
3. UC San Diego Health Sciences. Healer Education Assessment and Referral (HEAR) Program. Available at: https://bit.ly/2U8GEu7.

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CE QUESTIONS

1. **A Chinle, AZ, health center that provides diabetes case management to a Navajo population has to consider two important barriers to care — economic and:**

   a. nutritional.
   b. mental health.
   c. cultural.
   d. substance abuse.

2. **SMART goals are:**

   a. structured, measurable, abstract, ready, timely.
   b. specific, measurable, achievable, relevant, timebound.
   c. subjective, maintenance, attainable, trustworthy.
   d. stable, must-do, acceptable, total.

3. **Which is one of the 8 Ps of Project BOOST?**

   a. Patient support
   b. Principles
   c. Physical therapy support
   d. Problem-solving

4. **Encompass Health uses a risk stratification tool to predict which patients are at highest risk of hospitalization. Which is a metric collected and analyzed by the tool?**

   a. Physician's name
   b. Patient's family status
   c. Decline in appetite
   d. Spiritual practice

CE OBJECTIVES

After completing this activity, participants will be able to:

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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.