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INSIDE

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As Pandemic Rages, Case Managers Can Focus on Crisis Management

The COVID-19 pandemic began a dangerous phase in the fall of 2020, continuing into the winter as case rates skyrocketed and hospitals reached saturation levels of infected patients.

Even with potential vaccines on the horizon and better treatments than when the pandemic began in early 2020, the healthcare world prepared for shutdowns and disruptions in care transitions.

Case management leaders can best handle the crisis by focusing on their staff's and their own resilience, as well helping patients safely and successfully navigate the continuum of care.

> "IT'S AN OCCUPATIONAL HAZARD THAT THE HEALTHCARE WORKFORCE TAKES CARE OF EVERYONE ELSE BEFORE THEMSELVES. WE CAN'T AFFORD TO DO THAT ANYMORE."

One thing case managers learned during the past year is COVID-19 patients need post-acute help that is individualized for their needs after experiencing the devastating disease.

"There were a significant number of COVID-positive patients who went to the emergency department (ED), but did not meet criteria for admitting," says **Gary Rogg**, MD, FACP, co-director of WMCHealth's COVID-19 Recovery Program at Westchester Medical Center, the flagship of WMCHealth Network in Valhalla, NY. "They did not have primary care doctors. They'd have ongoing symptoms, and would keep coming back to the ED. We started an outreach

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

program and with video visits and televisits to take on these patients and provide ongoing care to them."

The pandemic reinforced the idea that providing follow-up care is crucial for successful case management, notes **David Wilkinson**, BSW, director of case management services at Central Behavioral Health in Norristown, PA. "Everyone has a caseload, so they need to look through their notes and charts, using basic technologies, and look for gaps in care."

Case managers should know if it is unusual for a patient to go two weeks without a call or visit to a provider. "In those two weeks, maybe they missed an appointment," Wilkinson says. "Missing an appointment [is important], even in telehealth. I've heard there has been a higher show rate in people seeing a psychologist or therapist on telehealth because they don't have to get physically to the agency."

It should be concerning any time patients miss a visit or are unavailable when called. Case managers need to make the follow-up call. If that fails, they should reach out physically to check on patients, Wilkinson says. *(See story on case management follow-up during the pandemic in this issue.)*

As the pandemic wears down everyone in the healthcare world, fatigue, stress, and burnout increase. "One of the things I talk about is this concept of collective occupational trauma," says **Ellen Fink-Samnick**, LCSW, CCM, CRP, principal with EFS Supervision Strategies in Burke, VA.

Case management leaders need to care for and nurture their staff through this challenging period. "If there was ever a time we needed to stop looking at mental health as a stigma for the healthcare workforce, it's now," she adds. "You must pay attention to your own self-care so you can be attentive to the care of others. It's an occupational hazard that the healthcare workforce takes care of everyone else before themselves. We can't afford to do that anymore."

To combat the repercussions of the pandemic, case management leaders should identify staff members who are resilient and can proactively help improve the team's ability to handle the crisis.

"I created this idea of proactive personality," says **Mike Crant**, PhD, MBA, professor of management and organization at the University of Notre Dame. "I'd expect more proactive people to be more likely

EXECUTIVE SUMMARY

Crisis management is important to case management leaders and their teams as the COVID-19 pandemic continues. COVID-19 cases and hospitalizations sharply increased through the end of 2020.

- One way to cope with the uncertainty and disruptions is to focus on staff and individual resilience.
- Case managers find it challenging to provide follow-up for patients as more care occurs via telehealth. Some patients are difficult to reach.
- Proactive case management leaders and staff learn how to shape their jobs in ways that make them comfortable, while handling the crisis as effectively as possible.

to raise their hands and volunteer. Proactive people tend to look at things, which other people see strictly as threats, as opportunities to learn new things and to make a difference."

People with proactive personalities shape their jobs in ways that make them comfortable and capitalize on what they like to do. "They create a situation that they're satisfied in. This makes them less susceptible to stress," Crant explains. "Reactive people, who don't like changing anything, might be totally stressed out in a crisis because there isn't a policy manual for them to follow."

Crant recently co-authored a study that showed healthcare professionals with proactive personalities redesigned their jobs, making them more flexible and effective in combatting an emerging new virus when SARS-CoV-2 first struck Wuhan, China, and overwhelmed the healthcare infrastructure.[1]

"Doctors in Wuhan, in the early stages of the pandemic, were better able to cope with this crazy, uncertain situation if they were more proactive," Crant says.

In days before the viral infection had a name, a hospital in Wuhan changed to a strictly respiratory hospital. There was no roadmap for how to handle an unknown and rapidly spreading disease and overflowing patient load.

"It was a difficult situation for frontline healthcare workers. There was no policy, and no one knew how to treat it," Crant explains. "Those who were more active and self-directive were better able to come up with effective ways to do their work."

Physicians and other staff were given 24 hours to adjust to complete changes in their jobs, and they had to be self-directed in figuring out how to make that change, he adds.

Proactive personality is associated with resilience and thriving. It also is at the heart of effective leadership. "What we showed in the study was it's really important to encourage and at least give permission to people to act without waiting to be told what to do," Crant says. "It's OK in a crisis to go after what you need and to craft your job in a way that works for you."

Healthcare organizations need people to be more self-directed — not just sitting and waiting to be told what to do, he adds.

Crant's study outlined a 10-item proactive personality tool. Participants indicated on a seven-point Likert scale whether they strongly disagree (1) to strongly agree (7). Here are a few of the 10 items:

- "I am constantly on the lookout for new ways to improve my life."
- "Wherever I have been, I have been a powerful force for constructive change."
- "I excel at identifying opportunities."
- "I can spot a good opportunity long before others can."[1]

A five-item resilience scale includes:

- "I am getting better at my work because I learn from my mistakes."
- "I find ways to handle unexpected situations."
- "I bounce back when I confront setbacks at work."[1]

Case management leaders can make changes that will enable their staff to better cope with crises, Wilkinson says. For example, case management teams can hold meetings more frequently to go over changes and cover new knowledge during the crisis.

"One thing we do is each team holds a brief morning meeting," Wilkinson says. "It could be for half an hour to an hour, and we look at the case situations and immediate follow-up of the day. We also talk about how things are going that day. This is a way to connect and feel connected."

Connecting with colleagues is especially important when staff work from home. "If you're working from home, that can have its own worker isolation feel," Wilkinson says. "Staying connected and client-related is important."

The daily conversations among team members also improves patient care by letting more people hear about patients' struggles and chime in with potential solutions. "If someone is feeling frustrated about something, someone might say, 'Yes, I've had this similar situation, and this just happened yesterday,'" Wilkinson says. "It's a daily check-in to hear what's going on."

Daily meetings also enhance resilience and self-care. If someone appears to be under the weather, the team can encourage him or her to take the afternoon off and someone else on the team would cover their cases, he adds.

At the beginning of the pandemic in Wuhan, proactive physicians would come into work early to talk about the new things they had learned about the virus. Then, they would meet again at the end of the shift, Crant says.

"They created a situation that allowed them to succeed, and they were learning more than peers who were not proactive," he adds. ■

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Follow-Up Is Crucial but Difficult for Case Managers During Pandemic

More challenges expected in 2021

Case managers in all areas found their roles were challenged since the COVID-19 pandemic started, particularly when it came to follow-up.

"Pre-pandemic, during the pandemic, and whatever the situation, follow-up is important," says **David Wilkinson**, BSW, director of case management services at Central Behavioral Health in Norristown, PA.

The pandemic exacerbated social determinants of health for many people, including clients of Central Behavioral Health. Basic needs related to food, housing, transportation, and connection with others were more challenging in 2020, he notes.

Case managers had to work hard to make sure their clients were stable and to see if they needed to be connected to legal aid or to community-based organizations that received pandemic funding through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, he says.

The CARES Act was signed into law on March 27, 2020. The $2 trillion economic relief package includes assistance for state, local, and tribal governments, as well as direct funds for individuals and small businesses. *(More information is available at: https://bit.ly/35tMTjF.)* Local governments often provided community-based organization grants related to education and other services affected by the pandemic. The CARES Act directly provides sector-specific aid for nonprofit services that include food banks, legal aid, arts and humanities, substance abuse and mental health, and children and families.

"If a person is over age 60, then maybe they need subsidized housing, Meals on Wheels, or in-home support," Wilkinson says. "As a case manager, part of the effort is to be aware of their needs."

As the weather grew colder and the pandemic brought more COVID-19 surges, hospitalizations, and economic hardship, case managers also had to be on alert for patients who were homeless and in danger from freezing temperatures. Case managers should continue to be on the lookout for patients experiencing food insecurity and rental evictions, Wilkinson notes.

"We're concerned we'll see an increase in evictions," he says. "There has been an increase in food connection needs and food resource needs in the community."

Case managers should provide clients with information about local food pantries and soup kitchens, as needed. "In our continued follow-up with people, if someone is out of food, we may go to a food cupboard and get some food for them and safely drop it at their door," Wilkinson says. "We follow CDC protocols with wearing masks and staying distant."

Telehealth Continues to Grow

Telehealth is continuing through the pandemic. Case managers should look for technology gaps among patients. "When clients have a smartphone or computer, it has helped a lot, even when they're seeing their therapist or psychiatrist," Wilkinson says. "It's important to see them, and it's true from the case management standpoint, too."

Second to that is for case managers to stay in touch with clients via phone calls. However, case managers can find follow-up is difficult when patients are not keeping their in-person appointments, and phone calls

EXECUTIVE SUMMARY

The pandemic exacerbated social determinants of health problems for many patients seen by case managers.

- Case managers had to find new resources for patients, including aid from the CARES Act.
- Colder weather, coupled with the economic fallout of the pandemic, also raised the likelihood of patients needing case management help with housing and food insecurity.
- Telehealth has continued, creating opportunities to connect with patients more frequently, but also the challenge of follow-up when patients do not return for in-person visits.

go unanswered. If a patient's situation might be urgent, case managers may need to decide how they could safely track down the person.

"From a client care standpoint, we need to look to see if there are gaps in care, and we need to get our eyes on the client," Wilkinson says. "If you have video [visits] it helps a lot, too."

One important gap that has repeated itself throughout the pandemic relates to increased isolation. "Many clients are fearful of catching COVID, and that definitely has increased," he says. "Also, I don't have data, but I think one of the things that has happened is an increase in substance abuse situations."

An Oct. 31, 2020, report from the Advocacy Resource Center of the American Medical Association noted that more than 40 states have reported increases in opioid-related mortality and ongoing concerns for people with a mental illness or substance use disorder. The 20-page issue brief included 19 pages of media headlines and links to articles about overdoses and substance abuse. *(The report is available at this link: https://bit.ly/2UwC1ek.)*

Case manager leaders can help mitigate this unfortunate phenomenon by advocating for local pharmacies to carry Narcan, the drug that reverses opioid overdoses. Case managers could see if clients need a prescription for Narcan in the event of an overdose emergency. They also can keep track of substance use rehabilitation facilities and their availability to take on new clients.

"Educate people around this, mitigate some of the risk, and help them with access to Narcan to reverse the effects," Wilkinson says. ■

Researchers Study the Effects of Intensive Primary Care

Services mirror case management follow-through

A case management-type of model, called primary care intensive management, could provide some limited benefits for more complex patients, research shows. But the research also suggests questions about how population health resources are best spent.[1]

"We performed a pilot program in the VA [Veterans Affairs], based in five sites across the country, where we implemented something called intensive primary care," says **Jean Yoon**, PhD, MHS, investigator with the VA Health Economics Resource Center at VA Palo Alto Healthcare System in Menlo Park, CA. "There are patients who are sicker than the average patient and have more complex, more chronic conditions, and social and mental conditions that complicate their care. They have a lot of utilization and are at high risk for future hospitalizations. Our project attempted to intervene with these patients by implementing intensive primary care."

The project leaders used an algorithm to find patients, then randomized them to regular primary care or intensive primary care.[1,2] Primary care intensive management involves an interdisciplinary team of physicians, nurses, mental health specialists, social workers, and others. They perform chart reviews to determine the care patients are receiving and identify any gaps.

"They did home visits as part of the needs assessments and saw how patients were managing their chronic condition in the home environment," Yoon says. "After the needs assessment, they determined which services the patient might benefit from."

For instance, patients might need more care coordination, referrals, and medication management help. The team performed medication reconciliation, reviewing patients' prescriptions with them and helping them understand their medications and when to take them. The team also helped patients use pill boxes, obtain refills, dispose of expired medications, and improve their life circumstances and instability when obstacles to medication adherence appeared, Yoon explains. "Helping patients fill pill boxes seems small, but patients really liked that."

Medication Adherence Largely Unaffected

Yoon and colleagues found high-risk patients demonstrated similar rates of medication adherence to patients in usual primary care with one exception: The intervention group saw a significant increase in adherence for DPP-4 inhibitors, which are used to treat patients who have not

responded to other diabetes drugs or have problems with formulary medications. The intensive management program was better for patients who faced greater challenges to their diabetes management, the authors concluded.[1]

"We wanted to see if there were any differences in medication adherence and adjustments," Yoon explains. "We found their adherence was pretty high to begin with. We did find the team had some positive impact on the patients — but, overall, the impact was somewhat mild."

The team also screened patients for mental health issues and helped them with mental health referrals. Patients might experience depression, post-traumatic stress disorder, bipolar disorder, or other problems that could be treated by mental health professionals.

"Some of these can be treated in primary care, and some needed specialty mental healthcare," Yoon says. "A lot of times, there were mental health specialists as part of the team who could provide the mental healthcare themselves."

In the original study on the program, published in 2018, the primary care intensive management program did not produce any reductions in hospitalizations, costs, or ED visits.[2]

"It did look like there was some offsetting of costs — some higher outpatient and lower inpatient costs," Yoon says. "The lower inpatient costs were not specifically significant, but were offsetting with higher outpatient costs."

As evaluations of similar programs have shown, including evaluations of randomized care coordination programs for chronically ill Medicare beneficiaries, most do not reduce hospitalizations or costs. Other research showed intensive outpatient care can positively affect patient experiences.[2]

Resource-Intensive, but Few Results

The primary care intensive management program required substantial resources to assess high-risk patients' needs and tailor services to meet their goals for long-term health improvements. It also facilitated referrals to a variety of additional services, including palliative, hospice, geriatrics, specialty mental health, and telehealth care. "Over five sites, they did it all differently," Yoon notes. "It depended on the patient and their needs."

For instance, some patients might need only a couple of visits with the team, but others needed more visits over a one- or two-year period. "Not all patients who were assigned intensive teams received services from them," Yoon explains. "The team decided which patients would benefit from their services, so some patients got really good care from primary care. They didn't feel like they needed additional care."

The team conducted in-person assessments with patients to determine their needs. Patients could refuse the extra services, if they desired.

The study's design might have affected the results. "We underpowered our results by not giving [intensive management] to every patient randomized," Yoon says. "Not every patient was a perfect fit, so only a minority of patients got intensive management."

When the intensive management team conducted a needs assessment, they found many patients were already receiving good primary care and would not benefit from the intensive management team.

The VA implemented the patient-centered medical home model before the primary care intensive management study. That might have been one of the reasons the results were similar between the primary care group and the group that received intensive management. "We think the VA was already providing pretty good primary care," Yoon says. "The other factor is these patients were very sick, and even though more care was provided to them, it wasn't enough to impact ED visits and hospitalization costs. Even with an improvement in care, they were sick enough to have a high rate of hospitalization."

EXECUTIVE SUMMARY

Primary care intensive management uses some case management tactics to closely follow patients with chronic and complex illnesses to improve their usual primary care.

- A study among five Veterans Affairs hospital sites did not reveal many differences in medication management, and no differences in reducing hospitalizations, emergency department visits, and costs.
- The intensive management team conducts medication reconciliation and helps people fill their pill boxes.
- The program appeared to help diabetic patients who faced greater challenges to their disease management.

The researchers found that primary care intensive management may need to focus more on patients amenable to intervention to see a significant effect on outcomes.[1]

The findings suggested that when healthcare resources are used to make critically ill patients healthier, they should be more focused on the population targeted to be both efficient and effective.

"This was an expensive intervention, treating a relatively small number of patients at each site," Yoon notes. "The VA now is focusing more on improving regular primary care and developing tools in regular primary care to manage these very sick patients." ■

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Try Using Telehealth to Diagnose and Manage Patients with Dizziness

One symptom that emergency providers know well is dizziness. As many as 4 million patients visit the ED every year with this complaint, but pinning down precisely why a patient is suffering from dizziness often is not immediately apparent.

There is a wide range of possible causes, ranging from something as simple as dehydration to a much more serious underlying neurological cause, such as stroke. Experts suggest 15% of patients who present to the ED with dizziness have a serious, underlying issue that requires immediate care. It is critical for frontline providers to recognize these cases and to accelerate care accordingly.

But because of COVID-19, many of these patients with dizziness may be seeking care virtually, both through primary care settings and many EDs that have established telemedicine infrastructure. It has become increasingly important for practitioners to be able to recognize whether there is a serious underlying cause via two-way video hookup.

Appreciating the need for more guidance in this area, an international task force comprised of physician-scientists from 10 countries developed consensus-based guidelines to help frontline providers diagnose and triage patients with dizziness over a telehealth or virtual platform.[1]

Facilitate Expertise

Aasef Shaikh, MD, PhD, a research scientist from the Cleveland Functional Electrical Stimulation Center at the Louis Stokes Cleveland Veterans Administration Medical Center, led this task force.

"There are not many doctors who specialize in dizziness," Shaikh laments. "Emergency physicians are trained in distinguishing one form [of dizziness] from another, but still there are not enough people who are qualified enough to manage dizzy patients."

Shaikh explains there has been a supply-and-demand mismatch. There are few specialists in this area, referred to as neurotologists, yet there is high demand for services.

"This all became worse when COVID-19 came through. We already had very limited space, and then we needed to see patients and prioritize them based on their need to come into the hospital," says Shaikh, chair of brain health at the University Hospitals Neurological Institute in Cleveland.

The pandemic accelerated the specialty's plans to introduce a virtual way of practicing, something that could be used especially for patients who would otherwise have to travel a long distance for care.

"I get patients who see me from Texas, Florida, Georgia, and sometimes from overseas," Shaikh reports. "We noticed firsthand that this was working very well, so then we talked about developing a set of guidelines."

The recommendations are designed to serve two purposes. "One purpose is to help ED physicians or other frontline clinicians to determine who really needs urgent, immediate care — who needs to come into the hospital," Shaikh explains. "The second part of the guidelines is to tell people how to examine [a patient with dizziness], and what to look for virtually."

Often, when patients with dizziness present to an ED, neurology will be consulted if there

is any question about the underlying cause. However, if a neurologist is unavailable, the patient will be transferred to where this type of service is available.

"If you have a virtual way to [access this expertise] ... you will save a lot of expense in patient transportation or in triaging the patient," Shaikh notes.

Look for Tip-Offs

There are general signs frontline providers should watch for when examining a patient with dizziness, either virtually or in person.

"One is how miserable the patient is — miserable in a way that the patient cannot get up from the bed and walk without any assistance," Shaikh says. "[For that] patient, I would definitely suspect that something major is wrong in the brain, and that could potentially be a patient who is [at risk] for a stroke."

A second indication that something serious is going on is what Shaikh describes as perception of motion. This may not just be abnormal movements of the eyes, but rather the patient's own feeling he or she is moving or spinning while seated. "It is vertigo, but frequently we correlate the vertigo with involuntary movement of the eyes," Shaikh says. "If that is present, that is suggestive of certain types of [stroke], or some kind of structural deficit in the brain." Shaikh notes that even if clinicians resolve eye movement issues, a patient still may perceive vertigo.

With practice, emergency providers can become better at assessing dizziness. Shaikh says the key is "you want to know what not to miss rather than what to diagnose."

While virtual examinations are important to ensuring expert care is accessible to all patients, Shaikh says in-person encounters remain important. "If someone calls me 100 miles from my hospital, I am able to address their question in a very effective way using these guidelines that we have published. But that does not mean that everything I do would happen virtually," he says. ■

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Accreditation Program Elevates Pain and Addiction Care in the ED

Long before the COVID-19 pandemic, frontline providers were confronting an epidemic of patients struggling with opioid use disorders (OUD). It appears the pandemic has exacerbated the problem, with rising numbers of opioid overdose deaths.

Recognizing the urgent need for improvement in this area, the American College of Emergency Physicians (ACEP) is rolling out a new accreditation program that is aimed at nudging EDs across the country to up their game when it comes to both the treatment of pain and the way they manage patients who present with OUD.

Called Pain and Addiction Care in the ED (PACED), the program sets benchmarks for best practice in these two intertwined areas while recognizing EDs vary widely in terms of size and the populations they serve.

Program developers are sensitive to the fact that resources are strained in many areas hit hard by the pandemic, but they are nonetheless urging frontline providers to stay open to make long-needed improvements.

"We have to remember that [EDs] are open 24 hours a day for anyone who comes and sees us. The majority of our patients come to see us for pain," observes **Alexis LaPietra**, DO, FACEP, chair of the PACED board of governors. "Pain and addiction are rampant. The opioid epidemic is not going anywhere, and it does not have an expiration date. We feel that COVID-19 does."

Highlight Best Practice

While treating pain is a bread-and-butter issue for emergency providers, ACEP maintains there is ample room to progress. "We know EDs are good at lots of things, but we also know there is a lot of practice variability from physician to physician," observes LaPietra, chief of pain management and addiction medicine at St. Joseph's University Medical Center in Paterson, NJ.

With the opioid epidemic raging, emergency providers must adopt

better prescribing habits because they do play a role. "We are not the main prescribers of opioids nationally, but sometimes we are the first place that patients touch down after a painful experience. Sometimes, we can really drive the care they receive based on the medication we give them in the ED," LaPietra says. "The goal [of the accreditation program] is really to elevate bread-and-butter [practice] through evidence, through support like an accrediting body of a national professional organization, and [through understanding] that the department and the hospital should be behind you in this effort."

For example, LaPietra notes PACED developers do not want one physician who is trying to engage in best practice to feel like he or she does not have the support of executive leadership. Developers also do not want these providers to struggle to access medicines he or she knows can be effective.

"We want hospitals, EDs, physicians, and all frontline staff to understand what is the best-case scenario for these pain management issues," LaPietra explains. "We all have a united front knowing that we are serving our communities in ... the best way possible with the constant reminder that we need to reduce opioid harms."

LaPietra stresses opioids remain a vital part of pain management, but providers need to be judicious in prescribing them. "Let's treat [opioids] like high-risk medicines because they are," she says. "We cannot live without these medicines. Patients need these medicines, but we should never give them out without appropriate education on the provider's part and appropriate education for the patient."

Considering the different characteristics of EDs across the country, it took time to develop the array of accreditation options available through PACED. The board of governors spent three years sifting through the literature, discussing what constitutes best practice, and determining how the program should be built.

"There is a lot of detail that goes into this, and we wanted to constantly have the focus be on opioid harm reduction," LaPietra reports. "We wanted opioids to be used, but we wanted them to be used really judiciously."

Pain and addiction are mutually exclusive, but a patient does not develop an OUD if he or she has never seen an opioid drug. Consequently, while program developers wanted to help frontline providers use opioids appropriately, they also wanted them to have the tools to properly treat a patient who presents with OUD.

Program developers solicited input from emergency medicine practitioners working in academic settings, small community hospitals, and critical access settings. "We tried to have a cross section of all different providers to see how all of [the evidence] could be pared down and translated into a best practice program that can be implemented at different levels," LaPietra says.

Choose from Three Levels

Ultimately, developers settled on three levels of accreditation: Gold, Silver, and Bronze.[1] Each level is associated with a range of capabilities. For instance, EDs seeking Gold-level accreditation need to maintain large, multidisciplinary pain and addiction management teams that involve nursing, information technology, pharmacy, quality improvement, and emergency providers.

Along with a broad array of pain medicine, Gold-level EDs should offer non-pharmacological interventions, such as ice and elevation.

"We are also asking the Gold-level EDs to address special populations. That would include pediatric, geriatric, and pregnant patients," LaPietra says.

For addiction care, Gold-level EDs must employ physicians who have obtained their DATA 2000 X waivers and can provide buprenorphine or naloxone when patients present in opioid withdrawal. Collaboration with outpatient treatment centers also is a must.

"Then we know exactly where the patient is going, and exactly what day and time they will receive follow-up care," LaPietra says. "[Patients] are not just discharged, and we say 'good luck.'"

Gold-level EDs also need to offer harm-reduction education to patients. For example, patients who are not interested in buprenorphine treatment need to be informed about where they can go if they decide to stop using, and where they can obtain clean needles.

In short, the Gold-level EDs should offer the highest level of pain and addiction care that may even go beyond pharmacological interventions. These might include ultrasound-guided regional anesthesia, nerve blocks, trigger point injections, and osteopathic manipulative therapy.

The Silver and Bronze accreditation levels each follow a similar pathway, but include fewer requirements. For instance, while the Gold level requires EDs to use at least four different pain management protocols, the Silver level requires two protocols,

and the Bronze level requires one protocol.

Similarly, where the Gold level requires EDs to offer at least six nonopioid medication protocols, the Silver level requires four such protocols, and the Bronze level requires two protocols.

When specifying the requirements for Bronze-level EDs, program developers were thinking about the resources available at many small critical access hospitals.

"The Bronze level does not require a physician champion, and does not require that a physician lead the pain and addiction care team," LaPietra says. "This can be a clinician or provider who is willing to at least review some cases looking at pain and addiction."

Further, these individuals need to understand the possibility of nonopioid alternatives for treating musculoskeletal pain, such as over-the-counter anti-inflammatories. Bronze-level EDs will reach for non-pharmacological interventions as much as possible.

They will provide information about OUD, and they will contact any treatment facilities within a reasonable drive to see if they can establish a relationship.

"We basically want the Bronze-level EDs to know there is still something that can be done," LaPietra says. "No, they may not be doing nerve blocks and, no, they may not have their X waivers, but they can still use opioid-sparing strategies."

Involve the Team

The PACED board also includes members from the Emergency Nurses Association (ENA), the American Society of Health-System Pharmacists, the Society of Emergency Medicine Physician Assistants, and the American Association of Nurse Practitioners.

"Emergency medicine is a team sport," LaPietra notes. "We have our physician side of things, and then we have nursing, pharmacy, and mid-level provider input. When hospitals are applying [to PACED], we want to make sure we are addressing the needs of each those frontline providers."

WHEN IT COMES TO ADDICTION CARE, NURSES PLAY A CRITICAL ROLE IN ASSESSING WHETHER A PATIENT IS READY TO ENGAGE IN TREATMENT.

Cathlyn Robinson, MSN, RN, CEN, a clinical education specialist in the ED at St. Joseph's University Medical Center, is serving as ENA's representative for the PACED program. She worked alongside LaPietra in implementing the Alternatives to Opiates (ALTO) program at St. Joseph's several years ago.

Robinson testifies to the importance of making such programs interdisciplinary. "When we were developing that program, I developed the nursing education component that went along with it," she explains. "[That involved] teaching nurses how to identify a patient who would be appropriate for an ALTO approach, and how to communicate with these patients and families. Many patients do not necessarily understand why we are not going to give an opioid first."

Much of that work has carried over into PACED. Of particular importance to nurses is education about how to use the medications in a way that is not particularly conventional. For example, Robinson notes nurses generally are accustomed to administering lidocaine for a cardiac condition, but the drug also can be used for pain control.

"Teaching nurses why this works, how it works, and how we administer it is completely different," she says.

Another non-opioid therapy that can be used effectively in some patients is nitrous oxide. Robinson encourages nurses to suggest this option to the treating provider.

"I can't give nitrous myself as a nurse, but I can certainly go get the machine, and set it up for the physician," she says.

Optimize Communication

Robinson says nurses often encounter pushback from patients when a physician prescribes a non-opioid drug for pain.

"The patient will say that drug is not going to work for him. Then, it is up to the nurse to communicate why [the care team] wants to use this drug, how it works, and how to take it," she explains. "Generally, with that sort of communication, patients better understand how we are trying to treat their pain." When it comes to addiction care, nurses play a critical role in assessing whether a patient is ready to engage in treatment, and then explaining to the patient how a warm handoff will work. Robinson says whether a patient enrolls in treatment depends on whether the nurse has engaged and connected with him or her during their encounter.

Nurses may be the first providers to identify patients who are in withdrawal from an opioid. Such patients may be candidates for buprenorphine. Further, if a physician orders buprenorphine for a patient, a nurse usually will administer the drug, a task that requires appropriate education.

"It is an interesting drug to administer because it is given under the tongue," Robinson explains, noting the nurse needs to direct the patient to avoid swallowing the drug because it deactivates in the stomach.

However, Robinson stresses nurses need to understand buprenorphine carries much street value. "If you don't go back and check on the patient in about 10 to 15 minutes after you have given them the drug, they may take it out of their mouths and stick it in their pockets to sell on the street," she shares. "If the drug is not under their tongue — it takes a while to dissolve — we will know that the patient has either pocketed it or swallowed it."

Sometimes, an initial buprenorphine dose is not enough to provide sufficient recovery to a patient in withdrawal. A nurse may observe a second dose is necessary.

"Make sure that the physicians and nurses are all on the same page, and that we are constantly thinking about opportunities to help these patients, whether that is through a warm handoff or considering buprenorphine as an option," Robinson says.

Start the Process

EDs interested in becoming PACED-accredited must complete an application.[2] LaPietra advises ED leaders to review the requirements for each accreditation level to see where their facility fits. The cost to become accredited is $2,500 for Bronze, $5,000 for Silver, and $10,000 for Gold.

Two members of PACED's board of governors review applications, which include proof facilities have met each requirement for the desired accreditation level.

"There is also an opportunity for [applicants] to comment or [correspond] with the review team as they are going through the process," Robinson says. "We, too, reserve time to reach back out to the institution if things are not clear."

The reviewers selected for each application always work outside the applicant's region. "We do not want anyone to be reviewing colleagues or places where they work," Robinson says.

After reviewing the application, the two governors will score it. "If there is a discrepancy between the reviewers, the [application] will then be opened up to the entire board of governors for a formal review," LaPietra explains.

If there is no discrepancy, the reviewers will provide their reasons for accepting or rejecting the application. Then, the full board will vote. "If it is determined that the institution fulfills all criteria, then we will formally accredit it," LaPietra says. "We also have a marketing team available to [successful applicants] if they need some assistance on how to let their communities know ... that they have just been recognized [for pain and addiction care quality]."

Additionally, following an initial accreditation designation, EDs can reapply after three years to seek a higher-level designation. LaPietra's facility recently became the first Gold-level ED. There were at least two other EDs working toward Gold certification. At least two other facilities are working toward Bronze-level accreditation.

Ultimately, LaPietra is hopeful the new program will disseminate best practices for pain and addiction care nationally, and help frontline providers understand there is a mechanism available to guide them toward improvement in this area. "We would like to present EDs with a checklist that has been thoroughly reviewed by a national, professional organization," LaPietra observes. "It is hard for EDs to digest all of the evidence and to know what exactly is best practice right now for pain and addiction care. We wanted to take that work out of it."

For EDs that are lacking in certain areas, the PACED program offers educational resources that can be leveraged to help them improve. "If an ED is close to Gold, and [department leaders] are just lacking in one thing, they can click on an array of tools, educational podcasts, and different publications so that they can do some quality improvement work to get them to that Gold," LaPietra reports.

LaPietra sees the new process as similar to national guidelines that have been established for other conditions like stroke and heart attack.

"Now, we have pain and addiction guidelines," she says. "We wanted to make it that easy [for EDs] to provide the best pain and addiction care that they can for their communities." ■

REFERENCES

1. American College of Emergency Physicians. Pain and Addiction Care in the ED. Accreditation levels. https://bit.ly/32Y8RKa
2. American College of Emergency Physicians. Pain and Addiction Care in the ED. About the process. https://bit.ly/3kKy3tT

CASE MANAGEMENT ADVISOR™

CE QUESTIONS

1. **What is a good description of a proactive personality and how it affects crisis leadership, according to Mike Crant, PhD, MBA?**

   a. People with proactive personalities are more likely to find opportunities during crises and create satisfactory job situations, which makes them more resilient.
   b. People with proactive personalities will look for leaders or policy manuals to guide them through a crisis.
   c. People with proactive personalities become more stressed because they anticipate all crisis contingencies and what must be achieved.
   d. Leaders with proactive personalities ask staff to write their own new job descriptions during a crisis and give them leeway to implement them.

2. **What are additional problems patients might develop as the pandemic and its hardships continue, according to David Wilkinson, BSW?**

   a. Transportation and lack of access to COVID-19 testing
   b. Dementia and congestive heart disease
   c. Coping with homeschooled children, multigenerational homes, and pandemic fatigue
   d. Substance use/opioid problems, homelessness, and food insecurity

3. **According to Mike Crant's research on proactive personalities, which is an item on the proactive personality tool?**

   a. "I tend to win whatever competition I enter."
   b. "Wherever I have been, I have been a powerful force for constructive change."
   c. "My main motivations in life involve faith, family, and helping others."
   d. "When I make a mistake at work, I spend a week going over the causative factors and then change them."

4. **Research into a primary care intensive management program on complex patients revealed what effect on medication management, hospitalizations, and costs?**

   a. The intensive management program reduced hospitalizations by 18%, lowered costs by 5%, and improved patients' medication management.
   b. The program had little effect on medication management and did not reduce hospitalizations or costs.
   c. An intensive management team helped reduce patients' missed pill days by 10%, lowered costs by 15%, and reduced hospitalizations by 33%.
   d. Due to site-specific problems in implementing the intensive management program, the overall effect led to a slight increase in medication problems, hospitalizations, and costs.