CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

SEPTEMBER 2020 Vol. 31, No. 9; p. 97-108

Coordinating Care for Patients with Dementia Challenges Case Managers

Proportion of people with dementia on rise

As the population ages, case managers sometimes find their patients with chronic illnesses, like diabetes and heart failure, show signs of dementia.

The proportion of Americans with Alzheimer's disease and related dementias is expected to grow from 1.6% of the U.S. population in 2014 to 3.3% of the population in 2060. *(Find out more at: https://bit.ly/2DgyT0O.)*

Case managers might see patients who have not been diagnosed with dementia forget their medications, or not eating, exercising, or sleeping well. Their family caregivers might say the patient is driving them crazy, but cannot explain any recent behavioral changes.

"You can almost diagnose dementia by the anger in the family and the spouse," says **Toni P. Miles**, MD, PhD, professor of epidemiology at the University of Georgia College of Public Health.

> "FROM A CASE MANAGEMENT PERSPECTIVE, THERE IS A LOT THAT GOES INTO CARE FOR PERSONS WITH DEMENTIA AND THEIR CAREGIVERS."

Since dementia is common, particularly in areas with many retirees, case management teams should include a member with dementia training and expertise, she suggests.

Patients' families often miss the signs of dementia. Case managers and providers also might miss the signs. "Usually, dementia is a problem

Financial Disclosure: Author **Melinda Young**, Editor **Jill Drachenberg**, Editor **Jonathan Springston,** Editorial Group Manager **Leslie Coplin,** Nurse Planner **Toni Cesta**, PhD, RN, FAAN, and Accreditations Director **Amy Johnson,** MSN, RN, CPN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

CASE MANAGEMENT ADVISOR™

***Case Management Advisor™*,**
ISSN 1053-5500, is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Case Management Advisor*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.

GST Registration Number: R128870672.

POSTMASTER: Send address changes to:
Case Management Advisor
Relias LLC
1010 Sync St., Ste. 100,
Morrisville, NC 27560-5468

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

ACCREDITATION: Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers.

TARGET AUDIENCE: This educational activity is intended for nurses and nurse practitioners who work in case management environments.

This activity is valid 36 months from the date of publication.

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

AUTHOR: Melinda Young
EDITOR: Jill Drachenberg
EDITOR: Jonathan Springston
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS DIRECTOR: Amy M. Johnson, MSN, RN, CPN

with older adults. We're used to depending on these people for their wisdom and finances, and these are critical people in their social circles and families," Miles says. "The hardest part is just seeing it."

Once they recognize the patient might have dementia, there are actions they can take. "What makes families and providers angry is they assume the patient's noncompliance is willful, and it's not," she explains. "The person just can't get their act together."

Primary care providers (PCPs) also might miss opportunities to screen for dementia. "Some primary care providers do not want to entertain a diagnosis of dementia because they feel like there's not anything they can do about it, and not everybody who acts crazy has dementia," she adds.

Screen Patients for Dementia

It is important for patients with signs of cognitive impairment to be evaluated for dementia and their ability to manage their own health needs, says **Stephanie Hughes**, MPP, public health researcher with RTI International in Chicago.

"Research suggests that people with dementia who receive care coordination may experience improved quality of life and benefit from increased connection to community-based supports and services," Hughes explains. "Their caregivers may also experience decreases in depression and feelings of stress or burden."

Clinicians should try to identify the cause of cognitive issues. Case managers can collect information from adult day center staff to identify causes other than Alzheimer's disease. What appears to be dementia could be a side effect from medication or the result of poor sleep habits or sleep apnea, Miles says.

"Dementia can be caused by things, or it can be its own primary problem," she adds.

PCPs struggle with how to start a conversation around dementia, says **Tina Sadarangani**, PhD, ANP-BC, GNP-BC, assistant professor at New York University Rory Meyers College of Nursing.

"From a case management perspective, there is a lot that goes into care for persons with dementia and their caregivers," she explains. It is helpful for case managers to facilitate these discussions with PCPs and families.

EXECUTIVE SUMMARY

Case managers will see more patients with chronic illnesses along with signs of dementia.

- Family caregivers might be unaware of the early signs of dementia. They may be angry at the patient's noncompliance.
- Case managers can work with adult day care facilities to help patients with dementia and comorbidities adhere to their medication and treatment regimens.
- One technique to employ is a feedback loop between case managers, primary care providers, patients and caregivers, and community-based organizations that see these patients.

Also, the staff of adult day care centers, which provide Medicaid services, know which patients show signs of dementia — even when it is undiagnosed, Sadarangani says.

"Maybe a person at the care center will say, 'I do art with Mr. X every day. He's very agitated, and that's not normal for him,' while a primary care provider who sees the person every six months might say, 'He seems normal to me,'" Sadarangani explains.

Adult day center staff have excellent observational and functional assessment skills, she adds. *(See story in this issue on how case managers can work with adult day care centers to help dementia patients.)*

"The analogy is the school teacher: If you have a child with developmental disabilities or behavioral issues, the teacher has a lot of information on the student, how he or she interacts with other people, and the student's academic performance," Sadarangani explains.

Case managers might ask the adult care center staff about any concerns or issues they suspect. They also should keep in mind that undiagnosed dementia could be a factor in the patient's difficulty in staying healthy.

"If you have someone you're seeing who is not taking care of their diabetes or wound and are not managing very well, you have to think about it," Miles says. "They know what to do, but can't get their act together and get it done."

The goal of case management is to care for the whole person to identify and overcome their obstacles to staying well and avoiding hospitalizations and emergency department (ED) visits.

"This is why we have case managers and why we've evolved in medicine to have medication reconciliation and all of these support services," Miles notes.

The challenge is how to pay for population healthcare coordination. "We still need to learn more about the impact of care coordination healthcare utilization and costs," Hughes says. "There are so many variables involved in care coordination, including characteristics of the patient and of the healthcare system, frequency of contact, and details of how coordination is delivered."

One technique — with negligible cost — is for case managers and caregivers to work together to assist with care management, Hughes says.

"People with cognitive impairment often need this support," she adds. "Informal caregivers may also be assessed for unmet needs."

Also, case managers should keep in mind that people with dementia tend to benefit from more frequent contacts and in-person interactions with a care coordinator. "This may require smaller caseloads than with clients who have other conditions," Hughes adds.

When there are problems with patients' adherence to treatment regimens, case managers could suggest a dementia screening test. Case managers can help families and other providers see the patient's dementia as a factor in their health management.

"Just because a person has a diagnosis of mild-to-moderate dementia doesn't mean they can't engage in advance care planning and making decisions for themselves," Miles says. "But, if you don't see it, you can't plan for it."

People with mild-to-moderate dementia should not be infantilized. They can participate in decisions, but some of those decisions should be made soon, through advance care planning, before they progress to advanced dementia.

Case managers will need to discuss potential changes. For instance, they need to consider how to modify the patient's home environment or anticipate a move to a long-term care setting.

"Maybe the time to move is before they no longer can navigate those stairs," Miles says. "Ask yourself, 'What is happening that will change the way that person is able to care for themselves and others in their household?'"

While it sounds simple, it is a difficult concept, emotionally, for families and patients. "There's a whole recognition that you are not going to be the person you thought you were, and a lot of people are not going to accept that," Miles explains.

Case managers also need intimate knowledge of the individuals, their social history, and their likes and dislikes. A patient with dementia might have worked as a physician before he was ill, and it would help for the people working with him to say, "Hello, Dr. Smith," Sadarangani says.

The case manager is the ideal person to facilitate the feedback loop between healthcare providers and caregivers, she adds.

Case managers can identify resources available to patients with dementia and partner with informal caregivers involved in their care, including staff at adult day centers. "They can help create meaning for patients with dementia," Sadarangani says. "A lot of experts in dementia care say we see dementia incorrectly as a death sentence. It needs to be framed as a positive journey that can provide fun and meaning if done correctly."

The challenge for case managers is to provide meaning and resources that mitigate caregiver strain and leverage the capacity and strength of available community-based organization resources, she says. ■

Community-Based Organizations Help with Care Coordination for Patients with Dementia

Key is a feedback loop with primary care, too

Older adults with chronic conditions, often including dementia, sometimes receive services from adult day programs that are funded through Medicaid. These might include services from nurses, social workers, and therapists.

"This is a complex, ethnically diverse population with high levels of functional decline and who might have multiple chronic conditions, including 30% with dementia," explains **Tina Sadarangani**, PhD, ANP-BC, GNP-BC, assistant professor at New York University Rory Meyers College of Nursing. "What I, as a researcher, truly believe is that for dementia care and for those with chronic conditions of any kind, we need to reimagine what we think of as a care continuum."

When most people think of the care continuum, they might imagine it as from the hospital to skilled nursing facilities (SNFs) to home, maybe with a primary care provider (PCP) visit here and there. But that is not all, and case managers can use many more resources than those.

"I believe the continuum of care is much broader than that, even within the community," Sadarangani says. "A majority of Americans wish to age in place at their homes in their community. When you go to the doctor's office and you go to the pharmacy to pick up your medication, that is a care transition."

Adult day programs also are part of the care continuum. They offer resources that could give case managers detailed information about how patients function in their daily lives. "They have a tremendous amount of observations on functional assessment," Sadarangani says.

Start the Conversation

The New York University Center for the Study of Asian American Health (CSAAH) has worked to culturally adapt the Kickstart-Assess-Evaluate-Refer (KAER) framework created by the Gerontological Society of America:

- Kickstart a conversation about cognition;
- Assess for cognitive impairment;
- Evaluate for dementia;
- Refer for community resources.[1]

CSAAH adapted KAER to support earlier detection of dementia in Asian American communities. As researchers worked on the framework, they partnered with three senior centers and adult day service centers that serve the Asian American community.[1]

"The idea is to get improved access to care and health outcomes where there may be high levels of limited English proficiency, low income, etc.," Sadarangani says.

Researchers studied how community-based organizations (CBOs) and providers could work collaboratively to improve care for patients with dementia, using the framework, she explains.

"We found out that the conversation around dementia starts in the community-based setting," Sadarangani says. "We found if you want to improve care for Asian American communities, the framework needs to be used by both the CBO and the primary care provider."

Create a Feedback Loop

Case managers, CBOs, PCPs, and caregivers need to work together to create comprehensive standards of care.

A good way to coordinate care for patients is through a continuous feedback loop between case management, PCPs, and patients/caregivers. "If there was a better feedback loop, couldn't we deliver a much higher standard of care for these populations?" Sadarangani asks.

PCPs might not know where they could refer patients with dementia for better coordinated care, particularly when patients are from minority communities, she notes. With a feedback loop, case managers can fill in the gaps.

"Perhaps care can start around dementia care, kickstart that in the community setting, and then send it to the primary care provider for proper evaluation and diagnostic testing," Sadarangani explains. "Then, the primary care provider can refer patients back to the community center as a resource."

The community center/adult day center can provide breakfast and help patients with medication, as well as provide art therapy and other services that keep older patients independent longer. The services also help prevent burnout in caregivers.

The value of this community

resource was never more apparent than when COVID-19 hit. In New York state, the pandemic forced adult care centers to close — some permanently. Others transferred staff to SNFs, and some provided remote services by calling their former patients, Sadarangani says.

"In the wake of a pandemic for which there seems to be no end in sight, these community-based organizations are contending with a number of challenges," she says. "This should not diminish the work they do. Instead, it should highlight how valuable they are and the key role they play in management and care of persons with dementia."

Some centers reported an increase in falls, hospitalizations, and emergency department visits in patients who do not have day center care. Some of their family members talked about precipitous cognitive decline, she adds.

"We talk with centers about when they'll reopen, and some say, 'I don't know if some of these people, who have deteriorated so much, could come back,'" Sadarangani says.

Anecdotally, Sadarangani has learned nurse case managers now realize how valuable these programs are for their patients. Some case management programs have paid to keep the day program staff involved with their former in-person patients by phone.

"They gave responsibility for case management to the nurses and social workers at the center because they knew so much more about the patient's family life and meal access. They know which services they would benefit from," she explains.

The KAER framework is helpful to show what this population needs. But it also must to be strengthened to achieve comprehensive case management through more emphasis on integrating care for persons with dementia, Sadarangani says.

Including adult day care centers in the care continuum makes a great deal of sense because the populations they serve include older people with chronic illnesses, frailty, and dementia.

"Maybe 30 years ago, these centers had a lot of well seniors and featured dancing and dominoes, but now most of their participants should be in a nursing home," Sadarangani says.

The closing of adult day care programs during the pandemic has created a big gap in services, she adds. Some of these programs have reopened at least partially. Even with marginal community spread of COVID-19, the benefits of these programs might outweigh the risks — at least for some patients and families, she notes.

"For persons living with dementia, their social needs and psychosocial needs are just as important as their medical needs," Sadarangani says. "That is the challenge of using case management in a primary care provider office, where the focus is on medical care. For case managers who are involved with these patients, what they need is to be able to excel at integrating care." ■

REFERENCE

1. Sadarangani TR, Salcedo V, Chodosh J, et al. Redefining the care continuum to create a pipeline to dementia care for minority populations. *J Prim Care Comm Health* 2020;11:2150132720921680.

Add More Screening Tools to Case Management Toolbox

Stick to evidence-based measures

Case managers need better tools more than ever before to manage patients in this era of population health and an all-inclusive continuum of care.

"Case management as a practice has evolved to acknowledge and recognize that it's not just episodic and doesn't have recognition of only one disease state with blinders on," says **Ellen Aliberti**, MS, CCM, RN, clinical educator at Intermountain Healthcare — Nevada Market in Las Vegas. Aliberti also is the director of the Case Management Society of America (CMSA) of Las Vegas. "It has potential solutions and strategies to manage populations of health across many continuums of care and with key focuses on helping patients be self-reliant. Case management has always had advocacy at its roots, but case management now lives in a much broader focus."

Case managers need tremendous tools to help them manage care of chronically ill patients along the continuum, she notes. It is important that case managers use evidence-based tools in their practice,

outcomes, and decisions, Aliberti suggests.

"That's a huge thing for all of us case managers to really be serious about because we're probably not doing as good a job as we could as far as educating ourselves about evidence-based criteria and screening tools to help us make better decisions for our patients," she says.

Here are Aliberti's suggestions for which evidence-based tools to use and how to find new ones:

• Utilization management decision tools. "When case managers are working within settings where they have to make determinations about whether a patient can stay someplace or the level of care they need, then they should ask the facility for the criteria it uses and copy it," Aliberti says. "We're entitled to have that as case managers, but how many people ask about that?"

Also, case managers should obtain the criteria that payers use and compare that to the criteria used by the setting, she adds.

There are commercial utilization management screening tools as well, such as InterQual. (https://bit.ly/30UzLAy) Another screening tool is the Milliman Care Guidelines. (www.careguidelines.com)

• Seek guidelines from national associations. National websites for the American Diabetes Association, the American Health Association, and others include guidelines for screening and working with patients with these diseases.

For example, the American Diabetes Association (ADA) posted a Type 2 diabetes risk test on its website at: https://bit.ly/3fuRbsI. The organization also offers a diabetes self-management education and support consensus report for adults with Type 2 diabetes. That 2020 evidence-based report is an update of the 2015 joint position statement, found at: https://bit.ly/3398ixY.

The ADA calls this method diabetes self-management, education, and support services, or DSMES. The report describes positive outcomes when DSMES is used. For example, one key clinical benefit is a reduction in hemoglobin A1c and a reduction in the onset and/or worsening of diabetes-related complications.[1]

Keeping up with guidelines and consensus papers is important for case managers and prevents them from becoming stale in their knowledge of evidence-based information, Aliberti says. Payers use evidence-based criteria to make decisions about authorizations for treatment. Case managers should be able to point to information that supports their requests for patients.

"You also need to be mindful of national screenings you can use to benefit your patients," Aliberti says.

• Use PAM and health literacy screening tools. The Patient Activation Measure (PAM) is a valid and reliable scale that reflects the four stages of activation:

- Believing the patient role is important;
- Possessing the knowledge and confidence to take action;
- Taking action to maintain and improve one's health;
- Staying the course under stress.

(For more information, visit: http://bit.ly/2EUBuLT.)

CMSA's 2020 Case Management Adherence Guidelines (CMAG) highlight PAM in a section on engagement. *(For more information, see the article in the May 2020 issue of* Case Management Advisor *at: https://bit.ly/339Au3M.)*

"PAM is something CMSA has helped us learn about and encouraged us to use with our patients," Aliberti says.

Another important tool can screen patients for health literacy. The Rapid Estimate of Adult Literacy in Medicine is a word recognition test that quickly provides clinicians with an assessment of a patient's health literacy. *(Find out more at: https://bit.ly/3118xYV.)* Understanding a patient's health literacy can help

case managers identify adherence challenges, Aliberti notes.

• **Screen for depression and anxiety.** The nine questions in the Patient Health Questionnaire-9 (PHQ-9) can screen patients for depression, anxiety, and severity. *(More information is available at: https://bit.ly/30XmvLu.)*

For instance, the first question is "Little interest or pleasure in doing things?" The choices are as follows:

- Not at all, which has a zero score;
- Several days — 1;
- More than half the days — 2;
- Nearly every day — 3.

"PHQ-9 is a great tool for depression and anxiety, which are understated in the populations we serve," Aliberti says.

Case managers also should ask about loneliness, which always is a risk for older patients, but might be more pronounced during the pandemic and social distancing practices, she adds.

• **Assessing fall risk.** The Timed Up and Go test is a fall risk assessment tool. Patients sit in a chair, walk to a line on the floor, and then return to the chair. They are timed with a stopwatch. *(A demonstration can be viewed at: https://bit.ly/338HNbC.)*

There are other screening tools that case managers can use as well. For instance, some healthcare organizations use their own checklists for assessing patients' social determinants of health.

Case management assessments must be robust and include details such as patients' physical limitations, behavioral health issues, and social determinants of health. "We now know that all of these social determinants of health are influencing our patients' willingness, ability, and desire to be engaged with their health or not," she adds.

When deciding which screening tools to use, case managers should base their choices on their patient population and whether the tools are evidence-based.

"Look at what are the tools we need to be aware of and incorporate into our practice to evaluate our patients' willingness and ability to engage in care," Aliberti says. "A majority of patients are being cared for in outpatient settings, and the focus is on self-reliance. Case management has opened our ability to influence in a number of different spheres." ■

REFERENCE

1. Powers MA, Bardley JK, Cypress M, et al. Diabetes self-management education and support in adults with Type 2 diabetes: A consensus report of the American Diabetes Association, the Association of Diabetes Care & Education Specialists, the Academy of Nutrition and Dietetics, the American Academy of Family Physicians, the American Academy of PAs, the American Association of Nurse Practitioners, and the American Pharmacists Association. *Diabetes Care* 2020;43:1636-1649.

Nurses Call for OSHA Regulation as Pandemic Takes Bitter Toll

Hundreds of healthcare workers dead in CDC 'underestimate'

The continuing onslaught of COVID-19 is decimating the ranks of U.S. healthcare workers, leading to calls for the Occupational Safety and Health Administration (OSHA) to issue an infectious disease standard requiring employers to protect medical staff.

OSHA had an infectious disease standard in the legislative pipeline, but it fell into political limbo after the 2016 presidential election led to a new antiregulatory environment. The recently proposed Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act (H.R. 6800) would require OSHA to issue an emergency temporary standard to protect workers in hospitals, meatpacking plants, retail stores, and other workplaces during the pandemic. Although stuck in the Senate, the proposed law also would prohibit employers from retaliating against workers for sounding the alarm about unsafe conditions.

"There is no question that an OSHA infectious disease standard would prevent illnesses and deaths among healthcare workers," says **David Michaels**, PhD, a professor of environmental and occupational health at George Washington University. "For the sake of the thousands of healthcare workers not yet sickened by COVID-19, I hope that Congress can overcome this shortsighted opposition and pass this important legislation."

Michaels served as OSHA director during both terms of the Obama administration, shepherding the

infectious disease standard and other regulations forward. Hospital groups have opposed OSHA regulations as burdensome, and the agency itself has said in recent congressional testimony that it currently has sufficient regulatory authority under its general duty clause to protect healthcare workers from COVID-19.

"The at least 400 deaths among nursing home and hospital workers are proof that just recommendations are not enough," Michaels says. "We have to do better than that. To hear hospital administrators say we don't need this standard is unfortunate and tragic."

As originally proposed, the standard would include a Worker Infection Control Plan (WICP). Employers would have been required to create a WICP for those at risk of occupational exposures to infectious diseases during patient care and other duties. In a provision that seems particularly germane to the situation, the standard called for worker protections to be reviewed and updated to meet the threat of new and emerging infectious diseases.

As of Aug. 4, the Centers for Disease Control and Prevention (CDC) reported 123,738 COVID-19 infections in healthcare workers, with 598 deaths. However, the precise count is likely much worse, as the CDC data came from limited reports.[1]

Data were collected from 3,551,226 people, but healthcare personnel status was only available for 776,820, the CDC noted. Of the 123,738 cases, death status was only available for 84,388.[1]

"The CDC reporting is not mandatory. That is really the problem. You are not required to report any of this," says **Deborah Burger**, RN, president of the California Nurses Association and co-president of National Nurses United (NNU). "We are calling for federal OSHA to pass an emergency temporary standard on infectious disease to mandate that our employers give us the highest level of protection."

Burger is not optimistic about their chances. "It's gotten attention, but it has become a political pawn," she laments. "We can't even get a consistent public health message that everyone should be wearing masks. I have been a nurse for over 45 years and I never thought that the federal government would play such a large role in politicizing a public safety issue."

A new regulation likely is a nonstarter politically, but current Principal Deputy Assistant Secretary of Labor for Occupational Safety and Health **Loren Sweatt**, BA, MBA, said the agency can protect workers without creating a new standard.

"While extensive guidance is important as the rapidly changing dynamic of this pandemic continues, it is important to recognize OSHA also has existing standards that serve as the basis for its COVID-19 enforcement," she said at a recent congressional hearing. "Those standards include rules regarding respiratory protection, personal protective equipment [PPE], eye and face protection, sanitation, and hazard communication."

U.S. Rep. **Alma Adams**, D-NC, chair of the House Subcommittee on Workforce Protections, gave a withering assessment of OSHA at the hearing.

"OSHA, the agency that this nation has tasked to protect workers, has been largely invisible," she said. "It has failed to develop the necessary tools it needs to combat this pandemic and it has failed to fully use the tools it has."

In March, OSHA rejected Alma's request for an emergency temporary standard "on the grounds that the healthcare industry fully understands the gravity of the situation and is taking the appropriate steps to protect its workers," Alma said.

Depending on the outcome of this year's election, an infectious disease standard could be back on the table. California's state regulation on infectious diseases might form the basis of an eventual federal standard, Burger says. Creating a standard before the next pandemic hits could prevent worker protections from politicization.

"Healthcare worker safety would be a bit more insulated from the political arena," Burger says. "There is no reason we have to lose doctors, nurses, and other healthcare workers in an infectious disease environment if we are given the proper equipment."

The mixed messages from political and public health officials have given the pandemic response an "Orwellian" tone, she says. "I can't even wrap my mind around how crazy this whole thing is."

Although it has always been the case, the situation has revealed how voluntary guidelines from the CDC can be diluted or simply ignored if there is no regulation behind them.

"It's voluntary — you can follow these, or not," Burger says. "We know that the employers are going to do whatever they can to spend the least amount of money."

The 'Terrible Reality'

There certainly are exceptions to that harsh assessment, but the infections and deaths of healthcare workers on the frontlines are strongly linked to the lack of PPE, particularly N95 respirators, says **Daniel Lucey**, MD, a professor of infectious diseases at Georgetown University.

"Something needs to be done," he says. "The very terrible reality is that the strategic national stockpile did not get replenished with masks and N95 respirators after the influenza pandemic of 2009-2010. Why not?"

Other public health measures took precedent, resulting in insufficient supplies and shifting CDC guidelines, dropping from N95 recommendation to masks, and the widely criticized last resort of "bandanas and scarves."

"The proof is in the numbers — the 84,000 — they didn't have the PPE," he says. "What is the CDC's role? To say it is OK to use something that doesn't protect you — a surgical mask when you need an N95 — simply because we don't have enough N95s? It has really damaged the faith of healthcare workers in the CDC, and there are still shortages now."

After spending decades investigating pandemics and major outbreaks, Lucey's grim take on the healthcare worker toll carries considerable weight.

"It is unlike anything I have ever seen," he says. "It is an astonishing number of infections and deaths. It is going to continue to climb, hopefully not as quickly." The healthcare workers who survived COVID-19 may still have health problems, both physical and mental, in the future, he notes.

The current situation does not bode well for the fall and winter, when there will likely be a "high tide" of COVID-19 cases during seasonal influenza, Lucey says.

"I think it is going to take some authority to make sure that we have enough tests, and it looks like it is not going to be the federal government," he says. "The Trump administration has said it is up to the states."

Healthcare worker flu vaccination also will be critical. Messaging to the public will emphasize the threat of a "double-barreled" viral season in 2020-21, says **William Schaffner**, MD, professor of preventive medicine at Vanderbilt University.

"With flu and COVID — not to mention RSV [respiratory syncytial virus] and all the other viruses — we fear a great surge of patients coming into the healthcare system," Schaffner says. "At the moment, flu vaccine is the best intervention we have — not only to provide individual protection, but to mitigate the impact of a very substantial demand for medical care."

'We Are Expendable'

Will there be enough PPE to face such a surge? A recent NNU national survey of 23,000 nurses found the lack of PPE has become a chronic problem, leading to frequent reuse of equipment that was not designed to be reprocessed. The survey results included responses from union and nonunion nurses in all 50 states polled from April 15 to May 10. Overall, 87% of respondents reported reusing a single-use, disposable respirator or mask with a COVID-19 patient. In addition, 28% of respondents had to reuse "decontaminated" respirators with confirmed COVID-19 patients, a practice equipment manufacturers do not recommend, the NNU reports.[2]

The survey results revealed 27% of nurses providing care to confirmed COVID-19 patients reported they were exposed without appropriate PPE and then worked within the next two weeks. In addition, 84% of respondents had not been tested for the novel coronavirus. Of those nurses who have been tested, more than 500 reported a positive result, and another 500-plus were awaiting results when surveyed.

"How can we protect our patients form COVID-19 if we ourselves do not know whether or not we are positive?" Burger asks. "Nurses are fighting to get tested."

One-third of survey respondents reported having to use their own sick leave, vacation, or paid time off to miss work or quarantine if they acquire or are exposed to COVID-19. The NNU argues illness caused by the novel coronavirus should be presumed to be occupationally acquired and covered by workers' compensation. The nurse union is calling for states to pass bills ensuring nurses are protected with "presumptive eligibility" for COVID-19.

"Our employers won't act to protect us on their own," says **Zenei Cortez**, RN, co-president of the NNU. "They have totally disregarded the health and safety of nurses and the patients we [care for] every day. It was not a secret that a pandemic was coming. Nurses have been standing up and demanding infectious disease protections for years and years, during SARS, Ebola, and MERS."

In addition to an OSHA emergency standard, the NNU is calling for implementation of the federal Defense Production Act to ramp up testing and PPE supplies.

"It's been five months now and we haven't gotten the adequate stores we need to provide care," she says. "We are still in the first wave of this, and we are reopening."

Certainly, some healthcare worker infections and deaths were a result of the shortage of PPE, she emphasizes.

"We know that because in Spain, where they used the correct PPE, they had four deaths of nurses," she says. "We know when the proper equipment is used, there are fewer deaths."

As CDC mask and respirator messages steadily weakened in the

face of shortages, the message to nurses was "we are expendable," Burger says. ■

REFERENCES

1. Centers for Disease Control and Prevention. Coronavirus disease 2019 (COVID-19): Cases in the U.S., Aug. 4, 2020. https://bit.ly/3eIgPdW
2. National Nurses United. New survey of nurses provides frontline proof of widespread employer, government disregard for nurse and patient safety, mainly through lack of optimal PPE. May 20, 2020. https://bit.ly/2VozWlN

Chicago ED Accelerates Care, Improves Behavioral Health Prescribing Practices

For a long time, **Meghan Stahulak**, DO, medical director of emergency services at St. Joseph Hospital in Chicago, believed there was something amiss in the way behavioral health patients were managed in emergency departments (EDs). "They are overprocessed, they are overmedicated, and they end up waiting a long time," she says.

Consequently, when Stahulak's ED took the opportunity to implement a new screening process for behavioral health patients, she was fully onboard. "The key for us is that 10% of our volume is psychiatric patients. We just wanted to try and streamline the way that we were risk-stratifying them, and then also provide them with better, less-sedating medications when they were agitated," she explains.

Beginning in January 2019, the new approach was put into place at St. Joseph as part of a six-month pilot project, producing positive results. This included shorter lengths of stay in the ED among behavioral health patients deemed low risk and better prescribing practices with respect to a targeted group of psychiatric medications.

Today, the system is firmly ingrained into the way the ED operates, even as more improvements are in development.

Clinicians use a matrix to stratify behavioral health patients into low-, moderate-, and high-risk categories based on their diagnosis. The basic idea is that not every behavioral health patient needs to be treated the same. Risk-stratification puts each patient on a pathway that is most appropriate for his or her needs.

For instance, if a patient suffering from anxiety presents to the ED because he has run out of his medicine and cannot see his therapist, it is unlikely that patient requires an extensive workup, Stahulak explains.

"If the patient doesn't feel like harming himself, he doesn't feel that his life is out of control, and his anxiety is not impairing his day-to-day living, he is low risk," she says. "[Low-risk] patients don't need blood work, and they don't need to be medically cleared because they are not going to be admitted to the hospital."

A moderate-risk case might involve a patient who is depressed, perhaps because he lost his job or is grieving the loss of a loved one. "There might be a situational component to the patient's depression, and it might be remedied by making an appointment for him to see a therapist the next day," Stahulak offers. "This patient requires a little bit more intensive evaluation than a low-risk patient."

Then there is the case of a patient who is thinking about ending her life. "Automatically, that puts [someone] into a high-risk category," Stahulak notes. Such patients will require the most attention and resources, and they may need to be admitted.

While a triage nurse will identify that a patient has presented with a behavioral health issue, it is the medical provider who will evaluate the patient and determine the risk category accordingly, Stahulak explains.

In most cases, a low-risk patient will not require any added resources beyond the physician intervention. However, a crisis worker, usually a master's-level social worker or licensed clinical counselor, may speak with both moderate- and high-risk patients. "The intake worker acts as a liaison for us [with] our psychiatric floor, as well as the psychiatrist to help with service planning, whether this involves follow-up the next day or admission to the hospital," Stahulak observes.

Notably, the intake workers are available in the ED 24/7, and they already were on staff before the new system was implemented. No new staff members were required. "We just used what resources we already had in the department," Stahulak adds.

Nurses have played a strong role, too, working alongside the providers when they perform their assessments, and following through on patients who will be discharged, observes **Steve Meier**, MS, RN-BC, manager of nursing operations in the ED at St. Joseph Hospital. "We make sure there is a safe discharge plan from a nursing perspective," he explains.

St. Joseph staff also shifted prescribing practices toward newer-generation psychiatric medications that do not just put people to sleep.

"When you just knock people out for a couple of hours, you can't really assess them in a timely fashion," Stahulak observes.

Consequently, to bring clinicians up to speed on the benefits of new medications, Stahulak and colleagues disseminated articles and research on the issue. "We had some input from pharmacy and from ED physicians who were more familiar with using the newer drugs to answer any of the questions the physicians may have," Stahulak explains. "Any time you are asking people to change their practice habits, there are going to be questions. It is great to have that dialogue."

Meier agrees, adding this is where nurses can be particularly helpful in ensuring physicians have all the information they need to guide their assessment and prescribing.

"Nurses are spending a lot more time at the bedside than the physician is during the initial assessment. [Nurses] are able to hone in on those very subtle cues that a patient might be agitating," he explains. In some cases, the early identification of such signs can lead to prompt use of gentler oral medications as opposed to heavy sedative injections.

"Once a patient has reached 100% velocity, it is hard to offer them an oral medication," Meier continues. "The nurse ... will assess the patient on an ongoing basis as well as reassess to make sure that any medications have impacted the patient appropriately."

Following some initial education and open dialog about the new drugs, ED staff tracked the usage of both the older and newer medicines, comparing usage patterns from before the initiative was implemented to patterns in place following implementation.

"We saw a big change [following the implementation]," Stahulak reports. "We saw that 93% of the time, the second-generation antipsychotics were being used, which was a huge improvement. Before the implementation, [the newer drugs] were being used only 18% to 20% of the time."

Stahulak acknowledges that as a small ED that sees only about 20,000 patients per year, St. Joseph physicians and nurses form a close-knit group that generally is open to fresh ideas. Thus, implementation went smoothly, although compliance was not 100% at first.

Stahulak notes there were one or two people who lagged behind other clinicians in dispensing the updated medicines. However, leaders continuously monitored the data so they could intervene in those cases. "If we saw trends like that, we would go and talk to those physicians, and ask if they had any additional questions," Stahulak explains.

Early data show the initiative is making a difference on patient flow, too, particularly regarding the time low-risk people spend in the ED. "Before we did the project, they were in the ED around 114 minutes ... but after [implementation], we got the in-and-out time for the low-risk patients down to about 73 minutes," Stahulak says.

Among the patients categorized as moderate-risk, there was about a 50/50 split in patients who were admitted vs. those who were discharged, Stahulak observes. For those who were discharged, the updated process shaved about 10 minutes off the time they spent in the ED. "A lot of the moderate-risk patients end up requiring blood work, which adds to their length of stay," Stahulak notes.

To accelerate the time-to-treatment for behavioral health patients who require admission, Amita Health, the system that operates St. Joseph and more than a dozen other hospitals in the Chicago region, is developing an online hub to make it easier for facilities to locate an open behavioral health bed within the system. "All the psychiatric units are ... sharing what beds they have available. If our psychiatric unit is full, or if you are in a different ED that doesn't have a psychiatric floor in your hospital, you can figure out where in the system you can send a patient for a psychiatric admission," Stahulak shares.

This hub will be phased in with the gradual participation of additional hospitals and enhanced capabilities. "As we get rolled into this whole process, it has helped us in getting beds and in moving patients out of our ED and into the right place for them," Stahulak says.

For those struggling with similar problems, Stahulak recommends gathering key stakeholders and mapping an action plan for change. The more staff who can engage in the project, the better the solution will be. "Getting nurse champions and a physician lead other than myself [involved], and getting the psychiatric folks on board and aware that we are changing some processes in the ED, was really huge for us," Stahulak says. "That just helps you lay the groundwork for having a good, cohesive team to deal with any issues that are inevitably going to come up any time you make a process change."

Meier echoes these sentiments, stressing the importance of a supportive culture. "All the players need to be on board. You can't have any bad apples or sour grapes heading into a new process," he stresses. "You need to have everyone on the same page supporting the process. That includes everyone from the housekeeper who works in the ED to the ED physicians. Everyone is integral to making sure the ED is a safe environment." ■

CASE MANAGEMENT ADVISOR™

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log onto ReliasMedia.com and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

CE QUESTIONS

1. **In what setting could case managers find employees who understand well the day-to-day changes of patients with dementia?**

   a. Primary care clinics
   b. Hospital intensive care units
   c. Adult day care centers
   d. Physical therapy clinics

2. **According to Stephanie Hughes, MPP, what are some of the variables in care coordination?**

   a. Patient's learning style
   b. Patient characteristics, healthcare system, frequency of contact, how coordination is delivered
   c. Educational level of practitioners
   d. Setting of care, cost, infectious disease practices

3. **The Kickstart-Assess-Evaluate-Refer framework created by the Gerontological Society of America aims to increase cognitive awareness. It was designed for use by:**

   a. primary care providers.
   b. case managers.
   c. social workers.
   d. psychologists.

4. **Which is a good screening tool for assessing patients' risk of falls, according to Ellen Aliberti, MS, CCM, RN?**

   a. Timed Up and Go test
   b. The Meyers Briggs Falls Test
   c. Asking caregivers about the number of times a patient has fallen in the past 30 days
   d. The Medicaid/Medicare database

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.