CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

Relias Media
From Relias

APRIL 2021 Vol. 32, No. 4; p. 37-48

Military Service Can Be a Social Determinant of Health

Depression, PTSD, suicide are issues

By Melinda Young

Case managers sometimes work with military veterans who struggle with social determinants of health, such as housing issues and behavioral health challenges. But one researcher says that military service can be considered a social determinant of health.

"We typically look at specific social determinants of health as an influencer of the needs or health status of an individual or group of people, but in this case, military service itself is considered a primary social determinant of health," says **Charles William White**, EdD, MBA, faculty member in the department of public health at California State University in Fullerton.

> "IT'S VERY UNUSUAL THAT AN OCCUPATION HAS THE ABILITY OR POWER TO COMBINE ALL THOSE SOCIAL DETERMINANTS OF HEALTH UNIFORMLY ACROSS THE POPULATION."

Case managers are familiar with some of the social determinants of health that can affect veterans. These include housing instability, gambling, substance use, depression and post-traumatic stress disorder (PTSD), and food insecurity.[1-6] But few case managers may consider how much of a physical and emotional strain military service is on individual patients. "This combines all the individual

Financial Disclosure: None of the planners or authors for this educational activity have relevant financial relationships to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

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:
(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.

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

ACCREDITATION: In support of improving patient care, Relias LLC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

1.5 ANCC contact hours will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791. It is in effect for 36 months from the date of publication.

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

social determinants into one," White explains. "It's very unusual that an occupation has the ability or power to combine all those social determinants of health uniformly across the population." For example, the Office of Disease Prevention and Health Promotion's HealthyPeople.gov website explains how the worksite is a physical determinant of health.[1]

Consider the Issue of Control

It is the issue of control that makes military service a social determinant that case managers and other healthcare providers should consider when seeing these patients. "Military service has direct control over the people on a military base, providing them with housing, food, education, and employment," White notes. "The military base also has control of all the environmental factors within that base community."

Civilians can find different places to live, different jobs, and different sources of food and environmental factors. "Those are more random influences, rather than a direct ability of the occupation to directly influence all of those social determinants of health into one," he says. "The culture, the values, the prescribed norms are all regulated by military service. Those folks in military service are required to follow all those norms and rules. When we deploy forces to another country, say Afghanistan or Iraq, that's a prime example of how the occupation — military service — puts those individuals into situations that they have no control over."

As the authors of one study noted, people may join the military to escape dysfunctional and chaotic situations, which may increase their vulnerability to long-term social stressors.[2] The researchers found that people with military service had a higher prevalence of poor physical health, but there was no association between military service and food and housing insecurity, says **Mark Schure**, PhD, assistant professor of health and human development at Montana State University in Bozeman.

The researchers analyzed data from respondents in nine states, using the 2011 or 2012 Behavioral Risk Factor Surveillance System, a phone survey that involved random-digit dialing of landline and cellphone numbers of adults. Veterans were a subset of the general population.[2]

EXECUTIVE SUMMARY

It may help case managers identify obstacles and problems for patients who are serving or have served in the military if they view this service as a social determinant of health, a researcher suggests.

- Veterans struggle with many of the same social determinants of health as non-veterans, including housing instability, gambling, substance use, depression, food insecurity, and post-traumatic stress disorder.
- It is important to ask patients if they had served in the military and to screen for depression and other problems.
- One study revealed that veterans who served in combat early in their military service experienced higher rates of negative mental health.

"If you look at prior military service variable, you're 1.06 times more likely to have poor mental health, but it's not significant," Schure says of the study results.

The results did not suggest a strong association between military service and mental health — a finding that was a little surprising, and possibly attributed to the limitations of its database because military service respondents were a small percentage of the data set.

"In Montana, we have one of the highest [per capita] veteran populations and the highest suicide rate in the state,"[7] Schure says. "I feel there are still a lot of barriers that need to be addressed both on the population level and clinical level to make sure veterans have access to the care they need and are properly screened for mental health issues."

Military Service and Mental Health

The nature of military's physical control and culture can cause major problems, such as substance use disorder, depression, anxiety, and suicide. If healthcare providers and case managers do not consider military service to be a social determinant of health, they may miss opportunities to suggest patients seek help in the community.

For example, in a paper, White told the story of his brother, a decorated U.S. Army officer with 24 years of service, who shot himself in the head after dropping off his preschoolers at school. There were no apparent mental health symptoms or history. But he had served in numerous combat missions in Afghanistan and Iraq, and sometimes spoke about losing fellow soldiers.[1]

When case managers work with veterans, they could keep in mind the patients' military service could be a risk factor for mental and behavioral health issues and routinely screen for depression and other problems — even if the patient does not volunteer a mental health challenge.

"Research says the military really turns into a family unit, so the ties that the service people have with one another is much stronger than you would see in other occupations," White notes. "So many times, there are significant transition problems or issues when someone leaves active military service and goes into civilian life. That transition can be very hard."

A recent study revealed combat exposure in the first two years of military service was associated with higher rates of mental health diagnoses when compared with deployment and no combat exposure, and no deployment.[6]

Even small things, such as the visual and tactile experiences of returning from an overseas deployment, can affect a person's mental well-being. "If you're deployed in a desert situation that you've never been in before, and then you come back after six months, then it's [disturbing]," White explains. "My brother said that the color green of grass was so overwhelming to his troops when they came back to the United States because for six months they were in a desert."

These are the sensitivities case managers should ask about when working with patients serving in the military or recently discharged. "We do little to record social determinants of health in the medical record, so we may not ask someone if they are a veteran or on active military duty," White says. "We need to collect more information about social determinants of health at the point of entry into the healthcare system."

Veterans Affairs (VA) has worked with veterans to identify mental health issues and develop ways to reduce suicide of veterans. "But, we're still seeing extremely high suicide rates out of the military community, and it continues to be that way despite interventions happening," White says.

Between 2005 and 2018, the overall suicide rate among veterans was between 17 and 18 episodes a day, despite numerous public awareness campaigns, new training mandates, and VA outreach programs.[8]

"There's quite a bit of research demonstrating that the amount of exposure in combat missions compounds over time, so the more exposure you have to active combat, the higher risk of PTSD that a soldier has," White says. "When military service folks are in active combat, their exposure to death and dying is extremely high compared to folks in the civilian world."

While people in military service are trained to be psychologically strong, they also are trained to use lethal weapons. Research suggests owning a gun in the home increases the likelihood of successful suicide.[9]

"An active duty deployment gives someone exposure to death among themselves and also among the combatants they're engaged with. That is extremely mentally challenging," White says. "When you're exposed to that kind of death or killing, that has an impact on your mental health."

Case managers are not the healthcare professionals who can help prevent or change a military service social determinant of health, but they can help veterans access the resources they need. "When we have an opportunity, we should look into the world of people who are serving and look into their potential

needs," White says. "That's the most important thing."

White wrote his paper for this purpose: "My article is to build awareness about this issue and reconfirm that suicide in the military is a pressing issue," he explains. "Case managers need to think about how they can best meet the needs of folks who've had military service." ■

REFERENCES

1. White CW. Professional case management and military service as a social determinant of health. *Prof Case Manag* 2021;26:46-49.
2. Cypel YS, Katon JG, Schure MB, et al. Food insecurity in US military veterans. *Food Nutr Bull* 2020;41:399-423.
3. Szymkowiak D, Montgomery AE, Tsai J, O'Toole TP. Frequent episodic utilizers of Veterans Health Administration homeless programs use: Background characteristics and health services use. *J Public Health Manag Pract* 2020; doi: 10.1097/PHH.0000000000001252. [Online ahead of print].
4. van der Maas M, Nower L. Gambling and military service: Characteristics, comorbidity, and problem severity in an epidemiological sample. *Addict Behav* 2021;114:106725.
5. Montgomery AE, Rahman FAKM, Cusack M, et al. Correlates of transitions into housing instability among veterans accessing Veterans Health Administration health care. *Med Care* 2020;58:1105-1110.
6. Campbell MS, O'Gallagher K, Smolenski DJ, et al. Longitudinal relationship of combat exposure with mental health diagnoses in the military health system. *Mil Med* 2021;186:160-166.
7. Veterans Health Administration, VA Montana Health Care System. Montana veteran demographics. Jan. 6, 2017. https://bit.ly/3dlInYJ
8. Shane L. Suicide rate among veterans up again slightly, despite focus on prevention efforts. *Military Times*. Nov. 12, 2020. http://bit.ly/2ZqPXt2
9. Handgun ownership associated with much higher suicide risk. Stanford Medicine News Center. June 3, 2020. http://stan.md/3jUkGbm

Post-Acute Care Transitions Were Problematic in Pandemic-Ravaged Areas

By Melinda Young

The continuum of care hit roadblocks in some U.S. cities as the COVID-19 pandemic made post-acute care transitions extremely challenging.

In New York City, the epicenter of the pandemic in March and April 2020, case managers needed to transition patients from acute care beds quickly, but had to adjust to surge obstacles to their usual post-acute options, according to the results of a recent study.[1]

In late March 2020, Montefiore Health System of Bronx, NY, increased its bed capacity by up to 150% in anticipation of receiving a surge of COVID-19 patients. This affected care transitions with its partners, an inpatient rehabilitation hospital and a skilled nursing facility.[1]

The health system had multiple options for transitioning patients to post-acute care facilities before the pandemic, says **Sheryl R. Levin**, MD, clinical director of rehabilitation consultation and post-acute care in the department of rehabilitation medicine at Montefiore Medical Center.

"What happened during the surge — and it's happening to some extent now — is our rehab in the Bronx was closed," Levin says. "There was limited availability for rehab, and we were not able to send patients out of our system because other systems were struggling, too."

Maintaining adequate stores of personal protective equipment (PPE) and other supplies also was challenging in both acute and post-acute care settings, including home care services. Subacute organizations also struggled with adequate staffing because many of their employees were sick with COVID-19.

Limited Options for Transitions

This early tactic evolved into a more efficient process of transitioning severe, recovering COVID-19 patients with rehabilitation needs to the inpatient rehab setting, and keeping medical patients with COVID-19 at the acute care hospital until they stabilized.[1]

"Usually, you could offer patients choices, but we didn't have those choices available to us," Levin says.

"We had very little bed availability for acute rehab, and we also had to worry about PPE [and] how much oxygen a patient was on."

If patients were ready for discharge, but COVID-19-positive, the question was whether they could be sent home, where other members of the family might not be able to provide adequate care. Home care was limited, she adds.

Some medically stable patients were transitioned to an acute, inpatient rehab hospital in the health system, but this facility remained full, limiting it as an option. "We needed beds, but where would we send them because our partners for subacute rehab could not accommodate the patients, and [the acute care rehab hospital] also remained full," she explains.

Inpatient rehab can provide a higher level of medical care and supervision. They can help acute care hospitals with bed availability by accepting patients who are stable enough for acute care discharge, but are not ready to be transitioned home. But many of these facilities were temporarily suspended during the COVID-19 surge because their beds were needed for medical/surgical patients.[2]

In turn, case managers and facilities were creative with care transitions. "Part of our surge plan was to take patients, who were not ready to go home and could not transition yet to rehab, and put them in the conference center, a transitional area, where they could receive medical care," Levin says.

Regulatory and rule changes helped facilitate transitions of care during the pandemic. For example, some insurance companies lifted authorization requirements. This meant patients could be moved as needed.

One of the most important ways they facilitated better transitions during the surge was through improved internal communication. "We have fabulous case managers here. For me, the greatest lesson was communication, relying on each other's strengths, and talking about it early on in the patient's care," Levin says. "We're so much better at [transitions] now with social work case managers, the medical team, and acute rehab."

They also worked with home care organizations to set up oxygen-weaning protocols in the community and establish therapy expectations. "We developed an intensive rehab option, where home care might not have nursing staffing, so we could send in a good therapist to provide patient support almost daily," Levin says.

This helped patients who would have been sent to a subacute facility. "This was a way to help us free up acute care beds and to get patients to appropriate discharges. It was all about communication with case managers and the rehab team and pulling together as teams to work together intensely," Levin says. "We instituted physician-to-physician discussions, and case management was very involved. Physicians talked with each other and updated each other about expectations for rehab, outcomes, and prioritizing patients, according to who could best benefit from acute inpatient rehab and from subacute care."

Restructuring the Process

Before the COVID-19 crisis, the care transition pathway involved nine steps, including insurance verification, patient/family facility choice, facility referral, and insurance authorization. During the crisis, those steps were eliminated, and the transition pathway moved from patient consent to one of two options: direct physician-to-physician discussion for immediate acceptance and an inpatient rehab transfer when the patient was medically ready, or a facility admission screen and acceptance, followed by a skilled nursing facility transfer when the patient was medically ready.[1] "Our processes are better streamlined than before," Levin says.

By late summer and fall, the care transition process returned to a more normal course, but some resurgence occurred in late 2020. "We worked seven days a week until the middle of July," Levin says. "We're definitely not inundated the way we were before. The [COVID-19] long-haulers here are people with chronic symptoms, and they may not need inpatient rehab."

The health system began a post-COVID-19 program, where people go home and receive follow-up care for chronic issues. Other COVID-19 patients, including people who had a stroke, respiratory failure from pneumonia, or those who underwent an amputation because of COVID-19 blood clots, are more debilitated and require acute rehabilitation.

"There are problems like that, which are really devastating," Levin says. ■

REFERENCES

1. Levin SR, Gitkind AI, Bartels MN. Effect of the COVID-19 pandemic on postacute care decision making. *Arch Phys Med Rehabil* 2021;102:323-330.
2. Gitkind AI, Levin S, Dohle C, et al. Redefining pathways into acute rehabilitation during the COVID-19 crisis. *PM R* 2020;12:837-841.

Patients with Diabetes Might Need Help Using Mobile Apps for Self-Care

By Melinda Young

New research suggests older patients with diabetes and depression are less likely to use a smartphone app to help with diabetes self-management.[1] Self-care apps are an important tool, and use likely will increase as people become more comfortable using them.

"I see apps as being the future [of disease self-management]," says **Diane Orr Chlebowy**, PhD, RN, MSN, MA, MSN program director and association professor in the University of Louisville (KY) School of Nursing. "There are a lot of considerations in the app development and in the implications for when those apps are ready for use among those with chronic illnesses and those with diabetes. Diabetes management is very complex with comorbid conditions. Taking all of that into consideration is really important."

The study was developed around the question of whether adults with diabetes would be interested in using a mobile app for self-management. "We did survey research and asked 35 adults to tell us a little bit more about whether they have smartphones and if they use mobile apps," she explains.

Researchers also asked:

- Do you use any apps specific to diabetes?
- Do you use any health-related apps, such as apps that help with physical activity or diet management?

Most adults surveyed did not use a health app or diabetes-specific app. "We did not necessarily ask them as part of the survey why or why not, but we were interested in looking at whether they had any visual problems that could be affecting their use of apps," Chlebowy says. "Nearly half of participants had visual problems." Visual problems can affect whether a person is comfortable using mobile apps.

Participants also reported numbness, pain, and/or tingling in their hands. This could contribute to a person's decision to not use mobile apps. "We did not ask whether that impacted their use of apps, but we felt those were important findings," Chlebowy says.

> "ONE TAKEAWAY FROM THIS STUDY AND WHAT WE LEARNED IS THAT THOSE WHO HAD MORE EDUCATION WERE MORE LIKELY TO USE APPS."

In additional, unpublished research, Chlebowy and co-investigators worked with participants with diabetes on a mock-up mobile app and found the participants were interested in the technology. "They felt like anything like an app that could help them with management would be very beneficial," she says.

Respondents were interested in participating in the study and receiving help to manage their diabetes. "Some said the apps could help them and remind them of self-care behaviors and what they should be doing on a daily basis in an effort to manage diabetes. One takeaway from this study and what we learned is that those who had more education were more likely to use apps. If we think about the general population as people get older and are trying to manage not just their diabetes, but other comorbid conditions, we realize they will, in many cases, need some additional education."

Case managers should remember patients could benefit from mobile apps for self-care, but they likely will need education on how to download and use them — particularly if the patients are older.

"They were not always as comfortable using apps as young adults, but they were not resistant to using apps," Chlebowy says. "As future apps are developed, or if we suggest diabetes patients use apps on their phones, we should think about how they may have visual problems related to diabetes, which can definitely impact their comfort and ability to use these apps."

Case managers and other healthcare professionals who seek ways to improve patients' adherence to self-care and to promote behavior changes should remember that technological tools can be challenging for some patients.

"It's challenging for them to manage and to make some of the necessary behavior changes," Chlebowy says. ■

REFERENCE

1. Chlebowy DO, Coty MB, Lauf A, et al. Mobile app use in adults with comorbid type 2 diabetes and depression. *West J Nurs Res* 2021:193945920988791. doi: 10.1177/0193945920988791. [Online ahead of print].

Tools Keep Tabs on Patients Remotely, Predicting Outcomes and Conserving Resources

By Stacey Kusterbeck

In the early days of the pandemic, some patients with COVID-19 were deteriorating a few days after their initial contact with a physician in the ED.

"For a lot of respiratory illnesses like the flu or colds, we generally expect those illnesses to get better when patients leave the ED. Because this particular viral illness was defying our typical expectations for how viral respiratory illnesses behave, we were trying to figure out if there were any risk factors [to explain] why patients might return," explains **Austin Kilaru**, MD, MSHP, an emergency physician and researcher at the Perelman School of Medicine at the University of Pennsylvania.

Consequently, Kilaru and colleagues examined the outcomes of about 1,400 patients with COVID-19 who were treated and discharged from the ED between March and May 2020. Investigators found 5% returned to the ED within 72 hours of their initial visit and required admission. Another 3.5% required hospital admission within a week of their initial ED visit.

Additionally, the researchers found (perhaps not surprisingly) age was a significant risk factor. "Patients who were older than 60, compared to younger patients between the ages of 18 and 39, had three times the probability of coming to the hospital within 72 hours vs. 2.5% [in the younger patients]," Kilaru reports.

Other risk factors associated with a return visit to the ED included low blood oxygen levels (a pulse oximetry reading less than 95%), an abnormal X-ray, or a fever upon presentation to the ED. Each factor was associated with double the probability of a return visit to the ED within 72 hours.

"We also looked at patients who came back [to the ED] within seven days. For that group, we found additional risk factors [for a return visit to the ED] were obesity as well as having hypertension as a comorbid illness," Kilaru says.

Knowing which COVID-19 patients may need closer monitoring is helpful, but carrying out such a task when staff resources are strained is tough. To address this issue, the University of Pennsylvania Center for Health Care Innovation developed COVID Watch, an automated text messaging approach that checks in with patients twice a day. The tool escalates concerning cases to a team of telemedicine clinicians who are available to respond 24/7. If a patient reports any deterioration in his or her ability to breathe or other worsening symptoms, that case will go to a clinician who will follow up with the patient quickly. The clinician can refer the patient to the ED, if necessary, or arrange for further assessments or care, as needed.

Clinicians in the ED greatly appreciate COVID Watch because they know their patients will be followed once they leave the ED. Patients seem to appreciate the monitoring, too. "The goal of the program is to make sure patients are feeling better, but also to make sure that our outpatient colleagues aren't overwhelmed with calls or concerns so we can all be more efficient," Kilaru says.

Further, there now is an additional program for COVID-19 patients who meet higher-risk criteria. These patients will receive both the automated text messages through COVID Watch and a pulse oximeter upon discharge from the ED. "We collect ... their pulse oximeter readings, and are able to again escalate [patients with] increasing hypoxia to a pool of nurses and a physician. If necessary, we are able to bring patients back to the hospital," Kilaru explains.

These tools help prevent patients from becoming so sick that no one can help them.

"We want patients to come back if they are starting to get sicker," Kilaru adds. "We have better therapeutics, and we can put those patients on oxygen."

COVID Watch is available to a broad patient pool. "Anybody who interacts with our health system, whether they are in the hospital setting or outpatient setting, can be enrolled in this program," says Kilaru, adding there is no cost to the patients or their insurance companies. "This program significantly benefits our health system in terms of triage and capacity as well as patient satisfaction, but this is not a profit-seeking enterprise."

Of the first 3,000 patients invited to participate in COVID Watch, researchers found 83% were managed through the tool without escalating to a clinician for follow-up.[1] They also found 78% of patients who were offered the program accepted enrollment and remained engaged for a mean of about 12 days. Further, about half of participants asked to

extend their involvement with the 14-day COVID Watch monitoring period to 21 days.

About 2% of participating patients were escalated to a nurse every day. Of all the patients who escalated to a nurse during the study period (396), 83 patients were advised to go to the ED. An additional 26 patients were in the ED or admitted to the hospital by the time a COVID Watch nurse responded.[1]

More data should be forthcoming soon. Funding from the Patient-Centered Outcomes Research Institute is enabling investigators to rigorously study outcomes from patients enrolled in the COVID Watch program. "We are essentially comparing patients enrolled in the program to patients not enrolled, and examining outcomes for 30 days after getting symptoms from COVID-19 and getting tested," Kilaru observes. "That study is actively going on right now."

Researchers also are analyzing the benefits of providing higher-risk patients with pulse oximeters to determine if this approach enables clinicians to identify worsening symptoms faster, and whether earlier detection can help patients recover without returning to the hospital.

COVID Watch does not require a smartphone. Most patients own some kind of cellphone that allows them to participate. Kilaru says a goal of the program is to cut the number of check-in phone calls staff have to make "so that we are only responding to patients who are worsening or reporting some kind of concern rather than calling every patient every day. The use of these automated programs reduces the amount of human power needed."

Another plus is the ease with which emergency clinicians can enroll patients, essentially with one click in the electronic medical record during discharge. "We had to have a system that was essentially very easy to implement in the ED," Kilaru says. "We purposefully didn't want it to take an hour to get someone into the program."

Further, investigators note that automated text messaging backed up by clinician support carries potential beyond the monitoring of COVID-19 patients. Researchers at the University of Pennsylvania have produced a similar approach for patients with COPD, and they are in the process of developing programs for patients with other chronic conditions, such as congestive heart failure and hypertension.

Another way to better manage available resources is to develop a tool that can provide frontline providers with keener insight on which patients who present to the ED with mild symptoms from COVID-19 are at the highest risk for requiring intubation or succumbing to the illness within 30 days. Researchers at the Icahn School of Medicine in the Mount Sinai Health System in New York City created an artificial intelligence-driven algorithm they say can deliver such insight based on routine test data and a chest X-ray. This is information emergency physicians generally have at hand.

Fred Kwon, PhD, a researcher in biomedical sciences at Icahn, says this algorithm differs from other predictive tools. "There are algorithms that use only imaging data or that only use the clinical data from EMRs. What our algorithm does is combine [both sets of data] together similar to would a clinician would do," he explains.

Further, Kwon notes most other prognostic algorithms only take information from patients who have been admitted or have undergone more advanced imaging tests, such as a CT scan. "You only need to take information that is obtained within days, if not hours, of patients coming to the ED to get an idea of the potential severity so that you can triage the patient and make sure appropriate resources are allocated," he says.

To develop the algorithm, researchers used data from 338 patients ages 21 to 50 years with COVID-19 who presented to EDs in the Mount Sinai Health System between March 10 and March 26, 2020. The data included chest X-rays, basic blood work (including a metabolic panel and complete blood count), and blood pressure readings. Researchers applied the algorithm to adult patients of all age groups.

Researchers reported the algorithm offers 82% sensitivity in predicting intubation and death within 30 days of initial arrival to the hospital, producing a severity score clinicians can use to plan care. For instance, a patient with a higher severity score likely would be placed under close observation and perhaps given more aggressive or rapid treatment.

However, Kwon acknowledges these results are based on a patient population served by EDs within the Mount Sinai Health System. While this cohort was diverse, other investigators are collaborating with 20 different hospitals around the globe to train a more generalizable algorithm with data from more than 60,000 patients.

"Our algorithm can be readily adapted to be used in patients not just positive for COVID-19, but hopefully in the future, other acute respiratory syndromes and other respiratory illnesses," Kwon says. "Pneumonia and acute respiratory distress syndrome — those are the big ones." ■

REFERENCE

1. Morgan A, Balachandran M, Do D, et al. Remote monitoring of patients with COVID-19: Design, implementation and outcomes of the first 3,000 patients in COVID Watch. *NEJM Catalyst*. July 21 2020. https://bit.ly/35ZqOt8

Help Physicians, Nurses Overcome Fear of Seeking Assistance for Stress Relief

By Greg Freeman

Stress has long been a serious problem for physicians and nurses, but the added burden of COVID-19 is bringing attention to a particular challenge: All too often, clinicians are reluctant to seek the support of their employee assistance programs (EAPs) and other mental health resources available to them.

A primary reason they avoid seeking help is that they fear they will face negative repercussions at work, even losing their jobs, according to recent research.[1]

A survey conducted by the American College of Emergency Physicians (ACEP) revealed 45% of emergency physicians do not feel comfortable seeking mental health treatment. Most emergency physicians (87%) said they have felt more stress since the start of the COVID-19 pandemic, citing a lack of personal protective equipment (PPE) and other resources as key reasons.

"These new data add real urgency to the need for emergency physicians, policymakers, and clinical leaders to work together to change our approach to mental health. Every healthcare professional, especially those on the frontlines of the pandemic, should be able to address their mental health without fear of judgment or consequences," **Mark Rosenberg**, DO, MBA, FACEP, president of ACEP, said in a statement.[2]

ACEP reports physicians avoid seeking help because they fear being asked about mental health treatment at some future point in their careers. Specifically, the poll revealed stigma in the workplace (73%) and fear of professional reprisal (57%) as the top reasons for avoiding mental healthcare. Additionally, many state medical boards require disclosure of mental health problems on physician licensing applications, although there appears to be ongoing debates and evolution about these policies.[3,4]

In the early stage of the pandemic, an emergency physician serving as medical director at a New York City hospital committed suicide. Her family cited the stress of treating COVID-19 patients as a primary cause. In the same week, a paramedic in New York City also killed himself; the family cited COVID-19 stress.

It is important to separate the mental health resource from the place of employment, says **Charles Rothberg**, MD, chair of the Physician Wellness and Resilience Committee at the Medical Society of the State of New York (MSSNY). "Physicians in general are in one of the high-stress professions, like law enforcement and the military. Like both of those professions, there is a culture where physicians don't seek help because of certain cultural and professional hurdles," Rothberg says. "Layered on that is the stress related to COVID-19. That stress is extraordinary."

Medical students and residents suffer the same stress. The additional burden of feeling like they are not ready for the COVID-19 pandemic exacerbates the problem.

"When you combine that with the social isolation, particularly for people like residents who have traveled to a new city and don't have the support of local family and friends, all of that disrupts a person's natural ability to cope," Rothberg says.

In July 2020, the MSSNY launched a program to assist physicians, residents, and medical students who may be contemplating suicide. The week the MSSNY P2P started, three physicians reached out requesting support.

The program can offer independent support that may appeal to physicians who do not want to reach out to their own institution for help.

"The idea of peer-to-peer is that it is a nonjudgmental, nonthreatening, noninstitutional encounter that calms people, reassures them, validates their thoughts and feelings, and supports people by telling them that what they are feeling is normal and not extraordinary," Rothberg says. "Or, if it's not normal, they provide resources to pursue a remedy."

There are similar peer-to-peer programs that are institutionally driven, Rothberg notes, but the MSSNY program is not tied to any healthcare institutions. The program ensures the peer supporters do not have an employee-employer relationship or supervisory control over the person seeking support, Rothberg notes.

The goal of the program is to assist physicians before their stress reaches a critical point and affects their performance at work or leads to related issues like substance abuse. Those seeking help are matched confidentially with a peer physician through email and a toll-free phone number. The program matches the physician in need with a peer in similar professional standing, but not necessarily in the same geographical area. For confidentiality, physicians seeking help do not want to talk with someone in their immediate community.

Some hospital systems have expressed interest in adopting an approach like the MSSNY program as part of existing EAPs. However, Rothberg urges caution to leaders considering this path.

"There needs to be a firewall. An in-house program, no matter how well intentioned and designed, is not going to work as well as something that is separate from the institution," Rothberg says. "They want to set it up through human resources because it is an employee benefit, but I don't think that any system in house can be as effective as a [external] physician-run program."

Rothberg notes physicians in a peer-to-peer program remain obligated to report impaired physicians and misconduct. If either party learns of misconduct or that substance abuse has affected the other physician's work, that must be reported to the proper authorities.

"This program is not made for someone who is already impaired. A physician who is impaired might be reluctant to seek help for fear of being reported, so we are sensitive to that and have mechanisms to avoid getting into that situation," Rothberg says. "An employer might not feel the same way about that sensitivity."

The greatest difficulty in treating frontline healthcare workers for their COVID-19-amplified stress is their resources for help are tied so closely to their employers, says **Wilfred G. van Gorp**, PhD, ABPP, who offers neuropsychology testing in New York City and Chicago.

"That is a huge hurdle for healthcare institutions to overcome, especially with doctors," he says. "The very act of acknowledging you have a problem and asking for help could derail your career. It's a quandary that is very problematic for some professions and difficult to overcome."

Van Gorp advocates for strong barriers between the EAP and the employer. Confidentiality must be absolute and promoted effectively to employees and physicians.

"The confidentiality must be explained, guaranteed, and agreed to by hospital administration. Otherwise, no one would avail themselves of this resource," van Gorp says. "This has to be widely endorsed by hospital administration because the repercussions could be quite serious if the employer is not serious about it. You need to be physically distant from the hospital, and available off hours, not on the second floor where everyone sees the chief of surgery going in to the therapist's office."

Nurses deal with the same reluctance to seek help for stress, says **Mike Hastings**, MSN, RN, CEN, president of the Emergency Nurses Association (ENA).

"We are the caretakers. Historically, we just don't do a good job of taking care of ourselves," he says. "With COVID, we have seen some hospitals focus more on wellness issues and pushing out more resources for healthcare workers. Convincing nurses to take full advantage of those resources can still be a challenge." Many nurses fear they might lose their license to practice nursing or lose their employment if they seek mental healthcare, according to **Holly Carpenter**, BSN, RN, senior policy advisor for the Nursing Practice and Work Environment and Innovation departments with the American Nurses Association (ANA).

Hospitals should offer mental health screenings and crisis response protocols, according to Carpenter. She also says mental health treatment should be covered by employee health plans — and that information should remain private. State laws and boards of nursing regulations concerning mental healthcare treatment, substance abuse treatment, disclosure, and possible penalties are not uniform. This prevents nurses from knowing exactly how to proceed if they think they need help.

"Those fears can be a reality if the care was not confidential and there was not a program in place to safely transition them back to work," Carpenter explains. "Patient safety, nurse safety, and the employer obligations all have to be taken into account. It's not as cut and dried as you might think when nurses ask about how this can affect their careers."

ENA has encouraged the use of peer support groups in which nurses can talk about their struggles and find healthy ways to cope.[5]

"It's a good chance for them to realize they are not alone. For nurses, that can be critical. A lot of times, when you only know what's happening in your one institution, there can be a mindset that you're the only one facing these problems," Hastings explains. "When we're able to reach out to others, we realize that the problem is more global than just your own institution. It at least allows you to understand you're not alone in what you're facing. Together, you'll get through this."

Hastings says talking about stress in the workplace regularly can help remove stigma about the subject. "This is something that everyone in our world experiences sometimes," he adds. "It's important to establish that it's OK to talk about it and get help."

"We really want to see the assessment and screening so they don't get to the point of crisis, and then a form of help that doesn't threaten their license, their confidentiality, or their employment," Carpenter says. "Optimal staffing is a big help. It would be great if a nurse could actually take her breaks as scheduled. If you don't have time to eat or go to the bathroom in a 12-hour shift, that's not going to help anybody."

Nurses need time and space to decompress after a patient death. Avoid mandatory overtime, and provide resources like float nurses so colleagues can take these breaks. Effective and enforced workplace bullying and violence prevention policies help, too.

"I'm a nurse working at the ANA office. If we had a death at the ANA, we'd probably all be given time off and have people calling to check in on us. But for most nurses, they have to prepare the body for the morgue and get ready for the next patient," Carpenter says. "They may have known that patient for days, and they need a nice, serene place where they can decompress for five to 15 minutes. Nurses are used to death, but they're not inured to it — nor do we want them to be."

The most important thing is for nurses to know they are not alone, Carpenter adds. Hospitals should offer some type of free, confidential, and easily acceptable mental health screening, she says. The goal is for people to obtain help before the stress leads to a more serious condition.

The symptoms of stress can manifest in many ways, including headaches, lethargy, emotional outbursts, and sleep disorders, says **Jorge Palacios**, MD, clinical researcher at SilverCloud Health, a digital mental health company with offices in Boston, London, and Dublin.

"The more experienced the healthcare workers are, the less likely they are to experience mental health issues related to work. It's the new people who have been on the job for less time that are at higher risk," he says. "Adequate training and support also have been identified in scientific studies as lowering the risk. Healthcare workers who don't feel they have enough training to deal with these situations, and who don't have the support to deal with their own problems, are at greater risk."

On top of everything else, healthcare workers have been anxious about bringing COVID-19 home and transmitting it to loved ones. This leaves workers feeling even more vulnerable. "There is a loss of control, even though they have been trained and know more than most about the virus. They worry about the unknowns, the symptoms and the mutations, whether the vaccine will work," Palacios says. "That has an effect on mental health."

On the bright side, Palacios says research has indicated some healthcare workers feel an increased sense of meaning and purpose because of the pandemic.[6] Exercise, talk therapy, meditation, yoga, in-person support groups, and online therapy tools all could help healthcare workers cope, according to Palacios.

Physicians or nurses seeking mental healthcare are making themselves vulnerable, not just professionally but on a personal level. Any program seeking to help them must acknowledge that vulnerability and assure users of confidentiality.

"It's important to understand the needs of your frontline healthcare workers and provide the kind of assistance they need in the form that makes them most comfortable accepting it," Palacios says. "It's not enough to say that you have these resources within the hospital or health system and you should make use of them. If the help is not provided in a way that makes them feel safe, they will not use it."

(Editor's Note: For those in need, contact your state's medical society or medical board to identify resources in your area.) ■

REFERENCES

1. American College of Emergency Physicians. Poll: Workplace stigma, fear of professional consequences prevent emergency physicians from seeking mental health care. Oct. 26, 2020. http://bit.ly/37TmhK6
2. American College of Emergency Physicians. As stress during the pandemic grows, nearly half of nation's emergency physicians uncomfortable seeking mental health care. Oct. 26, 2020. http://bit.ly/3pvrzBs
3. American Medical Association. AMA adopts policy to improve physician access to mental health care. June 13, 2018. http://bit.ly/3rG07TE
4. House Committee on Energy & Commerce. Hearing on high anxiety and stress: Legislation to improve mental health during crisis. June 30, 2020. http://bit.ly/2WZVC7X
5. American Psychiatric Nurses Association. Well-Being Initiative. Nurses' guide to mental health support services. https://bit.ly/38In4ge
6. Shreffler J, Petrey J, Huecker M. The impact of COVID-19 on healthcare worker wellness: A scoping review. *West J Emerg Med* 2020;21: 1059-1066.

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. **Why should case managers consider military service a social determinant of health, according to researcher Charles William White, EdD, MBA?**

   a. Many enter the military with behavioral health and other problems.
   b. It is the issue of control over their environment.
   c. It is because of low wages.
   d. Military service creates excessive stress.

2. **A study of people with military service and social, physical, and behavioral health revealed people in the military experienced higher prevalence of:**

   a. food insecurity.
   b. mental illness.
   c. poor physical health.
   d. housing insecurity.

3. **In the early weeks of the COVID-19 crisis, case managers at a health system in Bronx, NY, faced obstacles to transitioning patients from acute care beds because:**

   a. inpatient rehabilitation facilities were suspended because their beds were needed for medical/surgical patients.
   b. nursing homes in the area closed.
   c. family members refused transitions to residential facilities out of fear of the disease.
   d. the beds at inpatient rehab facilities were full from stroke, brain injury, car accident, and other patients.

4. **According to the results of a new study, which group of patients with diabetes is less likely to use a smartphone app for diabetes self-management?**

   a. Patients with four or more comorbidities
   b. Male patients
   c. Sicker patients
   d. Older patients