HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Cultural Competency Is Essential in an Increasingly Diverse Society

Understand your patients' cultural beliefs and practices

If case managers don't learn about their patients' cultural beliefs and practices and incorporate them into the plan of care, their efforts to develop a trusting relationship with their patients and create a successful discharge plan may be in vain.

That's why case managers need to be aware of their patients' cultures and conduct research to learn about the beliefs and practices that could have an effect on the healthcare of each individual patient, says **Jose Alejandro**, PhD, RN-BC, MBA, CCM, FACHE, FAAN, director of case management at Tampa General Hospital.

"When providers are not familiar with the cultural beliefs of the population they serve, it can cause unintended consequences such as lack of adherence to treatment plans, fragmentation and disconnects in care, medical errors, and, increasingly, patient dissatisfaction," says **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management training, education, and consulting firm.

> WHEN PROVIDERS ARE NOT FAMILIAR WITH THE CULTURAL BELIEFS OF THE POPULATION THEY SERVE, IT CAN CAUSE UNINTENDED CONSEQUENCES.

America has always been a nation of immigrants, and the population is becoming increasingly more diverse, points out **Vivian Campagna**, RN-BC, MSN, CCM, chief industry relations officer for the Commission for Case Manager Certification. She cites statistics that predict 85% of the nation's

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population growth in the next 50 years will be due to immigrants and their descendants.

"It's critical that all of us in healthcare get on board with cultural diversity and what it means to us personally and professionally. If case managers ignore a patient's culture and beliefs, they might as well throw out the entire treatment plan and discharge plan," Campagna says.

Case management directors should take a close look at the population they serve and compare it to the ethnicity of their staff, Mullahy suggests. "For instance, if the hospital is serving an increasing number of Chinese, Russians, or people from other parts of the world and the staff looks the same way it did 10 years ago, that's a problem," she says.

Make it a point to hire staff members who are from the populations you serve, Mullahy suggests. "The way the staff looks speaks volumes. Having nurses or social workers from the same community as your patients helps increase communication and build trust," she says.

In addition, a multicultural staff can help their fellow staff members understand the preferences and nuances of patients from other cultures, she says.

If your patient population is becoming more diverse, it's probably time to review the educational materials you give to patients. If they are written only in English, and maybe Spanish, it's time to upgrade them, Mullahy says.

"Handouts need to be written in the languages that patients speak. What worked a few years ago may not be adequate now," she says.

To meet the needs of a diverse patient population, case managers should have a tremendous amount of education on the patients their hospital serves, their practices, and beliefs. Be familiar with likely economic, language, religious, gender, and other barriers that may interfere with treatment, Campagna says.

"If case managers are educated on the populations they serve, they may not have all the answers when they first encounter a patient but they'll have a foundation they can build on so they can understand the patient and come up with a successful plan," Campagna says.

EXECUTIVE SUMMARY

As the population becomes more diverse, it's important for case managers to be aware of their patients' cultural beliefs and practices, and respect them in order to build trust and ensure that patients and family members will follow the care plan.

- Hospitals should provide comprehensive education on the culture of the patients they serve, hire staff that are from the ethnic groups they serve, and revamp their educational materials so that they are in all the languages their patients speak.
- Case managers should have general information on patients' cultures but also should conduct a detailed assessment to find out the beliefs and practices of each individual patient, rather than making assumptions.
- Whenever possible, case managers should work with the rest of the team to accommodate the beliefs and practices of patients. In most cases, it won't interfere with the treatment plan.

The first step in becoming culturally competent is to examine what you think about that culture and how you feel about an increased number of people who look and think differently from you, Mullahy says.

"Understand how you feel when you come face-to-face with a patient and you don't speak the language," she says.

Examine your own values and preferences and convey to your patients a sincere desire to understand theirs, Mullahy says.

"Case managers need to be able to put aside their personal beliefs in order to advocate for their patients. I encourage my staff to put their viewpoints out of sight if they can. Case managers can't always choose the type of patients they see. It's better to recognize a potential conflict than to let a difference in beliefs have a negative impact in your relationship with patients," Campagna says.

Hospital leadership should be addressing cultural diversity and healthcare disparities and providing extensive, ongoing education that will enable the treatment team to understand and meet the unique needs of their patient population, Alejandro adds.

"If case managers do not address the cultural beliefs and practices of the individual patient, they run the risk of being unable to build a trusting relationship with the patient and family members, and ultimately creating a discharge plan that will not work," he says.

Healthcare professionals tend to think that patients and family members are not being compliant when they don't follow their discharge plan and end up back in the hospital, Alejandro says. "It may be because we haven't given them the tools to be successful. Readmissions could be the result of the patient not understanding the discharge instructions because of a language barrier, or not being able to follow them because of a socioeconomic barrier," he adds. Don't make assumptions when it comes to creating a discharge plan for your patients from diverse populations, Alejandro says.

"Healthcare providers have to integrate patients' culture and cultural beliefs within their healthcare system in order to provide care for all patients. If they don't accommodate the cultural practices of their patients, it will be much more difficult to build a trusting relationship," says **Donna Zazworsky**, RN, MS, CCM, FAAN, principal of Zazworsky Consulting in Tucson, AZ.

"HEALTHCARE PROVIDERS HAVE TO INTEGRATE PATIENTS' CULTURE AND CULTURAL BELIEFS WITHIN THEIR HEALTHCARE SYSTEM IN ORDER TO PROVIDE CARE FOR ALL PATIENTS."

"Everything we do in case management reflects our understanding of our patients. Assuming that an individual thinks and acts as we do, or perhaps making assumptions based on a superficial understanding of someone's culture, can be the beginning of problems that often result in mistrust, confusion, and costly complications," she adds.

"Even if they don't agree with the beliefs, case managers must be respectful of the individual. If they dismiss the beliefs or are unwilling to accommodate them, it's like dismissing the patient," Mullahy says.

Don't be ethnocentric and evaluate patients' cultures based on the preconceptions of your own culture, Zazworsky advises. Instead, be multicultural and tailor the care plan to each individual's beliefs and practices, she adds.

Building relationships with your patients is an essential part of ensuring that the treatment plan will work, says **Jill Lanning**, RN, BSN, chief nursing officer for Dependable Home Health, a home health agency headquartered in Tucson, AZ. "You have to build trust and it sometimes takes a long time. The bottom line is to get acceptance any way you can. Work within the culture and collaborate with the community to help patients follow their discharge plan and maintain their own health," Lanning says.

When patients don't follow their plan of care, if you can find out why they are responding the way they are, it will help you deal with the problem, Campagna says.

"For instance, if people don't understand how the healthcare system can help support their health, they will keep using the emergency department and wait to seek treatment until they are so sick they have to be hospitalized," Zazworsky says.

In those situations, case managers should help the patients understand the Western healthcare system and how to be proactive. Educate them on the importance of accessing primary care before they go back to the ED. "Educate, educate, and then educate them some more," Zazworsky adds.

Whenever possible, involve the caregiver in the discharge planning process to help with buy-in. Ask him or her to come to the hospital and

participate in the discharge education, Zazworsky adds. Find out what community resources are available to meet their needs after discharge.

Determine if your community partners are appropriate for an individual patient. Make sure the organizations to which you refer patients have staff who speak their language and understand the culture, Zazworsky says.

"When case managers and other clinicians make an effort to accommodate their patients' beliefs, they are truly providing patient-centered care and improving patient satisfaction. Patient-centered care is more than just involving patients in their medical care — it's accommodating their cultural practice and spiritual beliefs and treating the entire person as an individual," Mullahy says. ■

Base Your Plan of Care On the Individual's Beliefs and Practices

Don't make assumptions about a patient's culture

If case managers want their discharge plans to succeed, they should take the time to really understand their patients, says **Donna Zazworsky**, RN, MS, CCM, FAAN, principal of Zazworsky Consulting in Tucson, AZ. Incorporate a cultural assessment into your initial assessment so you can find out as much as possible about patients' beliefs and practices, she suggests.

If you have researched the beliefs and practices of the populations you serve, you should know something about the culture the patient comes from but you need to go further and understand each patient, Zazworsky says. The assessment should be designed to help you learn the patients' customs and beliefs — particularly about healthcare — how closely they identify with their ethnicity and religion, their support system, the languages they speak and read, she adds.

"Case managers have to understand where each individual patient is coming from, rather than relying on generalizations," adds **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates, a case management education, training, and consulting firm in Huntington, NY.

Making assumptions about patients based on a small amount of information is dangerous, Mullahy says. "Not everybody within a given ethnic group thinks and acts the same way. Case managers need to perform a complete assessment on every patient," she says.

During the assessment, case managers should listen to what the patient is saying — and what he or she is not saying, says **Vivian Campagna**, RN-BC, MSN, CCM, chief industry relations officer for the Commission for Case Manager Certification.

"The case manager should be aware of all aspects of the patient's situation, his or her clinical, emotional, psychological, and family needs, and work with the treatment team to put together a complete package that will result in the best outcomes," Campagna says.

Find out what is important and why, what they want out of their hospital stay, why they won't participate in a particular treatment, and what kind of treatments they will accept, Campagna says. "Case managers should get to know the patient and family to understand the best route and the best treatment plan for each individual patient," she says.

Ask pertinent questions to get to the "why," she suggests. Find out why they believe what they do and why they look at treatment in a particular way. If patients and/or family members object to the treatment plan, talk to them and try to understand why they feel like they do, she suggests.

Call on a nurse or another staff member who is from the patient's culture to help you identify who should be involved in the treatment plan and whether you should work with the patient on the discharge instructions or include a family member, Zazworsky suggests.

Find out who is the decision-maker in the family, or in some cases, in the community. It may be the patient, the spouse, or the whole family, says **Jose Alejandro**, PhD, RN-BC, MBA, CCM, FACHE, FAAN, director of case management at Tampa General Hospital.

"Tap into the individual's support system. It may be a spouse, an in-law, adult children, or a friend. Whoever is involved in caring for the patient and making decisions should understand what the patient should or should not be doing," he says.

For instance, if a patient needs to limit his or her sugar intake or eat a reduced-calorie diet, the person who does the cooking in the family should be involved, he adds. ■

Whenever Possible, Combine Western and Traditional Medicine

It builds trust, makes adherence more likely

When a patient's cultural practices, such as traditional healing, are incorporated into the treatment plan, it can go a long way toward ensuring that patients follow the plan of care, says **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates, a case management education, training, and consulting firm in Huntington, NY.

"It's not usually an all-or-nothing situation. Many practices don't interfere with Western medicine and it may enhance communication because the patients will feel that the hospital staff respects what they believe," she says.

Sometimes the case manager has to get in the middle and act as a mediator between the treatment team and the patient and family when the family has strong beliefs that need to be accommodated, says **Vivian Campagna**, RN-BC, MSN, CCM, chief industry relations officer for the Commission for Case Manager Certification.

"If the team doesn't know about the patient's beliefs, the case manager should educate them and work with them to modify the plan," Campagna says.

For instance, some members of the Jehovah's Witness faith don't believe in blood transfusions, Campagna points out. "If we don't make allowances for their beliefs, we may find ourselves at odds with the patient and family if someone of that faith has lost a lot of blood. As a treatment team, we need to look at alternatives," she says.

Mullahy recommends that case managers think outside the box and look for ways to work around patient's beliefs while delivering the needed care.

She describes how a case manager in the Aberdeen, SD, area was able to accommodate the spiritual beliefs of a Native American patient with severe diabetes who refused to consent to surgery to have his leg amputated. When the case manager called the Indian Health Service for assistance in understanding his position, she learned that many Native Americans believe that in order to go to heaven, they have to be buried in sacred burial grounds and that the patient was afraid he would be without his leg in heaven.

"The healthcare team made arrangements for the leg to be transported to the reservation and buried in the sacred burial grounds. They could accommodate the patient's beliefs without changing the treatment plan," she says.

In another instance, Mullahy tells of an Orthodox Jewish patient at high risk for a preterm birth who refused to use an electronic device to monitor contractions on the Sabbath when her religion forbids the use of electrical appliances. "The case manager encouraged the woman to take extra special care and stay on bed rest on the Sabbath," she says.

The same patient needed someone to take care of her children and household chores while she was on bed rest, but the family resisted because they kept a kosher home and the home health agency did not have any employees who kept kosher.

"The case manager worked around the problem by contacting the family's rabbi, who found someone in the community who could take care of the patient. The case manager worked with the patient's insurance company to pay for the service," she says.

The home health nurses at Dependable Home Health in Tucson, AZ, often encounter Mexican-American patients who resist following their treatment plans because they believe in folk remedies, such as drinking herbal tea for everything from hypertension to diabetes, says **Jill Lanning**, RN, BSN, chief nursing officer. *(To learn about Dependable Home Health's readmission reduction initiative, see related article on page 57.)*

"When we encounter practices that involve non-traditional medicine, we try to incorporate it into the treatment plan. For instance, we don't tell them not to drink the herbal tea. We tell them to take the tea along with their medication," she adds.

Flagstaff (AZ) Medical Center serves a large Navajo population who live on the reservation, and many of them have very strong Native American beliefs when it comes to health. Case managers and other clinicians make every effort to accommodate their beliefs, says **Lisa Brugh**, MS, BSN, RN, ACM, system director of case management for the two-hospital system. *(For details on how the hospital provides care for its Native American patients, see related article on page 50.)*

For instance, talking about death is taboo in the Navajo culture, as is dying in your home. Instead of telling a family member that the patient has only a short time to live, the palliative care team says, "someone like your mother would have only a few months to live." Since home hospice is not an option, the palliative care and case management team arrange for terminally ill patients to receive hospice care at an assisted living center so the patients won't die at home.

The Navajo language doesn't have words for some Western medicine terms, such as "cancer" or "dementia," Brugh says. In addition, the Navajo language has ways of explaining what is happening in the body without using words. When they are working with a Navajo patient who is not fluent in English, the case managers as Flagstaff Medical Center bring an interpreter who can talk about diagnoses and explain the patient's disease without using terms, she says.

The Chinese population tends to be family-oriented, Campagna says. "If the patient is Chinese and elderly, the family may not agree with your recommendation to transfer the patient to a skilled nursing facility. Instead of finding out at the last minute that the family is balking at a nursing home stay, the case manager should work with the family to come up with an alternative," she says.

End-of-life is a serious time for the Chinese, and many have strong feelings about ending treatment, Campagna says. "If case managers don't understand what their feelings are, they may alienate the family. Instead, they should help the patient and family approach care in the best possible way," she says. ■

Hospital Works to Make Native American Patients Feel Comfortable

Traditional foods, alternative healing are options

Flagstaff (AZ) Medical Center, part of Northern Arizona Healthcare System, created a program to accommodate the beliefs and practices of their Native American patients, which make up about 40% of the hospital's patient population.

The health system serves the Navajo Nation, the largest Native American reservation in the United States. The reservation is roughly the size of the state of West Virginia, and includes the Hopi reservation within its boundaries. Both populations have very traditional Indian medicine beliefs, says **Lisa Brugh**, MS, BSN, RN, ACM, system director of case management for the two-hospital system.

The reservation has limited services and only one assisted living facility, which sometimes makes it challenging to create a workable discharge plan, she says.

"Because we have such a large population who identify as Native American and they have such different cultural beliefs, it's really important for us to learn about their beliefs so we can take them into consideration when we create a treatment plan or a discharge plan. Our staff goes through extensive education on Native American beliefs and practices," Brugh says.

The hospital has three full-time Navajo interpreters who cover the hospital seven days a week and contracts with an interpreter service for evening hours. The Navajo chaplain is available to provide assistance. There are 39 back-up interpreters who work in various departments of the hospital.

To make its Navajo patients feel comfortable, the hospital offers traditional foods such as Navajo tea and blue corn mush on request, and support for alternative healing traditions such as medicine men and herbal medicine.

Patients frequently ask for a medicine man or traditional medical practices, says **Susan Wells**, manager of patient services. To meet their requests, the hospital recently hired a traditional healer to coordinate the spiritual side with the physical side of treatment.

"We respect traditional medicine and our patients' beliefs and try to accommodate them whenever possible. Our staff has been educated on the beliefs and practices of our Native American patients and tries to accommodate them," says **Gigi Sorenson**, RN, MSN, director of telehealth and community connected care.

In their initial assessment of patients, care managers determine the patients' language skills and bring in an interpreter if the patient or family members have trouble understanding what they are saying. The care managers spend a lot of time getting to know the patients and their families, and building trust, Brugh says.

When members of the care management team participated in a study

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Family Caregivers: What They Mean to Discharge Planning, Length of Stay, and Readmissions

By Toni Cesta, PhD, RN, FAAN

Introduction

The early days of discharge planning were slower, less intense, and typically occurred after patients had completed the majority of their recovery. For the most part, choices for continuing care outside the hospital were limited to long-term care and simple home care. Other levels of care were far more limited — or non-existent. Patients discharged toward the completion of the recovery period went home less sick, less fragile, and in less need of a lot of care in the home. Those days are clearly over.

In today's healthcare world, patients leave the hospital after they have achieved a minimal amount of recovery or stability, with the expectation that they will continue to recover in less expensive settings. One of those settings is the home. While many of the patients will receive some episodic home care, eventually that care will end and other support may be needed. This scenario is particularly true for the elderly and patients with chronic conditions or multiple comorbidities. This month, we will talk about the role of the family caregiver in supporting patients as they transition home, what the role is really about, and the role of the case manager in supporting and educating family caregivers.

SOMEONE CAN BE A FAMILY CAREGIVER IN THE HOME, THE HOSPITAL, A REHABILITATION UNIT, A LONG-TERM CARE FACILITY, OR ANYWHERE THE PATIENT IS LOCATED.

Who Are Family Caregivers?

Family caregivers are those who care for ill or frail family members or friends. They are not paid for these services, which is what differentiates them from nursing attendants or home health aides. One misconception about family caregivers is that they only support the patient in the home environment. In actuality, someone can be a family caregiver in the home, the hospital, a rehabilitation unit, a long-term care facility, or anywhere the patient is located.

In fact, a person is a family caregiver if they:

- take care of someone who has a chronic illness or disease,
- manage medications or talk to doctors and nurses on someone's behalf,
- help bathe or dress someone who is frail or disabled, and
- take care of household chores, meals, or bills for someone who cannot do these things for themselves.

Family caregivers do not suddenly appear after the patient goes home. Typically they are involved in the patient's life and may visit them in the hospital. As case managers, we must be on the lookout for family caregivers and ask the patient pointed questions about people in the patient's life. If we simply ask the patient if they have any family caregivers, the patient may not know what we mean. How do family caregivers know that this is the role that they are playing? In today's complicated healthcare environment, "taking care" goes far beyond what any family members had to do in the past. People are living longer, many with one or more chronic condition that they may not be able to manage independently. Or they may not be able to manage household chores, bills, or similar items. They may say, "I am not a caregiver. I am a daughter, partner, friend, or wife."

Family Caregivers and Healthcare Professionals

As case managers, we must view the family caregiver as a member of the patient's interdisciplinary care team. As such, it is imperative that we, the professionals, work together with the patient's family and family caregivers from admission to discharge and beyond. There are some critical points at which this need is particularly urgent. Specifically, it is during times of transition for the patient that this need comes to the forefront, and managing transitions means excellent communication at each and every patient handoff. In fact, communication is the key to all transitions for patients, families, and family caregivers.

In order to accomplish good communication between healthcare professionals and family caregivers, case managers and social workers must ensure the family caregiver is given a basic understanding of how things are expected to work in the next setting to which their family member is transitioning, including transitions to home. They must be given the opportunity to ask questions when they are ready. Each time a question is asked, consider this a "teachable moment" between you and the family caregiver. Supplement your teachable moment with guides and other written information to help them understand any new information. Provide online links that might supplement their education as well. Be sure to acknowledge that they are a family caregiver and they have a right — indeed, should have an expectation — of receiving this information.

When Does Caregiving Start?

The role of the caregiver may begin following a crisis that the patient has experienced, such as a hip fracture, a stroke, or an accident. These crises may present a sudden and unexpected need from the patient. Conversely, the patient's needs may have occurred slowly due to a gradual decline in the patient's condition. These kinds of declines may or may not have been obvious to the family caregiver, so never assume he or she saw it coming. Ultimately it is not the event itself, but what happens after the event, that will require the family caregiver to step in.

It is important that caregivers see themselves as family caregivers so they can act on their rights and authority as such. These rights include the right to receive information about the family member or friend's condition, that they be involved in decision-making about the patient's care, and that they see themselves as an essential partner on the healthcare team and be educated in providing care. Additionally, they will have access to services that they might otherwise miss, and in some states may even be protected from job discrimination.

Caregiving Should Never Be a Complete Surprise

Case managers and social workers may assume that the family caregiver is willing and able to help. In fact, we make many assumptions in this regard. As managers of the discharge planning process, we may assume that the individual will provide the extensive care needs in the patient's home. There may have been family caregivers who had helped in the past, and so we assume they will be able to help at the same level again. In fact, we must take the family caregiver's situation, availability, and willingness into consideration at each and every patient transition.

These transitions may include through the hospital experience to the community, through the community experience, through a disease process, through a situation, and/or from one provider to the next at each juncture. After all, it's all about transitions, and effective transitions are the core business of hospitals and a core responsibility of the case management department and staff.

Educate the family caregiver about the patient's condition. Help him or her to understand what the patient's insurance does and does not pay for. Review or create necessary legal documents. Be sure to consult with other family members regarding their feelings concerning medical care, living arrangements, how the caregiving tasks can be divided, and how to pay for anything that the insurance doesn't cover.

Discharge Planning Evaluations Must Include the Family Caregiver

The Centers for Medicare & Medicaid Services (CMS) standard on discharge planning states the following three things:

- The hospital must provide a discharge planning evaluation to the patients, to other patients upon their request, the request of another person acting on their behalf, or the physician.
- The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and the availability of those services.
- The evaluation must include an evaluation of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

As you review each of these elements it becomes clear that you cannot conduct an effective and complete evaluation without assessing the family caregiver when the discharge plan calls for one. This is particularly true if the very first transition is from the hospital to home. It is likely that the need for a family caregiver will involve a greater amount of education. But even before education, you must be sure that the family caregiver is a viable option to support the plan to home. If they are not, you will need to readjust your plan or find a different family caregiver. CMS is identifying the family caregiver as an important aspect of the discharge planning process. CMS's rules require the following:

• patient's discharge plan addresses patient's goals of care and treatment preferences,

• medical staff would discuss patient's post-acute care goals and treatment preferences with patient, patient's family, or their caregiver/support persons (or both) and subsequently document these goals and preferences in the medical record, and

• these documented goals and treatment preferences to be taken into account throughout entire discharge planning process.

In addition, CMS expects that the hospital:

• would be available to discuss and answer patients' and caregivers' questions about post-discharge options and needs,

• not make decisions on post-acute care services on behalf of patients and their families and caregivers, and instead focus on person-centered care to increase patient participation in post-discharge care decision-making (person-centered care focuses on the patient as the locus of control, supported in making his or her own choices and having control over daily life),

• discharge instructions be carefully designed to be easily understood by the patient or the patient's caregiver/support person (or both),

• as a best practice, should confirm patient or patient's caregiver/support person's (or both) understanding of the discharge instructions, and

• ensures that patients or caregivers (or both) should be informed, in advance of hospital discharge, of anticipated need for filling outpatient (discharge) prescriptions, and have a plan for how they will obtain those medications.

WHEN THE FAMILY CAREGIVER IS NOT INVOLVED EARLY ON, THIS CAN RESULT IN DELAYS AS YOU BEGIN TO TRANSITION THE PATIENT, THEREBY INCREASING THE LENGTH OF STAY.

It is clear from the elements listed above that discharge planning should and must include families and family caregivers. CMS goes on to state that:

• patient or patient caregiver capability and availability must be considered,

• availability and access to non-healthcare services must be considered — including home and physical environment modifications, assistive technologies, transportation services, meal services or household services (or both), including housing for homeless patients, and

• the discharge plan must address patient's goals of care and treatment preferences with documentation of such.

Meeting the CMS Rules

In order to meet these requirements, each case manager and social worker must complete an assessment of the family caregiver. Examples of tools that are available to assist you in completing these assessments can be found on the following websites:

• Medicare's "Your Discharge Planning Checklist," available at: http://bit.ly/2lcSbXl.

• Agency for Healthcare Research and Quality (AHRQ)'s "Taking Care of Myself: A Guide for When I Leave the Hospital," available at: http://bit.ly/2kQiJRS.

• Consumers Advancing Patient Safety (CAPS) "Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient" toolkit, available at: http://bit.ly/2lcNmND.

Length of Stay and Family Caregivers

Family caregivers sometimes complain that they are not involved in the discharge planning process and/or are not given details about the plan. When the family caregiver is not involved early on, this can result in delays as you begin to transition the patient, thereby increasing the length of stay. Length of stay can also be negatively affected when a late assessment of the family caregiver determines he or she cannot support the patient's needs in the home environment, and a new discharge plan must be initiated.

Proactively involve informal and formal family and family caregivers from the time of admission and each day thereafter until the point of discharge. Assess them as early in the stay as is appropriate, but don't wait until the point of discharge. If the patient needs additional family caregivers and/or paid assistance, this may take time and increase the length of stay.

Be sure to educate the family caregiver along the way as well, as many laypeople don't remember much detail about discharge instructions. Written communication and community follow-up are very important.

Family Caregivers and Readmissions

Be sure the patient's needs are hardwired whenever possible. Discuss advance directives in terms of two critical areas. First, discuss the kinds of treatments that the patient does or does not want. Determine who will be the person to make healthcare decisions if the patient is unable to do so. Addressing these kinds of issues can prevent unnecessary readmissions to the hospital if the patient's condition worsens.

Be sure that the family caregiver understands that follow-up appointments are important, and that they must be scheduled and kept. These may include the patient's primary care provider as well as any specialists involved in the patient's care. Routine visits to the primary care provider can reduce the likelihood of the patient experiencing an acute exacerbation of their illness that might result in a readmission to the hospital.

Other important visits might include a series of appointments for physical or occupational therapy. Be sure that the family caregiver can provide or obtain transportation to all healthcare appointments outside the patient's home.

One of the most troublesome areas that leads to many readmissions is mismanagement of the patient's medication regimen in the home. Not done intentionally, it is possible that the family caregiver might either over- or under-medicate the patient if he or she does not have a clear understanding of the patient's medications, when they are taken, what they are for, and any side effects. Help the caregiver to understand prescription versus over-the-counter versus herbal medications. Assist him or her in developing a process for ordering and picking up refills either at a pharmacy or via mail order. Be sure the caregiver understands that he or she must read all medication labels and follow all instructions. It is critical to give the patient the right medication at the right time and in the right amount.

IT IS POSSIBLE THAT THE FAMILY CAREGIVER MIGHT EITHER OVER- OR UNDER-MEDICATE THE PATIENT IF HE OR SHE DOES NOT HAVE A CLEAR UNDERSTANDING OF THE PATIENT'S MEDICATIONS.

Other things to teach caregivers about medication includes the following:

- types of side effects such as nausea and vomiting, confusion, or dizziness,
- checking labels for expiration or "use by" dates,
- making sure no one else takes the patient's medications, and
- keeping all medications in a safe place.

Medication reconciliation in the home is vital as well, particularly during times of transition when the medications or doses may have changed.

- Keep an up-to-date medication list.
- Keep this list nearby and easily obtainable.
- Bring the list each time you see a doctor or go to the hospital.
- Discuss all the medications with the doctor, including side effects or other problems.

Explain to the family caregiver that it can be easy to forget to take medications on time, even more so when the family member needs to take two or more medications. It may help to use special pill boxes that have sections for each meal and for bedtime. Some boxes even beep when it is time to take the medication. Ask about automatic pill boxes that can be set to open at specific times.

Summary

There are so many ways in which family caregivers can support the care of your patient in the home environment, but in order to do this adequately case managers and social workers must ensure the family caregiver is ready, willing, and able to support the patient's care needs. Ultimately, he or she will need to understand that the patient's condition may get better or worse, that new complications may arise, and that a new hospitalization may mean new medications or treatments. Family caregivers are a wonderful asset — use them wisely. ■

to determine how well the patients understood their discharge instructions, they found that there was a disconnect between what the care managers were teaching and what the Native American patients were able to understand, says **Tiffany Ferguson**, LMSW, ACM, director of community care management.

"Participating in the study made us stop and look at the relationship between the patient and family and their own community, and the role we play," Ferguson says. As a result, the case management team made changes in the discharge education, worked on building relationships with providers on the reservation, and improved transitions of care and relationships with the medical homes on the reservation.

At the time, all patients received a big packet of educational materials, prescriptions, and discharge instructions written in English when they were discharged. But the researchers found that many of the Native American patients didn't open the packet when they got home, but took it to their primary care providers to open during follow-up visits.

"Many patients speak Navajo primarily and can't read English or see the value in what we try to teach them, but they trust their medical homes and their primary care providers. We have cut back on the extensive education we provide and focus on their immediate needs while they are in the hospital. We then ensure that the discharge information and educational materials are given to the providers the patients trust in the medical homes on the reservation," Ferguson says.

The care management team arranges for patients to fill their prescriptions before they leave the hospital and collaborates with the primary care providers on the reservation to make sure patients have follow-up visits shortly after discharge.

"We found it was very important to involve the primary care providers and case managers in the clinics in remote areas in the discharge planning process," she says.

The hospital care managers work closely with their counterparts at the patient's medical home to create a workable discharge plan, Ferguson says. "They help us with post-discharge options and assist us in getting follow-up appointments with the right people," Ferguson says.

Diet is a problem, particularly for patients who live in remote areas and have limited access to fruits and vegetables.

The care management team at the hospital works with the Indian Health Service dietician to help patients adhere to their dietary restrictions. "They can go into the home, see what is in the cupboards, and educate the patients about healthful foods they can make with the ingredients they have on hand. This works better than if we dictate to them what they should eat," Sorenson says.

It's often difficult to line up post-acute services for patients who live in remote areas of the reservation, Brugh points out. For instance, setting up a patient with oxygen may require a two-hour trip to get to his or her home. *(For details on the telehealth program for Native Americans, see related article on page 56.)*

"It's very challenging for durable medical equipment providers," Brugh says. Some clinics in remote sites have wheelchairs and walkers that patients can use. If there is no other option, the hospital provides a walker.

Indian Health Service funding specifies that care be based on needs, Sorenson says. "The money goes only so far, and walkers are a low priority. Wheelchairs are another story because living conditions make it impossible for patients to use wheelchairs," Sorenson says.

The hospital care management team and representatives from the healthcare providers who serve the residents of the Navajo reservation meet regularly to collaborate on ways to better serve the patients.

"The end goal is to partner with outlying hospitals and clinics so they provide care management on the reservation. Our care management team is collaborating with several reservation clinics as they work to meet the requirements for medical home designation," Brugh says. ■

EXECUTIVE SUMMARY

To accommodate its Native American patients, who make up about 40% of the patient population, Flagstaff Medical Center offers traditional food and has a traditional healer on staff.

- The hospital has full-time Navajo interpreters as well as 39 staff members who are back-up interpreters.
- Instead of giving Native American patients a large packet of information they may not understand or trust, care managers work with the primary care providers on the reservation and ensure they are aware of the hospitalization and the discharge plan.
- At-risk Native American patients who need follow-up receive monitoring devices that use cellphone technology and transmit their data to a telehealth nurse who intervenes when the data are out of normal range.

Hospital Uses Telehealth to Monitor At-risk Patients On the Navajo Reservation

Program allows interventions to avoid readmissions

Faced with the need to provide follow-up care for its Native American patients, many of whom lack electricity or running water, the telehealth department at Northern Arizona Healthcare's Flagstaff Medical Center developed a remote patient monitoring program and worked with the care management staff to implement the program.

"Between 35% and 40% of our high-risk patients identify as Native Americans and most of them live on the Navajo reservation. It was critical for us to develop a process to help them follow their treatment plans and avoid readmissions," says **Lisa Brugh**, MS, BSN, RN, ACM, system director of case management for Northern Arizona Healthcare. Telehealth follow-up is available to all at-risk patients.

Some Navajo patients live in traditional Navajo hogans — small mud-covered huts with no electricity or running water. They don't have 911 service or home health services. Public health nurses on the reservation visit the patients, but it may take as long as two weeks to arrange a visit, Brugh says.

Outpatient RN care managers visit patients in the hospital and clinics, teach them how to use the home monitoring equipment, and begin to develop a relationship with the patients. Depending on the clinical condition to be monitored, patients may be given a scale, pulse oximeter, blood pressure cuff, or thermometer.

"When the program started patients were also given a cellphone, but we find now that most patients or family members have a cellphone," says **Gigi Sorenson**, RN, MSN, director of Community Connected Care and Telehealth.

"The equipment we provide is specific to patient needs and what they are willing to have in their home. Some feel threatened by technology, but the patients who agree to monitoring say they feel safe and supported," Sorenson says.

The remote monitoring equipment transmits the clinical data into the hospital's telemedicine care management program. It is scanned into the patient's electronic medical record. An outpatient RN care manager reviews the data, then contacts the patient to discuss the results along with any symptoms the patient is experiencing. The nurse also reviews the patient's

Questions About Your Patients' Culture? Look For Answers Here

Information that case managers can use to find out more about their patients is just a click away. The following are resources recommended by others in the case management field:

- **Case Management Society of America** *(www.cmsa.org)* addresses cultural competency in its revised Standards of Practice.
- **The U.S. Health Resources and Services Administration** has a wide range of educational resources on providing appropriate care for a variety of ethnic groups and special populations. *(http://bit.ly/1frYWw5)*
- **The Commission for Case Management Certification (CCMC)'s Body of Knowledge** includes education on how effective communication can be used to overcome cultural, socioeconomic, language, gender, sexual orientation, and racial barriers. *(www.cmbodyofknowledge.com)*
- **The Office of Minority Health** *(www.minorityhealth.hhs.gov)* has developed the National Culturally and Linguistically Appropriate Standards (CLAS) in Healthcare tool. The website has many resources on cultural competency.
- **The Agency for Health Research and Quality** officers a health literacy toolkit and other resources. *(http://bit.ly/2kLUbcO)*
- **The National Center for Cultural Competence at Georgetown** offers assistance in creating, implementing, and evaluating culturally and linguistically competent healthcare delivery. *(https://nccc.georgetown.edu)* ■

discharge instructions and medication regime.

If any of the data are out of normal range, the care manager discusses follow-up options with the patient and collaborates with the care manager, primary care provider, or other clinician at the patient's medical home to monitor the patients and to intervene before they end up back in the hospital.

Many of the Navajo patients live in remote areas with poor cellphone service, which means they have to walk down the road or drive to an area with better service and transmit the data to the telehealth computer. Some older patients rely on their children to visit and assist them in using the equipment. "It's not an ideal situation, but for the most part, we are able to connect with patients," Brugh says.

Spotty connections are another problem, Brugh says. If the patients can't transmit their clinical data, they keep a written log.

"One challenge is that 40% of patients who live on the reservation don't have electricity or running water in their homes. They rely on wind power and cellphone service," Sorenson says.

Most clinics, schools, and Navajo chapter houses have Wi-Fi, Sorenson says. The hospital provides the patients with chargers they can plug into a vehicle for another source of energy.

Flagstaff Medical Center's Meds In Hand program provides prescribed medications to high-risk patients before they are discharged from the hospital.

The inpatient team arranges for the health system's outpatient pharmacy or the Indian Health Clinic to fill patients' prescriptions while they are still in the hospital. "It's critical for patients who don't have easy access to a pharmacy to leave with their medications in hand," Brugh says. ■

Community Efforts Cut Readmissions for Low-income, Hispanic Patients

When Dependable Home Health Services in Nogales, AZ, began an initiative to reduce its readmission rate, 23% of patients served by the home health agency were readmitted to the hospital within 30 days. Within a year, the readmission rate was reduced to 19%.

Dependable Home Health Services currently serves a low-income, majority-Hispanic population with an average age of 76. About 85% of the patients are dual-eligible Medicare and Medicaid beneficiaries. The rest are covered by Medicaid. About half of the patients have been discharged from a hospital and about 15% from another post-acute facility, such as a rehabilitation facility or skilled nursing facility, reports **Jill Lanning**, RN, BSN, chief nursing officer.

Most of the patients are discharged to home from the hospital because there are no post-acute facilities in their county and they don't want to be far from home, reports **Arlene Madsen**, RN, BSN, quality consultant. Fully 95% are discharged with a change in the medical regime. There is a critical access hospital in Nogales, but the majority of the patients are transferred to hospitals in Tucson for specialized treatment, Madsen says.

The agency staff faces a variety of roadblocks to ensuring that patients follow their treatment plans and avoid unnecessary readmissions, Lanning says.

Many patients do not speak English and although they speak Spanish, they cannot read Spanish, she adds. Often, they can't afford the copay for their medicine or the type of foods they need to get well. Many have low health literacy and don't understand their medication regimen.

In January 2016, the home care agency began meeting with representatives of the federally qualified health center in Nogales to work together on better meeting patient needs. Other agencies and providers joined throughout the year and the monthly meeting now includes the medical director from the local hospital, case managers and social workers from the hospital, the medical director, pharmacist, and a care coordinator from the health center, representatives from the local fire department, two health plans, adult protective services, and two additional clinics.

"We want to build relationships and collaborate on ways to work with patients to keep them from going to the emergency department for situations that could be solved at the primary care provider level," Lanning says.

For instance, in the past, when the home health nurses or patients called the health center because patients experienced high blood pressure, high blood sugar, or other issues, they often were referred to the ED because the clinic didn't have any slots for appointments. As a result of the meetings, the health centers leave a few

appointments open every day so patients who call in with non-emergent problems can get in to see a physician instead of going to the ED.

Representatives of the community organizations worked together to produce a standardized patient information booklet that patients take with them on provider visits, Lanning says. Each time they see a patient, providers enter information such as medication, chronic conditions, physician notes, vital signs, and other information. "This ensures that everyone has the same information about the patient and that we all know what the other providers are doing," she says.

The next goal is to sync providers' electronic health records so the home health agency, the clinic, and the hospital all have access to patient information, she says.

The majority of nurses and nurses' aides who work for Dependable are bilingual and live in the community they serve. "We get a jump on building trust when our employees speak the same language as the patients and understand their culture and their community," Lanning says.

Medication issues are the biggest problems, Lanning says. "Many times, patients are discharged with prescriptions that they don't take correctly. It may be because of finances or because they don't understand their instructions," she says. Often, patients take their prescriptions across the border to a Mexican pharmacy that provides the medicines at a lower price than they would pay in the U.S.

However, in Mexico, pharmacies are not required to have a licensed pharmacist on staff and manufacturers of medication don't have to follow U.S. FDA regulations, she says.

"We try to educate our patients on the importance of getting their prescriptions filled by a pharmacy on the U.S. side, but we tell them that if they do go to Mexico to get their medication, we want to check it over before they take it," Madsen says.

The home health provider also works with pharmacists from the health centers to help with medication reconciliation.

The Rio Rico Fire Department staff was already making health check visits to people who frequently call 911 for health issues, and agreed to also see vulnerable patients referred by the Dependable Home Health nurses. The fire department staff have been trained to perform a medication review as well as monitor blood pressure and other vital signs.

"It's all a part of our community collaboration to see that patients get the services they need to stay healthy and out of the hospital," Lanning says.

Many of the patients served by the agency are low income, have little education, and speak only Spanish. The nurses use educational materials written on the fourth- or fifth-grade level, but some patients can't read. In that case, the nurses educate the patients orally and use the teach-back method to make sure they understand, Madsen says.

"It takes an individualized approach to getting patients engaged in disease management. Sometimes, we educate the patient; other times, it's a family member," Madsen say.

Many patients eat a diet that is low in protein because they can't afford meat, Lanning says. This poses a problem for patients with wounds since increasing protein in the diet helps wounds heal, she adds. "We contact the patients' family members who live in another area and ask them to send protein powder or money for protein powder so they can supplement their diet," she says. ■

Presidential Order Aims to Cut Down on Regulations, But What Will it Really Mean?

The healthcare industry is optimistic that the "one-in, two-out" executive order will relieve them of some onerous regulations — but remains uncertain about the end results.

On January 30, President Donald Trump signed Executive Order 13422, specifying that when any federal department or agency issues a new regulation, it has to identify two that will be eliminated and offset the cost of the new regulation.

"We all wish we knew what the rule will mean for healthcare," says. **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm. "Hospitals must comply with numerous regulations that are time-consuming and don't have much value when it comes to patient rights or quality of care," she adds.

Rick Pollack, president and chief executive officer of the American Hospital Association, expressed support for the executive order as a way to allow providers to spend more time on patients, not paperwork. He pointed out that in 2016, the federal

government added 23,531 pages to the regulations that affect hospitals and health systems.

"Excessive red tape not only stands as a barrier to care, but as a key driver of cost. Reducing the burden would not only provide relief, but would also provide an opportunity to make care more patient-centered than ever before," he says.

The idea is very appealing, considering the massive regulatory burden the healthcare industry works under, says **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, LLC, based in Beaufort County, SC. But, she adds, "the devil is in the details."

She points out that multiple agencies publish rules that affect healthcare. These include the Office of Inspector General, CMS, the Office of Civil Rights, and the Department of Health and Human Services, among others.

In addition, when one agency eliminates regulations or issues new ones, there can be a downstream effect on other organizations, she points out. For instance, if an insurance industry regulation is overturned, it may have an effect on hospitals, she says.

"This executive order has not been fully vetted and understood. The White House issued interim guidance Feb. 7, but says that it is subject to change," says **Steven Greenspan**, JD, LL.M, vice president of regulatory affairs for Optum Executive Health Resources in Newtown Square, PA.

The executive order specifies that regulations that are discontinued must offset the cost of the new regulation, until fiscal year 2017 ends on Sept. 30. Beginning Oct. 1, 2017, the cost of the new regulation versus the two being eliminated has to be less than zero. In addition to regulations that are in effect, regulations that were proposed but not implemented before noon on Jan. 20, 2017, may also be eliminated as part of the two-for-one swap, Greenspan says.

The new executive order specifies that the regulations that apply to the requirement must be "significant." The order does not define "significant" but refers to a previous order, Executive Order 12866, signed by President Bill Clinton in 1993. The earlier order defines "significant" as any rule that "may have an annual effect on the economy of $100 million or more," Greenspan points out.

Interim guidance states that all the requirements under Executive Order 12866 are still applicable. The interim guidance called for an eight-day comment period, but the comments have not been made public.

"One big question is what this will mean for Medicare, but nobody is sure yet," Greenspan says. "Everything I've heard or read indicates that Medicare regulations may be spared," he adds.

The White House guidance states that, "in general, Federal spending rules that primarily causes income transfers from taxpayers to program beneficiaries (eg. rules associated with Pell grants and Medicare spending) are considered 'transfer rules' and are not covered."

"Statements by the government say that it also will be very difficult to eliminate regulations mandated by law or statute," Greenspan says. He adds that the Recovery Audit program was authorized by the Medicare Modernization Act of 2003. However, he points out that Tom Price, the new HHS secretary, may consider rolling back some regulations on his own even without enacting a new regulation.

The Affordable Care Act is also primarily payment-related and it may not qualify to be included under the executive order, Greenspan says.

Even if Medicare regulations are eligible for elimination under the "one-in, two-out" rule, it may be difficult to identify individual rules that result in $100 million in costs per year, Greenspan says.

The yearly Inpatient Prospective Payment System (IPPS) rule might qualify, he points out. "But it doesn't make much sense for the Centers for Medicare & Medicaid Services to do away with the IPPS unless they are going to replace it with a different method of reimbursement," he adds.

Not much is likely to happen affecting Medicare until CMS has its new administration in place and the staff starts to look at new regulations, Greenspan says.

Lamkin expresses hope that the industry as a whole can work together to develop a roadmap to follow. "Hospitals, physicians, vendors, insurance, government, and the public need some agreement on what regulatory changes will be made and understand the implications for all stakeholders," she says.

"This is, perhaps, an historic opportunity for the healthcare industry to work with the government to reach the goals everyone wants — lower cost with better outcomes for all Americans. But it will take a massive effort with all the parties at the table and with no sacred cows," Lamkin says. ■

COMING IN FUTURE MONTHS

- Combining medical, behavioral case management
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HOSPITAL
CASE MANAGEMENT

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CE QUESTIONS

1. **According to Vivian Campagna, RN-BC, MSN, CCM, statistics predict that 85% of the nation's population growth in the next 50 years will be due to immigrants and their descendants.**

   a. True
   b. False

2. **According to Catherine M. Mullahy, RN, BSN, CCRN, CCM, what is the first step in becoming culturally competent?**

   a. Rely on what you have learned through the years talking to people from other countries.
   b. Conduct research online about the various cultures your hospital serves.
   c. Examine your own feelings about the culture and how you feel about an increased number of people who look and think differently from you.
   d. Attend a class on diversity.

3. **Which of the following has Flagstaff Medical Center added to make its Native American patients feel more comfortable?**

   a. Added traditional foods to the cafeteria menu.
   b. Hired a traditional healer.
   c. Supported alternative healing techniques.
   d. All of the above

4. **What is the biggest issue Dependable Health Services in Nogales, AZ, encounters with their low-income Hispanic patients?**

   a. Blood pressure that is out of control.
   b. Medication issues.
   c. Failure to eat a nutritious diet.
   d. Using the ED for primary care.

CE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.