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INSIDE

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Develop Best Practices for Shared Decision-Making

Share information with patients, other providers

By Melinda Young

Case managers are learning to fully include patients in medical care transition decisions, which can be challenging.

"Typically, people have allowed the healthcare provider to make decisions for them; it's the attitude of 'Oh, the doctor knows and it's up to him to decide what I need,'" says **Cheryl Acres**, RN, CCM, CDP, owner of Comprehensive Care Management, LLC, in Dallas.

"IT'S ALL ABOUT ADVOCACY AND EDUCATING CONSUMERS ON HOW TO ASK THE BEST QUESTIONS AND HOW TO GET ANSWERS."

But as the healthcare industry is shifting to patient-centered and value-based care, the traditional ways of making decisions are giving way to shared decision-making. "There are generational differences," Acres says. "You have to figure out how savvy they are."

For example, some elderly patients know how to use technology. "I have a woman who is 93 who uses a computer for emailing," she adds.

Younger people often are more likely to take control over their medical decision-making and to perform their own research online. "We have consumerism now," Acres says. "People are much more savvy, thinking, 'Maybe I don't want to have surgery and I can wait.'"

Shared decision-making includes patients gathering information from any and all sources, including literature, the internet, friends, neighbors, social media, and healthcare providers. Patients want to make an informed choice in their care, she adds.

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For example, a patient may experience chronic pain from arthritis in the knee. The physician might recommend surgery, injections, physical therapy, or pain medication. The doctor might believe surgery is the best solution, but that may not be the direction the patient wants to go. "You have to share information across multiple specialties, and the patient has to make the decision," Acres notes.

Sometimes, it will be the patient's guardian or a person with medical power of attorney who will make decisions, so case managers should know how to handle those situations as well. *(See brief on shared decision-making with guardians in this issue.)*

Acres offers these best practices on using shared decision-making:

• **Assess the patient's situation.** "It starts with assessment," Acres says. "Figure out what's going on, and whether they have concerns."

It also is important to educate patients about all facets of their self-care and health management before engaging in shared decision-making. For instance, there might be fall risks at home the patient never considered, such as rugs. "If they don't know that it's a problem, they can't fix it," she says.

Another obstacle is faulty information. When patients say they have heard a treatment or action would be beneficial, it is important to find out where they heard this.

"You have to keep questioning and interviewing them to find out who told them what," Acres says. "Where did they find that out? What are their sources of information that they're considering, and how does this factor into the decisions they have to make?"

• **Follow best practices.** "As a professional case manager, many of the guiding principles from the CMSA [Case Management Society of America] standards of practice [SOP] are key in the process of shared decision-making," Acres says.

Those standards include:

• facilitating the patient's self-determination and self-management;

• using a comprehensive, holistic, and compassionate approach to care delivery;

• practicing cultural and linguistic sensitivity;

• implementing evidence-based care guidelines;

• facilitating awareness and connections with community support;

• fostering safe and manageable navigation through the healthcare

EXECUTIVE SUMMARY

Case managers are learning more about how to include patients in their care transitions, as part of shared decision-making.

• While older Americans tend to rely on physicians to make their decisions, younger patients may treat their healthcare as something for which they perform their own research and come to their own conclusions.

• The first step in shared decision-making is to assess the patient's situation, followed by educating the patient about all facets of their self-care and health management.

• Teaching patients about their medications and addressing their social determinants of health are part of the shared decision-making process.

system. *(More information is available at: https://cmsa.org/sop/.)*

• **Teach patients about medications.** Patients hold many misunderstandings about the medication they are prescribed. For shared decision-making to work, they should understand what providers mean when discussing their prescriptions.

Acres created an educational sheet for patients, titled, "Medication — It can be a real pill ... Or not!" The idea was to review the basics and issues with medication, such as inhalers, sprays, nebulizers, under-the-tongue tablets, swallowed, creams, lotions, patches, injections, or infusions.

"It's designed for the lay person," Acres adds.

Her medication sheet includes information explained in simple terms, including:

• side effects, including reaction with other medications, and how using multiple pharmacies can lead to an omission of information about interaction issues;

• keeping track of dosage changes or when similar medication is substituted;

• feeling better does not mean it is time to stop taking the medication;

• talking to pharmacist or physician about issues.

• **Address social determinants of health.** Case managers should drill down into why patients say they make certain decisions that appear to run counter to their health and best interests. For instance, if a patient says he or she does not want to take a certain medication, the case manager should find out why.

"Keep probing until you get down to an answer of, 'I can't afford it' or 'I heard this about it,'" Acres explains. "If it's a money issue, then see whether there are funding resources available."

Or, there may be another medication that is generic or similar and more cost-effective the patient may be willing to take if the doctor agrees it is suitable. "You don't have to go with their first decision," she says. "You have to explore everything."

Open-ended questions and statements, such as "Tell me what you're thinking," can uncover underlying issues and improve shared decision-making.

Case managers should repeat what the patient says and ask if the patient

Tips for Coaching Patients to Talk with Doctors

By Melinda Young

Many patients find it challenging to speak with their physicians and ask questions. Case managers can serve as a go-between for patients and as an interpreter, teaching patients how to make the most of these doctor-patient encounters.

Before a scheduled doctor's visit, case managers can help patients figure out how to talk about their health concerns in a way the physician will hear them and help find solutions, says **Cheryl Acres**, RN, CCM, CDP, owner of Comprehensive Care Management, LLC, in Dallas.

The patient might have only a minute or less to get the doctor's attention as they describe their symptoms. Patients need to know how to cut to the most important information.

"Say, 'Here's my problem. It started like this,'" Acres says. "Describe symptoms, saying, 'It's affecting my sleep, and I've tried ice, heat, taken pain pills, gone to the chiropractor,' and tell them what you've done and whether or not it worked or partly worked."

Acres also lists these tips:

• Make a list of issues, including symptoms and changes — both good and bad;

• Bring a current list of prescriptions and over-the-counter medications;

• Write questions in advance and bring these to the appointment;

• Ask physicians for their thoughts on the problem;

• Ask how the patient and doctor can improve, fix, and/or prevent the problem;

• Ask what will happen next if the suggested treatment does not work;

• Ask for the physician's input on trying therapies, diet, exercise, massage therapy, acupuncture, and other methods;

• Find out if any clinical trial options or new medications are available;

• Take an advocate to the appointment;

• Consider addressing long-term needs, quality of life, and advance directives. ■

understood it correctly. "People are not always good at expressing things, so you have to keep dancing around the topic until you get them to open up more," Acres suggests. "Show them that your role is to help them with whatever situation they have."

• Translate what is happening. "My job as a case manager is to be a translator," Acres says. "We tell people, 'This is what it means. This is what a skilled nursing facility is.' People just don't know."

Patients and their families often do not understand how their insurance works, what will be covered, and when it will be covered. Case managers could ask patients if they are interested in how their insurance works. If they are not, then they can move on.

"It's all about advocacy and educating consumers on how to ask the best questions and how to get answers," she explains. "If you don't ask the right questions, you don't get good answers."

Case managers also translate what the patient's medication is for, and how the patient should watch for signs and symptoms of his or her disease. They also can teach patients how to talk with their physicians — particularly after they first received a diagnosis. *(See Acres' tips on talking with doctors in this issue.)*

"Someone said to me one time, 'When the doctor said cancer, I went deaf,'" Acres recalls. "When you get shocking news, your brain stops working."

Patients need time to absorb information and to gain the courage to ask questions. They cannot make decisions if they do not understand or hear what is said to them.

• Acknowledge patients' rights to make even bad decisions. "All of us, as our own decision-makers, have the right to make bad decisions," Acres says. "If the doctors say we really need to have some X-rays done to see what that lump is, and the person says, 'Nope, not going to do it,' they have the right to refuse care."

Case managers can acknowledge the patient's words and feelings. "All you can do is say, 'I hear you. Why don't we take a break and maybe come back and talk about this later? You have had a lot of information presented to you,'" Acres suggests.

With a little time to think about their decision, patients may ask new questions or want to talk about it with their families. "The case manager can say, 'I'm OK with your saying no, but I want you to talk about it with your family, do some research, and see if you have more questions,'" she says.

If patients are open to further discussion, case managers can hold discussions to discover what is really bothering patients about the proposed next step. Maybe there is a wedding the patient wants to attend, and he or she could not make it to the wedding while undergoing treatment or surgery.

"Put yourself in the other person's shoes and see from their perspective what they're really thinking," Acres says. "It could be misinformation that is so fearful for them they can't do this, so give them time, and don't put them on the defensive." ■

Shared Decision-Making Also Can Work with Patients' Guardians

Determine who makes decisions

By Melinda Young

Patients often lack the cognitive capacity to make their own decisions. In those cases, a family member or another person might be legally appointed medical power of attorney or guardian.

The laws vary by state, so case managers should learn what their own states require for a third-party decision-maker. For instance, a state might require that someone be appointed to make healthcare decisions for a patient if a physician certifies the patient cannot make his or her own healthcare decisions, says **Cheryl Acres**, RN, CCM, CDP, owner of Comprehensive Care Management, LLC, in Dallas.

The patient also might have already signed a legal document appointing a family member or other person as his or her medical power of attorney. Those circumstances can make shared decision-making tricky, particularly if disputes arise among other family members.

"Say you have a cognitively impaired person, and the appointed medical power of attorney says, 'I don't want Mom to have surgery,'

but the patient wants it, or the other children are involved," Acres explains.

Cases like this might have to go through mediation, and case managers will have to wait to see how it is resolved. Acres has experienced these complicated issues and has testified in court as a result. "I have to be objective," she says.

For example, Acres handled a case in which a woman in an assisted living facility also received costly 24-hour caregiving services. The woman's son, who served as her medical power of attorney, approved the 24-hour care. The woman's daughter disagreed the 24-hour service was necessary. Their dispute went to court, and Acres was asked to assess the woman's living situation.

"I met with the lady, checked her cognitive function, and talked with the assisted living facility to get an idea of what they were doing for her and how much help she needed," Acres says. "She has some cognitive impairment, so how much care does she need?"

One of the questions was whether the woman would benefit from living in a memory care unit, where she would be engaged at a level where she could participate. All issues and decision options needed to be explored, despite the legal dispute over who could make decisions.

"Sometimes, shared decision-making is with the medical power of attorney or the legal guardian," Acres says. "Someone may go for guardianship, and that may trump the medical power of attorney."

Also, there might be two guardians — one who makes the person's healthcare decisions, and one who handles financial issues.

When case managers engage people in shared decision-making, it is possible that four people are involved in considering options: the patient, the parent (if the patient is a minor), the person with a medical power of attorney, and the legal guardian.

"Each state has its own rules about decision-makers," Acres says. "It's usually the spouse, but if there is no spouse, then it's the children or oldest child."

Without a legal document naming the patient's decision-maker, it can be challenging for healthcare providers to determine who can share the decision-making process. Consider the case of a couple, both in their 80s. The husband is sick and needs medical care in the hospital. Without a legal document, the providers may turn to the wife. But she might show signs of dementia, although she had never been diagnosed with cognitive impairment, Acres says.

"Then, the children are weighing in, and it is so complicated," she adds. ■

Tips to Improve Relationships with Patients Over the Phone

By Melinda Young

As many case managers have learned during the COVID-19 pandemic, switching from in-person meetings with patients to phone sessions is challenging.

Case managers could miss certain cues, such as evidence of nutritional status, environmental cues, and body language that may indicate resistance or discomfort.

There are ways case managers can improve their phone relationships with patients/clients. These center around becoming better and more attentive listeners.

"Hone your listening skills," suggests **Eric Bergman**, RN, CCM, past president of Case Management Society of America Chicago. "You have to be able to hear better over the phone and be more focused than you would be in person. You don't get any visual cues, no body language, and you can't even see what the client looks like."

Bergman offers these tips:

• Listen for audible clues and cues. "Over the telephone, you're listening to a lot of breaths and pauses, and you need to be extremely attentive to what makes someone laugh," Bergman says. "As you practice, you can hear a smile over the phone. Those are the skills."

Case managers need to be sensitive to what makes a relationship work between relative strangers. "How are you connecting with somebody in a way that allows them to trust you and be comfortable with you so you can ask uncomfortable questions," he says. "You have to build a personal relationship, and a lot of practitioners are hesitant."

Listening for cues can help build trust, and it helps as case managers

work with the same people over weeks or months. "The other day I heard a patient's voice, and I knew she was tired and depressed," Bergman shares. "My immediate response was, 'I can hear it's not a good morning; you sound a little bit down today.'"

The patient laughed and joked about how Bergman was not her therapist. But she was pleased that he was paying attention to her, and she used that as an opportunity to talk and vent her frustration.

"I could just hear it in her voice," Bergman adds. "I think that if you are prepared to listen, you will hear their emotions."

• Share a little to help build the relationship. "One of the important aspects of that is learning to carefully share some personal information so you are building a relationship with somebody," Bergman says. "One thing I do is I have a little bit of personal information that I have carefully considered that I am willing to share. It's a careful line you have to walk."

For instance, every case manager will have little aspects of their life that they would be willing to share with patients to help build trust and rapport. "I know from personal experience that if you're only a voice over the phone, and you don't share something a little personal, you can't gain the trust of the patient," Berman says. "But if you can find those little aspects of your life that are not personal enough to give them too much insight into your life, but allow them to see you as a caring person, who has three dimensions, you're a little better off."

One such tidbit would be about where the case manager lives. It would be fine to mention a general area or a city, without naming the specific subdivision or street, he says.

"I tell people I have children, and then they will talk about their children," Bergman says. "I can reveal that I relate because I have children of similar age, or I have experienced that with my kids. There's acknowledgement that we share something."

• Be aware of roadblocks. The case manager might know a call might not happen at the best time. It could be the case manager is tired and has just this one last call to make after a busy day, and wants it to be over quickly, or the patient is tired and disinterested.

"Ask, 'Is this a good time for you?'" Bergman suggests.

If a patient arrives late to a case manager's office and looks disheveled and weary, the case manager has visual clues that something is off. But it is more challenging to identify these roadblocks over the phone.

"You have to be listening to hear whether they sound rushed and whether it took 10 rings for someone to answer the phone," he says. "Maybe there's a child crying, or you hear something else going on."

If the case manager launches into the agenda without paying attention, there will be a roadblock. "Depending on the person's personality, some people may just be polite and they won't say it's a bad time for them," he explains. "Others will say, 'Forget it — I'll talk to you another time.'"

The key is to be sensitive to the patient's mood and find a way to navigate around any problem with the timing. "You can say, 'It sounds like this is not so good a time for you. Do you want me to call you back later?" Bergman suggests.

• Learn relationship-salvaging skills. Bergman worked as a flight attendant for 27 years, learning every type of creative way to salvage encounters with customers. He has applied these skills to his work as a case manager.

"The thing about being a flight attendant is you're not only with people at a stressful moment, but you're locked up with people in a stressful moment," he says.

For example, Bergman recalls a major snowstorm at a Northeastern airport. The plane sat for hours on the tarmac for de-icing. Finally, the pilot received word the plane could take off, but it was unable to land in the destination city and had to land in another state.

"The flight took eight hours, and we ended up in the wrong place," Bergman says. "I was the one who led the crew and took care of people for eight hours, and when they got off the plane, they all said, 'Thank you.'"

The key to landing that kind of success in service and provider

EXECUTIVE SUMMARY

Phone communications jumped in importance over the past year of the pandemic, but there are tactics case managers can use to improve their technique and build rapport with patients or clients over the phone.

- One tip is to listen for audible clues about the person's mood and energy level.
- It helps if case managers share a little about their own lives to build rapport.
- Sometimes, the call, even if scheduled, comes at a bad time. Case managers should be alert to possible roadblocks to a successful conversation and do their best to reschedule or otherwise overcome those barriers.

relationships is to be completely genuine and honest with people. "In that flight circumstance, we didn't know what would happen, but I knew it would be bad. I said that, and I encouraged the captain to be brutally honest," he says. "We said, 'We're going to try to get you there, and we'll let you know what's going on.'" Even if nothing changed, they spoke with passengers every 30 minutes to let them know they weren't forgotten.

As a case manager, it is OK to tell a patient who needs help or is in a crisis that it will take some time to figure out the next step and to make arrangements. "You can say, 'I'll still call you in two hours if I haven't figured it out yet,'" he adds. "Most people want to know that you're really helping them and that you care and that you get it."

The other lesson Bergman learned from his flight attendant days to his case management role is to not take the other person's bad mood personally. "My experience as a flight attendant getting screamed at by somebody taught me to not take anything personally," Bergman explains. "People are frustrated, including people who are genuinely polite and would be mortified if they let something nasty slip."

When patients are unreasonable or angry, the case manager can de-escalate them by saying, "I understand. I want to do whatever I can do to help you. What can I do right now to make things better?" he suggests. ■

Hospital Reduces HAPI Rate by Half with Huddles, Rounds

By Greg Freeman

A hospital that had struggled to reduce hospital-acquired pressure injuries (HAPIs) has found success with an approach that emphasizes empowering frontline staff and consistent, structured huddles. After one year, the culture has changed, and HAPIs have been cut by 50%. Northwestern Medicine Lake Forest Hospital in Illinois had attempted to reduce HAPIs for years, with some success, but hospital leaders remained unhappy with the rate of pressure ulcers, says **Kathryn Thomas**, MSN, RN, CPHQ, director of quality and patient safety for the North Region of Northwestern Memorial HealthCare.

Lindsay Werth, MSN, RN, CMSRN, patient safety program manager at the hospital, led a new effort that took advantage of quality improvement workshops in conjunction with Vizient, a healthcare performance improvement company based in Irving, TX. The workshops focused on high reliability organization (HRO) principles. Thomas and Werth saw an opportunity to learn techniques that would help the hospital sustain HAPI improvements.

"We had tried to address pressure injuries in the past, but nothing would really stick," Thomas says. "We really needed to change the culture."

Deep Data Dig

Starting with an effort to understand why patients were experiencing HAPIs, the Northwestern Memorial team dug into the data and engaged frontline leadership. The nurses were interested in reducing the injuries and eager to find a solution.

"We interviewed almost every staff member in the units and tried to truly understand the gaps in knowledge and assessment, the interventions currently in use, to get a good assessment of where we were," Werth says. "Having that frontline buy-in was instrumental in getting us a good assessment of where we were and where we wanted to go."

Thomas says the hospital had implemented the well-known best practices for HAPI and seen some improvement, but over time the rate still was not what they wanted to see. This new effort put a particular focus on the hospital's own data.

"Not only did we take the HRO principles from the patient safety workshop, but we stayed data-driven and fixed what the data was showing us," Thomas says. "We wanted to keep our frontline staff highly engaged. One thing we did was implement weekly huddles. The huddles were very focused and structured, centered on a visual management board."

Originally, Werth led the huddles. Eventually, leadership transitioned to the charge nurse. The huddle participants examine what the barriers were last week and what they should do differently this week.

"They were kind of quiet in the beginning but slowly everyone

started opening up, throwing out ideas, talking openly about barriers. Through that, we discovered one of the main barriers for the nurses," Thomas says. "We found that in during their skin time-outs, the documentation was not in their actual workflow. A frontline nurse spoke up about it, and then we were able fix that and bring the solution back to them."

Gaining Trust of Nurses

Making that change in the electronic medical record was a significant step forward, even though it was not especially difficult to achieve.

"It showed the nurses that their voices really do matter. They were really excited, and the compliance with the documentation really went up," Werth says. "Keeping that engagement with the team, being honest and open, really helped us."

In addition to weekly huddles, the charge nurses check with their nurses daily to identify problems. Leadership rounding also was included in the effort. The hospital's chief nurse began rounding on a weekly basis with Werth, with a structured format to assess HAPI reduction rather than a general check-in. "They would start with the visual management board, go over the data to see how they were doing with both outcomes and process measures. The chief nurse would ask nurses what concerned them most about pressure injuries that day, what barriers they were encountering, what interventions they were using," Thomas says.

The rounds with the chief nurse have been reduced to monthly intervals, but Werth conducts weekly rounds with a nursing director to check on HAPIs on all units.

Another important change was for Thomas and Werth to "stop being the doers and start being the coaches," Thomas says. That meant teaching people how to fix their own problems rather than trying to fix everything themselves. It also meant focusing less on the presentation of data and more on encouraging frontline staff to use that information effectively.

"We had to learn that display of data doesn't have to be pretty and perfect. Our visual management boards are not PowerPoints with lots of colorful, perfect graphs," Thomas says. "Our visual management boards are literally graph paper where they plot how they are doing on whatever process they're watching, and another graph paper where they can write with a pen where they've had any events. They can write in any barriers for the week, and that becomes a focus of the huddles."

Thomas says through consistency with huddles and other measures, the strategy became the new normal. "It was all about change management. It was changing everyone's perspective about their role in managing a problem," Thomas says.

The hospital is on track to reduce HAPIs by another 50% this year, Werth says. Looking back on the effort, Thomas says support from top leadership was crucial to success, but perhaps they could have involved middle management more.

"I think better prep of our middle management might have been helpful because it does change their workflow the most," she observes. "It is quite an adjustment for middle management. If we had more training and education for them up front, it might have been a smoother transition."

Werth emphasizes patient safety and quality leaders should not assume they know what is happening on the front line. "Not only does going to that unit show you what is actually happening, but it also builds confidence among your frontline nurses and techs, everyone on the front line, when they actually see you there," Werth says. "There are days when I sit in my office all day long, but we make an effort now to go out there and round with a purpose. We want them to know that when they are experiencing a problem, this is a problem that we all should work to solve together." ■

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Safety Protocol Can Prevent Self-Harm Incidents

By Dorothy Brooks

Patients often present to the ED with behavioral health concerns, but psychiatric experts recognize the environment is hardly optimal for easing anxiety or calming a troubled mind. Further, patients with psychiatric concerns often wait in the ED for extended periods before they are connected with appropriate care, a time that can be fraught with danger for individuals at risk for self-harm.

Recognizing the safety challenges at issue, a multidisciplinary team at Massachusetts General Hospital (MGH) in Boston developed and implemented a protocol aimed at protecting such patients.

Early findings from a before-and-after study suggest the range of safety precautions included within the protocol are on target. Specifically, in the 12 months before the protocol was implemented, investigators reported there were 13 episodes of attempted self-harm among 4,408 emergency patients found to be at risk. In six cases, actual self-harm occurred.

In the 12 months following implementation, there were six cases of attempted self-harm in a group of 4,523 at-risk emergency patients, with one case that resulted in actual self-harm.[1] Investigators noted the precautions focus on creating safe bathrooms, increasing the number and training of observers who can monitor patients deemed at risk for self-harm, managing access to belongings and clothing, and the implementation of added measures for patients found to be at high risk.

Considering the positive results, the ED at MGH is continuing to adhere to the protocol. Investigators would like to see other EDs implement and monitor the effects of similar interventions.

The lead author of this research says when developing an approach to protect at-risk patients, it is critical to include representation from all groups that play a role in patient care and safety in the ED.

"In our institution, these groups include emergency medicine, emergency psychiatry nursing, police and security, and administration, representing both overall ED administration and administrative coordinators," explains **Abigail L. Donovan**, MD, associate director of the acute psychiatry service at MGH. "We also found consultation with the hospital office of the counsel invaluable." By taking a multidisciplinary approach, ideas for inclusion could be honed and improved before implementation. For example, Donovan notes some early discussions focused on searching patient belongings.

"Given the volume of patients at risk for self-harm presenting to our ED, searching the belongings of each patient would have required many hours of police and security time each day, and would have ultimately necessitated hiring additional police and security officers," she observes. "Furthermore, the police and security officers felt that searching belongings was not a foolproof safety measure."

Researchers decided to secure patient belongings away from patients. "The ED administrative coordinators were critical in devising this new workflow, which includes labeling belongings, storing them in a secure area, and logging their location," Donovan notes.

Another idea that benefitted from multidisciplinary review concerned how to manage personal cellphones. "Initial discussions were focused on removing cellphones entirely and storing them with patient belongings," Donovan recalls. "However, emergency psychiatry representatives felt that phones were an important way to connect with psychosocial supports, including family and friends."

Overall, emergency psychiatry believed cellphones help patients endure their ED stay and lower the risk of agitation and aggression.

"Administrative coordinators also felt that if patients did not have access to their phones, there would be a large volume of calls into the ED ... from family members looking to speak with patients, [creating] significant challenges with managing the volume of these calls and providing patients with access to ED phones," Donovan says.

Security representatives were concerned contraband could be hidden in cellphone cases. In the end, the multidisciplinary team allowed patients to access their phones as long as the cases were removed.

Protocol creators continue meeting as needed to review procedures and consider revisions. "These meetings are typically triggered by an identified safety concern," Donovan notes. "For example, [this could involve] a protocol lapse or an identified near-miss event or a change in regulations."

In the case of a safety concern, the group will meet, conduct a root cause analysis, and discuss potential interventions to prevent future challenges. A change in regulations will prompt a review of the new requirements and a brainstorming process on how best to meet them.

From there, the group will develop and implement a plan.

One example involves how the group responded to a new requirement by The Joint Commission (TJC) to complete suicide screening with a validated tool on every patient who presents to the ED with a behavioral health chief complaint. Donovan notes the approach used in this case illustrates the critical role emergency medicine clinicians play in the safety protocol.

In the MGH ED, nurses complete the Ask Suicide-Screening Questions and the Columbia-Suicide Severity Rating Scale at triage, Donovan shares. Before TJC issued its requirement, emergency medicine physicians would determine risk of self-harm as part of the initial triage.

"They would conduct a brief safety evaluation, which included a discussion of the presenting problem with a focus on safety concerns including suicidality and homicidality, a review of the pertinent clinical history, and focused mental status and physical exams," Donovan recalls.

As part of the process change, emergency clinicians participated in training, designed by colleagues in emergency psychiatry and psychiatric clinical nurse specialists, to better understand how to perform these evaluations and administer the screening tools.

"As roles change, additional training is completed to keep all clinicians updated," Donovan says.

Donovan emphasizes that safety reporting is a critical part of the protocol, not only for monitoring performance but also for continuous quality improvement.

"Even prior to the development of this protocol, we actively promoted safety reporting among all ED employees," she explains. "The safety reporting system has been streamlined to improve ease of use, [and] reporters receive feedback about their report, which reinforces their engagement in the system."

In an earlier quality improvement initiative, staff were required to complete one safety report so they would become familiar with the system. "The safety reporting system is [now] well-embedded within our workplace culture and day-to-day operations," Donovan reports.

To successfully implement a safety protocol of this nature, Donovan says leaders must be committed to making financial and time investments. "These investments are ultimately justified by the lower rates of self-harm within vulnerable populations and by improvements in staff perception of safety," Donovan says.

Donovan also notes a safety protocol must be customized to fit the needs of individual institutions. "Areas of vulnerability for at-risk patients may be institution-specific," she explains. "Identifying these individual vulnerabilities can be accomplished through completing a root cause analysis of self-harm events."

The development and implementation process may be long and challenging, so it is critical to keep goals in mind. "We were driven by the overarching goal of providing safe, humane care," Donovan explains.

At each step, developers asked themselves what they would want the care to look like for their family. "We felt that if we designed a protocol that we could feel good about for our loved ones' care, then we were on the right track," Donovan adds. ■

REFERENCE

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The Struggle to Immunize Long-Term Care Staff

By Gary Evans

Almost two-thirds of healthcare workers in thousands of skilled nursing facilities (SNFs) have turned down the COVID-19 vaccine, even though the mortality rates of long-term care residents are among the highest of any population.

Along with healthcare workers in hospitals and other settings, long-term care staff were considered a top vaccine priority because they care for frail residents, the Centers for Disease Control and Prevention (CDC) reports.

"Among 11,460 SNFs, with at least one vaccination clinic conducted during the first month of the CDC Pharmacy Partnership for Long-Term Care Program, a median of 77.8% of residents and 37.5% of staff members received ≥ 1 vaccine dose through the program," the CDC stated.[1] "SNFs that provide skilled nursing care and rehabilitation services for persons with complex medical needs have been documented settings of COVID-19 outbreaks. In addition,

residents of [long-term care facilities] might be at increased risk for severe outcomes because of their advanced age or the presence of underlying chronic medical conditions."

Historically, long-term care workers have shunned influenza vaccinations, citing skepticism about the vaccine's efficacy or that they do not get the flu. The COVID-19 vaccine raises its own set of suspicions.

Frequently cited reasons for vaccine hesitancy included the perceived rapidity of vaccine development; inadequate information received about vaccine safety, side effects, and administration; and skepticism regarding the clinical trials and vaccine approval processes," the CDC stated.

David Gifford, MD, MPH, senior vice president of quality and regulatory affairs at the American Health Care Association (AHCA), has been working with about 15,000 nursing homes around the country on vaccine issues. He spoke at a recent CDC forum on vaccine uptake issues for healthcare workers. "I think a number of the challenges mirror what we're seeing in the general population and elsewhere," he said. "People feel like the vaccine was rushed, shortcuts were taken. They're worried about long-term side effects."

These were the most common questions, but there also were concerns based on the misinformation that has spread along with the virus. "I try not to refer to them as conspiracy theories because that sort of sends a signal to the individual that their views and their information are discredited in some way," Gifford said. "The decision that the staff are making based on the information they hear makes sense. The information they're hearing is what doesn't make sense."

Drawing that distinction and listening carefully have proved key to successfully change workers' minds, particularly if a trusted source delivers the information. If possible, make sure that the information is personal and targeted to the individual, addressing their concerns in a nonjudgmental way, he said. "[With these measures], we have seen facilities with 75%, 85%, 90% vaccine uptake rates among the staff, while others are at 30% and 40%," Gifford said. "A lot of the divide is around different types of belief issues and where people get their information — from families and friends."

Gifford and colleagues also have started a follow-up campaign, "See Something, Say Something," to correct misinformation. "If you hear something inaccurate, speak up so that people are making the best decisions on the information out there," Gifford says.

In the long run, the attempts to offer the vaccine are less effective if the information is not clear and it is delivered by someone who does not look or sound like the targeted group. "A lot of this comes from the level of trust between management and [staff]," Gifford said. "You're not a used car salesman trying to sell people on it because that doesn't engender trust. It sort of has a predetermined outcome. I think that messaging and the involvement of nurses and physicians in delivering that message has been really key."

Successes should be celebrated by reminding all staff of the benefits of taking the vaccine after someone is immunized. "It's not just about protecting you and protecting your family, which are two important messages," he said. "It's about protecting your residents. It's about getting back to normal, being able to visit families, going out and doing the activities we have been all restricted from doing. I think those are messages that really resonated very well."

Making a point that the unvaccinated staff do not have callous disregard for the elderly residents, Gifford said the COVID-19 outbreaks in nursing homes have hit workers hard. "It's been ground zero," he said. "Depending on the state, anywhere from 30% to half of all of the [COVID-19] deaths come from the nursing home population. That's been devastating to the workforce. Not just the nurses and aides, but housekeeping, dietary. They work there because they care about the elderly. They know these individuals, treat them as family. Many of them don't have family — or family nearby — and certainly they haven't been able to have family visit." ■

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1. Gharpure R, Guo A, Bishnoi CK, et al. Early COVID-19 first-dose vaccination coverage among residents and staff members of skilled nursing facilities participating in the Pharmacy Partnership for Long-Term Care Program — United States, December 2020-January 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:178-182.

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CE QUESTIONS

1. **The Case Management Society of America (CMSA) standards include:**

   a. providing CMSA best practices.
   b. fostering simple language communication to patients.
   c. using comprehensive, holistic, and compassionate approach to care delivery.
   d. giving patients clear self-care instructions, preferably in a brochure with illustrations and graphs.

2. **Which is a good approach case managers could teach patients to improve their communication with doctors, according to Cheryl Acres, RN, CCM, CDP?**

   a. Give the doctor a handwritten or typed description of how the symptoms first appeared.
   b. Ask for the physician's input on trying a new diet, exercise, and therapies.
   c. Ask the doctor if he or she can record the conversation.
   d. Text or email the physician with any questions before the in-person visit.

3. **What is a good way to build rapport with patients during a phone visit, according to Eric Bergman, RN, CCM?**

   a. Case managers can share small aspects of their lives to build trust.
   b. Case managers can suggest a video call so the patient can see them.
   c. Case managers might open the call with questions about the patient's family and recent visits.
   d. Case managers could suggest the patient's caregiver also join the call.

4. **When engaging patients in shared decision-making, case managers should remember the person who is legally able to make the patient's medical decisions could be someone besides the patient, including:**

   a. the patient's oldest child.
   b. the patient's spouse.
   c. the patient's heir.
   d. the patient's medical power of attorney or guardian.