HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

## INSIDE



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# Two Essential Steps to Best Support Substance Abuse Patients

While opioid-related morbidity and mortality is an epidemic that dominates the news, the ripple effects of substance abuse among hospitalized patients are felt throughout healthcare facilities nationwide.

People with substance use disorders (SUDs) experience high rates of hospitalization, readmission, and long lengths of stay, according to the American Hospital Association.[1]

So how can nurse case managers best serve patients with SUDs, both during their stay and after discharge?

Without recovery services planned in advance, patients with addiction issues who are discharged are more likely to simply continue using drugs, explains **Lydia Anne Bartholow**, DNP, PMHNP, CARN-AP, associate medical director for outpatient substance use disorder services at Central City Concern in Portland, OR.

As an expert in addiction treatment, she recently spoke to the American Case Management Association's Oregon chapter to teach an introduction to the brain science of addiction from a trauma-informed, health equity lens. Part of her presentation was teaching an overview of the basic neurobiology of all substance use disorders, as well as a population-based look at who struggles with addiction and why.

> PEOPLE WITH SUBSTANCE USE DISORDERS EXPERIENCE HIGH RATES OF HOSPITALIZATION, READMISSION, AND LONG LENGTHS OF STAY.

She says there are two important steps hospital nurse case managers can take to support these patients:

• First, work on the connection around trauma and addiction. What is the link between trauma and substance use disorders?



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• Second, try to frame it as a disease and not a moral failing. What are some neurobiological processes that occur in all substance use disorders?

## Step 1: Understand Trauma and Addiction

Until healthcare providers understand the connection between trauma and addiction, some addicts in a hospital setting may feel stigmatized.

Bartholow says children who experience trauma are 46 times more likely to develop SUD as an adult. The understanding of addiction, and subsequently how case managers work to treat SUDs, must reflect this knowledge.

"You're less likely to think 'can't she just get herself together?' if you understand the background of substance abuse. The fact is, there's a 4,600% increase in developing substance abuse as an adult in patients with six or more ACEs — that means you're dealing with a population 46 times more likely to have this disease," she says.

But what, exactly, is the correlation between high Adverse Childhood Experiences (ACEs) scores and addiction? The original ACEs study asked a series of questions about incidents that occurred before the age of 18. Three questions focused on abuse — sexual, verbal, and physical — while other questions addressed types of family dysfunction — a parent who's mentally ill or alcoholic, for example. The ACEs include the following[2]:

- physical abuse;
- sexual abuse;
- emotional abuse;
- physical neglect;
- emotional neglect;
- intimate partner violence;
- mother treated violently;
- substance misuse within household;
- household mental illness;
- parental separation or divorce;
- incarcerated household member.

The original ACEs study showed a direct link between childhood trauma and adult onset of chronic disease as well as the following statistics:

• ACEs rarely happen in isolation. For example, 87% of survey respondents had experienced two or more types of trauma.

• Compared with someone with zero ACEs, people with four or more ACEs were twice as likely to be smokers, 12 times more likely to have attempted suicide, seven times more likely to be alcoholic, and 10 times more likely to have injected street drugs.

• For every additional ACE score, the rate of prescription drug use increased by 62%, according to

## EXECUTIVE SUMMARY

Patients with substance use disorder have high rates of hospitalization, readmission, and long lengths of stay. All healthcare providers must understand the connection between trauma and addiction. Because some addicts in a hospital setting may feel stigmatized, it's also important to:

- perform more care management;
- coordinate with local resources;
- develop a comprehensive treatment plan.

a 2017 study of adverse childhood experiences and adolescent prescription drug use.[3]

Not all hospitals track patients' ACEs score when they come in for services, but Bartholow says it can open up so much compassion.

"Patients with ACEs scores that are seven or eight? That makes you sit back and realize what you're dealing with. You can step back and say, 'I really had no idea.'"

## Step 2: Have Compassion for Addiction as Disease

It's also important for nurse case managers and their teams to really understand substance abuse as a disease, says Bartholow.

"We would never say to someone with uncontrolled diabetes, 'Just control your diabetes better.' Instead, we would arrange for them to see an endocrinologist and give them enough support to make sure they're getting their needs met," she says.

There often is a stigma around addiction as disease. For patients, it can be incredibly difficult to admit they have a problem and call on professional help.

"Extreme substance users who end up in the hospital — without a comprehensive treatment plan — go straight back to using because they don't have the skill set to not use. For people that have addiction issues, it's stigmatizing," Bartholow says.

"I've had a vision that we do more care management and coordination with local resources so when someone presents to the ER, perhaps an opiate overdose or IV wound, whatever it is, my dream would be that emergency rooms or inpatient providers have the skills to refer to treatment," she says.

"I think the hospital impetus is to treat the medical illness that is comorbid and get them out as quickly as possible with a lecture to never inject again," she explains, using the analogy of a patient presenting with signs of a heart attack. "In that case, we immediately connect them to a cardiologist. We never just give them a list of cardiologists and say, 'Don't ever have a heart attack again.'"

## The Next Frontier: Addiction Medicine

Is it possible that addiction medicine will be one of the next big frontiers?

As addiction medicine grows, so too will systems of care that are easy to navigate, nonshaming, and patient-centered. This system also will provide immediate access to pharmacotherapies for SUDs.

"What we'll see is a focus on creating systems of care, much of what we saw in primary care post-implementation of the Affordable Care Act," Bartholow says. "One of the things we see is that people are incredibly vulnerable in the gaps of care. If people are coming to the emergency room but never finding primary care, do intensive case management to get them to use those expensive treatments less," she says.

"Where we're seeing a lot of federal funding is around the opiate crisis; thus, we'll see people coming up with more creative ways to provide interventions that are also better care, [and] it'll save money and provide better care for patients. I hope there's more funding into intensive case management," she adds. ■

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# UMC Health Opens New Outpatient Observation Unit

*Streamlined approach provides cost savings for both patients and the hospital*

UMC Health System in Lubbock, TX, is just one example of a growing trend in outpatient observation status. It recently opened a 34-bed outpatient observation unit for patients requiring further testing and/or observation before deciding whether the patient either needs to be admitted to the hospital or sent home.

Before UMC opened the unit — where patients can stay for 8-24 hours — observation patients were spread throughout the hospital. Unfortunately, this led to patients experiencing delays with testing or treatments, increased length of stay (LOS), shortage of beds, and financial loss, according to **Nicole Bitar**, MSN, RN-BC, nursing department director of the new unit.

The following is *Hospital Case Management*'s Q&A with Bitar, who says UMC's new multidisciplinary approach will provide cost savings for both patients and the hospital. She says it also will ensure patients are receiving appropriate care.

**HCM:** Your new observation unit is attached to your hospital. Medicare doesn't explicitly state where to have an observation unit, but you chose to have 34 beds attached to your hospital. Had you tried other models before?

**Bitar:** Hospital administration identified an opportunity to better manage our observation patient population. Opening our observation unit is an innovative, interdisciplinary approach to the overall management of observation patients. It is a potential solution for our growing amount of observation patients and the daily capacity struggles we face in the emergency center.

Before opening the observation unit, we used a scattered unit model for observation patients as many hospitals do.

In a scattered unit model, observation patients can fill any inpatient bed. The problem with the model is observation patients are scattered throughout all of the inpatient units. They tend to fall through the cracks, getting lost in the daily shuffle. Their care was not standardized, and they were not always treated as a priority. Observation patients ended up staying in the hospital longer than necessary, receiving additional testing and treatment, which could have been safely handled on an outpatient basis.

**HCM:** How is the overall management of those patients since the observation unit opened in June? In particular, how are nurse case managers involved with and facilitating this transition and care? Does this observation unit have dedicated case managers?

**Bitar:** Case management plays a crucial role. The emergency center case managers are reviewing patients in real time to ensure they are being placed appropriately. Once the physician writes the order for observation, the case manager is reviewing the patient information, deciding if the patient can be targeted to the observation unit or to another floor.

Again, in order to improve patient flow, our unit's goal is for the patient's LOS to be 23 hours or less. If the physician and/or case manager believe the patient's stay will require more than 23 hours, the patient will be placed on another unit.

The observation unit does have a dedicated case manager, Monday through Friday. Our case manager screens all patients to ensure appropriateness for our unit. The case manager rounds with physicians, deciphers which patients meet inpatient criteria, helps the physicians understand medical necessity, and so much more.

Having a dedicated case manager has been invaluable. Case management has been an outstanding resource for nursing staff. Our nursing staff has really gained a better understanding of the role.

**HCM:** Things operate differently

## EXECUTIVE SUMMARY

UMC Health System in Texas opened a new 34-bed outpatient observation unit to ensure that all patients are receiving appropriate care.

- Observation patients are no longer spread across the hospital.
- Dedicated case managers screen patients to ensure appropriateness for the observation unit.
- Lengths of stay and costs have decreased since the observation unit opened.

in an observation unit. For example, how is length of stay measured? How are tests and diagnostics scheduled?

**Bitar:** Observation patients take priority behind emergent cases. Our timer for observation begins as soon as the physician places a status order to place a patient in observation. Monitoring of quality of care and appropriate utilization will be an essential part of performance improvement for our department. Our monthly unit metrics will include: conversion number (number of patients converted to inpatient status), number of patients over the 23-hour time frame, number of consults, length of stay by physician, number of diagnostic tests ordered, and number of physician consults.

In an effort to save time, our unit has become a nurse-draw unit and no longer utilizes our phlebotomy team. We met with all ancillary departments during the planning phase, and have continued to meet with them in an effort to seek out process improvement opportunities. Most ancillary departments have had to make subtle changes in an effort to accommodate our unit. Their willingness to be so flexible and accommodating has played a huge role in our success.

**HCM:** Patients typically stay less than 24 hours. How does it help prioritize care? Does it also prevent readmissions? If so, how?

**Bitar:** Our goal is to streamline all tests and treatments so a decision can be made on whether to admit or discharge in 23 hours or less. Our team provides expedited evaluations, therapeutic interventions, and coordinated services to safely discharge a patient home or determine the need for inpatient admission. Patients whose conditions improve, or can be managed at home, are discharged with a plan for appropriate care. Our team helps these patients set up their follow-up appointments.

Patients whose conditions fail to improve or worsen will be admitted to the hospital for further care. If the decision is made that the patient requires acute inpatient care, they will be transferred to an inpatient unit.

**HCM:** Have there been any concerns or surprises along the way?

Initially when we opened, our biggest concern was the turnaround time of radiology exams and stress test readings. We were actually blindsided with nurse staffing issues. Our census was not exactly what we expected in the beginning. Yes, our hospital typically has 80 observation patients in house daily; however, they do not all meet the 23-hours-or-less criteria we initially set. Therefore, we weren't receiving as many patients as we thought we would. Census dropped and nurses were being canceled frequently. Nurses would be placed on call at the beginning of the night shift. Then, we would receive a high volume of admissions, peaking from 1,900 to 2,100, so nurses would be called back in.

The observation unit is now trialing core staffing for four weeks. We also made the decision to toss the initial criteria, and decided to accept all observation patients (excluding pediatric, OB/GYN, and chemo). We decided this for two reasons. First, what impact could our unit have on these patients? And, second, to help with census.

**HCM:** Have you received feedback from patients, either positive or negative, when it comes to their transition to an observation unit? Do they understand why they're there, or ask questions?

**Bitar:** The observation unit has received positive feedback from patients. Patients are kept informed every step of the way. When the physician puts in an order to place the patient on the observation unit, the patient is made aware by the emergency center team. They explain what is to be expected under observation. The patients are also given a brochure that is filled with helpful information. Once the patient arrives to the observation unit, our team also reinforces to the patient that they are not being admitted to the hospital; rather, they are being placed in observation. We have all of our patients sign an observation notice form.

The patient is asked to keep a visitor with them at all times when possible. This way, they have transportation available if the decision is made to safely discharge the patient home. Patients have really appreciated the expedited, streamlined care. Having a dedicated observation unit allows our patients to be the focus of care.

**HCM:** Do you have any other tips or strategies to recommend if other hospitals are looking at creating their own observation unit?

**Bitar:** Once the decision was made to transition from a medical/surgical unit to an observation unit, we had approximately eight weeks before our open date. Evidence-based research and best practices related to observation units were pretty scarce. A lot of time was spent reaching out to hospitals with observation units in hopes of receiving any type of advice or tips. My colleagues and I joke that we will write the manual on opening an observation unit when all is said and done. Although eight weeks doesn't seem like a lot of time, it was just enough to prepare. The learning and adapting really began once we opened. We anticipated bumps along the way, and overall the transition has been better than expected. ■

# CMS Makes New Push for Electronic Health Records, Telehealth Reimbursement

When CMS unveiled its 2019 Inpatient Prospective Payment System (IPPS) several months ago, it ushered in a new era that emphasizes the exchange of health information between providers and patients. It also incentivizes providers to make it easier for patients to obtain their medical records electronically.

With its focus on reducing administrative burden and increasing time providing care to patients, CMS recently proposed new paperwork flexibility along with new proposals for virtual care reimbursement.

## Reducing the Paperwork Burden

The changes to paperwork would push clinicians to increase their use of electronic health record (EHR) documentation by including "clinically meaningful information," instead of information only for billing purposes.

CMS says the new proposals may allow doctors to spend more time with their patients — what the agency deems a "put patients over paperwork" approach.

"Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care. This administration has listened and is taking action," said CMS Administrator Seema Verma in a statement.

CMS says these proposed changes would save individual clinicians an estimated 51 hours per year if 40% of their patients are in Medicare.

CMS also said it acknowledges that getting to the doctor can be a challenge for some people. So now CMS is making new recommendations to modernize the Medicare program by leveraging telehealth technologies.

## Reimbursement for Virtual Care

For example, the recently proposed rule would expand Medicare-covered telehealth services reimbursement for virtual check-ins and telecommunications technology in the following ways:

"PHYSICIANS TELL US THEY CONTINUE TO STRUGGLE WITH EXCESSIVE REGULATORY REQUIREMENTS AND UNNECESSARY PAPERWORK THAT STEAL TIME FROM PATIENT CARE."

- paying clinicians for virtual check-ins, which are brief, remote appointments via video conferencing;
- paying clinicians to evaluate photos sent by patients;
- expanding Medicare-covered telehealth to include preventive services.

The American Hospital Association (AHA) is "pleased to see CMS taking some steps to expand the ability of physicians to serve patients through telehealth and virtual connections," AHA executive vice president Tom Nickels said in a statement.

Indeed, the National Institutes of Health has previously said "telehealth gives easier access to care and increases patient involvement and self-awareness for self-care and improved outcomes."[1]

For example, advances in virtual care can allow nurse case managers to effectively communicate with patients. Studies have shown that virtual check-ins can solve issues for underserved populations, geographically isolated patients, and those with transportation or mobility issues.

In addition, telehealth has been documented for effective outpatient management of cancer patients with new ostomies and for assisting acutely ill patients in the transition from hospital to home.[2,3] ■

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# Physician Sues Hospital Based on Attempts to Restrict Referrals

*Patients have the right to freedom of choice of providers*

It's important for hospital case managers to consider possible legal violations when it comes to offering choices for post-acute care. After all, there is the complicated matter of antitrust laws related to patients' right to freedom of choice to consider very carefully.

**Elizabeth Hogue**, Esq., a healthcare attorney based in Washington, DC, cautions that hospitals now face increasing pressure to honor patients' right to freedom of choice of providers from both competitors and physicians.

In fact, she highlights a recent lawsuit filed by a urologist against a large healthcare system in Boston. Hogue says the lawsuit was the result of doctors feeling "immense personal and financial pressure" to refer patients only to their own hospitals and specialists in order to increase profits.

Specifically, a doctor claims in his lawsuit that hospital representatives allegedly called patients and said they had to schedule their surgeries at their facility, even though the doctor had initially recommended another hospital.

The 35-page lawsuit also says hospital representatives would cancel appointments made by the doctor's office staff for patients of his practice at competing hospitals.

In response, the hospital's representatives said that their actions were justified based on concerns about quality of care. In terms of quality, hospitals and physician networks argue that doctors generally don't have access to other systems' electronic medical records, which makes it harder to coordinate care.

The doctor notes in his lawsuit that he has a contractual right to refer outside of the healthcare system if patients request it or if doing so is in their best interests.

While the hospital argued that policies discouraging referrals outside its system are legal and "extremely common," the judge said that defense is like a child telling a parent, "All the other kids do it."

## Compromised Care

Other lawsuit details include the following:

• A different doctor who was deposed in the case said the hospital rejects referrals to other providers regardless of patients' preferences and publicly shamed physicians who refused to comply with these restrictions. For example, during monthly group meetings, executives projected physicians' names on a screen along with the number of their patients who had gone outside the system for care.

• Approximately 20% of physicians' pay was withheld and pay out of these amounts was tied to certain quality goals, including keeping patients with the healthcare system. Generally speaking, the practice of withholding compensation "isn't necessarily unethical or illegal," says Hogue.

• Another physician testified that she ended her affiliation with the hospital due in part to its policies surrounding patients' right to freedom of choice. The physician testified that she was asked to call an elderly patient to persuade him to cancel his heart surgery at a large teaching hospital in Boston a couple of days before the operation and move the operation back to their hospital instead. When she refused, a hospital administrator contacted the patient and moved the surgery back to their facility.

## Refusal to Dismiss

Since the judge refused to dismiss the lawsuit (the case is pending in Suffolk Superior Court), now is a good time to consider the ripple effects for hospitals nationwide when it comes to honoring patients' right to freedom of choice. Hogue says hospital nurse case managers should clarify how they carry out discharge planning.

Because patients have the right to freedom of choice of providers, hospital case managers have the following legal and ethical obligations:

• Honor patient preferences for providers. All patients have a common law right, based on court decisions, to control the care provided to them, including who renders it. This includes Medicare beneficiaries and Medicaid recipients, per federal statutes.

• Develop a list of Medicare-certified home health agencies in geographic areas where patients reside (per the Balanced Budget Act of 1997).

• Disclose on the list any financial relationships or special interests with home health services.

• Use a neutral tone when presenting lists to patients, to not say anything negative about other healthcare facilities, and finally, to not persuade patients away from making their own choices. ■

# Emergency Providers Play a Pivotal Role in Suicide Prevention

*Train emergency staff how to manage patients at risk for suicide*

With suicide rates rising, there is a new focus on what frontline providers can do to address the problem. It is well-known that patients at risk for suicide often present to the ED, so developing an effective way to take advantage of this opportunity could prevent many patients from taking their own lives.

However, with EDs already overwhelmed with other tasks, taking on suicide prevention can be challenging, especially when there is a dearth of mental health resources in the community. But the urgency of this problem — reflected in newly released CDC data showing that suicide rates are up in every state with the exception of Nevada, where rates already were elevated — suggests that it is an issue that clearly requires more attention and new solutions.

What's pushing the suicide rates higher in this country? **Edwin Boudreaux**, PhD, a professor in the departments of emergency medicine, psychiatry, and quantitative health sciences at the University of Massachusetts Medical School, has been working on the issue for many years, and he suggests one of the biggest contributing factors is plain to see.

"The mental health treatment system in the United States is broken, so we have really poor access to high-quality behavioral healthcare," he says.

Thus, Boudreaux notes psychiatric patients who come to the ED often are boarded or "hung up" there at a much higher rate and for a much longer period than medical patients. "If you come into the ED, and you have a medical problem that requires hospital admission, you get into the hospital relatively quickly compared to psychiatric patients," he says. "The reason for that is there is no place to send psychiatric patients."

In fact, the scarcity of mental health resources extends from outpatient care to intensive inpatient care.

"If people can't readily access high-quality behavioral healthcare, then their behavioral health disorders go untreated ... and [they] are more likely to die by suicide," Boudreaux laments. "There is a clear problem with getting access to high-quality care that leaves people in the lurch, so they have no safety net and because of this, they end up dying by suicide."

Boudreaux acknowledges that it is difficult to prove this link, but he notes there are different bits of data that are revealing.

"We see the suicide rate increasing, but we also see the boarding rate in EDs increasing, and we see other data that suggest access to behavioral healthcare is problematic, with long delays and insufficient coverage," he says.

Another potential contributing factor to the rising suicide rate is the growing isolation of the modern tech era, Boudreaux offers.

"When all your friends are online, and there is an actual breakdown in community connectedness ... people become isolated, and they feel lonely and disconnected; they feel their lives have less meaning," he says. "When you have lonely, disconnected lives, people tend to resort to suicide more frequently."

Suicide prevention advocates also are concerned about the increasingly available access to information about highly lethal suicide methods.

"What we have seen is that when you can access on the internet information around exactly how [to commit suicide], including ways that are relatively painless and highly likely to be effective, then that information translates into action," Boudreaux says. "Where people may not have understood how to [commit suicide] in the past, and they have taken overdoses or used other nonlethal means and didn't die, now they are more often dying through their attempts because they are getting this information."

Indeed, in his own region, Boudreaux has observed people using different suicide methods than in the past, and the new methods tend to be more lethal. This is unfortunate because many people who get

through a suicide crisis without dying will recover and be just fine, he says.

"A low-lethal suicide attempt doesn't mean the person will inevitably die by suicide, but if you have available lethal means, you don't get past it."

Emergency providers must be particularly attuned to the issue when high-profile instances of suicide are widely publicized, as they have been recently with the suicide deaths of designer Kate Spade and celebrity chef Anthony Bourdain.

"We know that high-profile suicide cases lead to other suicides," Boudreaux says. "Suicide contagion is a pretty well-studied phenomenon."

When news coverage of these cases goes viral and is shared repeatedly via social media in ways that were not available before, it becomes an omnipresent type of reminder and stimulus, Boudreaux adds.

"If a person is already feeling suicidal, and now they are not only seeing it on the news, but they are seeing it on Facebook and seeing it in tweets, and it is retweeted and reposted and emailed ... it becomes a stimulus that is difficult to avoid in the way that in the past it could be avoided by just turning off the TV."

## Employ Screening

**Marian Betz**, MD, MPH, an associate professor in the department of emergency medicine at the University of Colorado's Anschutz Medical Campus, notes that many aspects of the suicide problem are beyond the immediate control of emergency providers. These aspects include not maintaining enough psychiatric beds or not employing enough outpatient mental health providers. However, Betz recommends emergency providers advocate for additional resources in these areas, stressing that this is just a start.

"I think sometimes people get frustrated, thinking there is nothing they can do," she says. "But there is a lot that we can be doing within the ED to identify and then [intervene] with people who are at risk for suicide."

For example, Betz's ED, and a growing number of EDs across the country, have begun to implement universal screening for suicide risk.

> "THERE IS A LOT THAT WE CAN BE DOING WITHIN THE ED TO IDENTIFY AND THEN [INTERVENE] WITH PEOPLE WHO ARE AT RISK FOR SUICIDE."

Typically, such screening takes place at triage or during the initial nursing assessment. The process involves asking patients a few questions regarding their thoughts about suicide or whether they have made any suicide attempts in the past. Such questions are embedded with queries about other risk factors such as domestic violence, smoking, and the like.

"The rationale for [suicide risk screening] is that prior estimates suggest that there is a decent proportion of people who are at risk for suicide who are seen in EDs and won't say anything unless you ask them about it," Betz says. "You don't pick up [the signs] unless you ask." While some EDs opt for targeted screening, which means they only screen patients in other high-risk groups such as those with substance use disorders or mental health conditions, that approach misses a group of patients at risk who have no presenting symptoms or obvious risk factors.

"That is why a lot of EDs have decided they will just screen everybody," Betz notes. "It is easier, and it has been estimated from prior research that about 10% of all adults in the ED have had recent suicide ideation or behaviors, but a lot of those people won't say anything unless you ask about it."

## Establish Protocols

Of course, there is no point in screening for suicide risk unless there are protocols in place for addressing next steps if a patient is found to be at risk.

"We do know some people feel some relief at being asked about the pain they are in, but certainly there should be a follow-up step to figure out what the person needs," Betz advises. "That is where it can get a little more difficult because we as emergency physicians practice in such varied locations. There are small, community, often rural EDs that don't have mental health specialists available, whereas I work in an urban, tertiary care center where we have 24/7 access to social workers within our ED to do our [follow-up] evaluations."

In Betz's ED, if a patient screens positive for suicide risk or presents with a complaint of feeling suicidal, the emergency physician will conduct an initial assessment. Many of these patients then will be seen by a licensed social worker, referred to as a behavioral health evaluator, for

a more comprehensive assessment. "It is really helpful to have those specialists because of their training, but also because they have more time to sit with the patient and really talk through all of the risks and protective factors, and to formulate a more detailed evaluation," Betz shares.

For smaller hospitals or EDs that do not have access to such specialists, the follow-up piece is a bigger lift. However, Betz says these facilities can contract with an outside group that can send a specialist to the ED, or through a telepsychiatry solution.

"I also think it is important to point out that we as emergency providers should develop a skill base to be able to care for at least the lowest-risk individuals without behavioral health specialists," she says, noting that it is analogous to caring for patients with chest pain. "We don't call a cardiologist for everybody who has chest pain. As emergency providers, we know how to do the initial risk stratification and decide who needs further testing or who needs to see a specialist."

Similarly, Betz notes that emergency providers should learn the skills to care for a patient who has had some suicidal thoughts, but demonstrates no other risk factors. "We should be empowered to be able to care for those types of patients sometimes, even without a specialist," she says. "That is important because at places where behavioral health specialists are not available, you are faced with transferring patients or keeping them for hours in the ED, which is tricky."

## Develop Competency

The array of skills Betz would like to see emergency providers acquire includes knowing what questions to ask and how to risk-stratify someone with suicide risk. "In my own training, and what I have seen since then, it often seems as though with psychiatric complaints, we hand off as opposed to owning some of that risk stratification," she says. "Some of this training should [be provided through] the development of better residency curricula and continuing medical education curricula."

"IT IS IMPORTANT TO POINT OUT THAT WE AS EMERGENCY PROVIDERS SHOULD DEVELOP A SKILL BASE TO BE ABLE TO CARE FOR AT LEAST THE LOWEST-RISK INDIVIDUALS WITHOUT BEHAVIORAL HEALTH SPECIALISTS."

Betz also would like to see guidance on how to help ED staff find ways to show empathy and connect with these patients. This can be difficult because, unfortunately, patients with suicide risk often get lumped with patients who have other behavioral disturbances that may make them very difficult to care for. Such patients may be intoxicated, violent, or verbally abusive to staff, Betz explains.

"Such behaviors can make providers feel angry, upset, or jaded ... so I think they need to learn to recognize the spectrum of emotional and mental health disorders, and recognize that when someone is in the ED with suicide risk, that person is feeling very real pain, too," Betz stresses. "It is emotional pain, but in the same way that we feel compassion for physical pain, we need to get better at knowing how to heal [these patients]."

Sometimes, this is as simple as helping people find hope, Betz observes. "Being able to connect [with people] and [help them] think about something worth living for, whether that is a child or a pet or something that is coming up that the patient is looking forward to," she says. "Emergency departments are not set up to be the most soothing or therapeutic places physically, so that is an added challenge."

Safety planning with patients found to be at risk for suicide is part of the equation, too. "This involves helping a patient develop problem-solving skills in identifying people they can turn to and activities that make them feel better," Betz explains. "They actually write these things down."

It is important to ask about firearms because they are the most lethal method of suicide, Betz notes. "Sure, you can ask about medications or access to hanging supplies. That may make people feel like you are not singling out guns, but it is really important that we talk about whether people have access to firearms, and if they do, how they can reduce that access at least temporarily," she says.

"Some people say, 'What does it matter? People [at risk of suicide] will just find another way.' Some people, if they want to attempt suicide with a method that is not available, will substitute with something else, but actually most don't. Even if they substitute something else, it is less likely to kill them than a firearm."

Providers may ask: If a patient is suicidal, and they own a gun, does that mean the patient should be hospitalized? "The answer is no," Betz adds. "You need to problem-solve with them, but just having a gun at home is not the thing that determines the risk assessment."

Policymakers need to acknowledge that emergency providers have liability concerns, especially when they are performing tasks that they have not handled traditionally in a high-risk area, Betz says. "That's why we need guidelines, tools, and policies from our national organizations that we can cite and say that we are sending a person home because that is in line with specific criteria and policies," she says. "That will make providers feel more comfortable that they are not out on a limb."

The Suicide Prevention Resource Center was developed to address some of these concerns. Funded by the Substance Abuse and Mental Health Services Administration, it includes a range of tools and guidance for emergency providers on how to assess for suicide risk as well as how to intervene when a patient is found to be at risk. *(Learn more information about these tools online at: https://bit.ly/2bIQgaP.)*

The site includes tools such as the Patient Safety Screener (PSS-3), a three-item instrument designed for use in the ED to assess for suicide risk *(https://bit.ly/2tBpBE8)*. There also is a safety planning guide that provides details about how to develop a safety plan for patients who are found to be at risk *(https://bit.ly/2K8rZxi)*.

Boudreaux, who worked with colleagues to develop many of these resources, explains that the idea behind the site is to make it easy for EDs to access information and training materials so that they can actively deploy the tools and strategies. "All of our resources related to the [PSS-3] and how to use it are all in one place now, which we didn't have before," Boudreaux notes.

In fact, Boudreaux says that his own ED has programmed the screening tool into the electronic medical record (EMR), and staff are working with several EMR providers to make the tool part of their standard systems. "We have made some progress with that, but we are not quite there yet," he says. Also in development is a second screening tool that could be used to risk-stratify patients further and gather more information about risk factors on patients who have screened positive on the PSS-3. "We are working on further building out decision support related to using the two tools together," Boudreaux reports.

In addition to these resources, Betz is working with a group within the American College of Emergency Physicians to develop a reference tool geared especially for emergency physicians who are working in a setting without access to mental health practitioners.

"It will help them think through all the steps," she says, referring to the many issues that need to be addressed when managing a patient at risk for suicide. "We need tools like that to help providers because they can't remember everything. They need to have a resource to go to, and something to be able to cite to justify what they are doing," she says. The reference tool should be available later this year.

## Handle Logistics

While new tools and guidance on dealing with suicide risk in the ED are released often, Boudreaux acknowledges that many emergency physicians are resistant to taking on additional tasks.

"It comes from a real place. Emergency physicians aren't trained to do this, and they are busy and have other priorities," he says. "That said, though, with suicide, we think we can train clinicians to do a better job of managing patients with lower-level risks. In fact, it is required because if we do a good job of screening, there is no way that we will have sufficient mental health resources to see and treat all of those patients. It's impossible."

When it comes to providing this training to emergency providers, the biggest obstacle that Boudreaux faces is logistics. "When clinicians are working, they can't be trained, and when they are not working, they don't want to come in on their off hours to get trained. There is no time to do it," he explains. "Coming up with innovative ways to train people and to reinforce those skills over time is really important, and right now we just don't have very good options. We do the best we can, but this is still an area that is evolving."

Emergency staff members need to be reminded continually that they can play an important role in preventing suicides, Betz explains.

"We know from some recent surveys that emergency physicians and nurses, just like the public, may be skeptical that suicide is even preventable. That is another challenge," she says. "We see people who are in crisis, but we don't necessarily hear about the successes. We don't hear about people getting better."

The nature of emergency personnel is such that providers miss the positive reinforcement of seeing patients whom they treated, and who got better, Betz notes.

"Now, it is two years later, and such patients may be thriving," she says. "We don't ever get that feedback." ■

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# CE QUESTIONS

1. **Lydia Anne Bartholow, DNP, PMHNP, CARN-AP, says patients with six or more Adverse Childhood Experiences are how many times more likely to suffer from a substance abuse disorder?**

   a. 10
   b. 22
   c. 40
   d. 46

2. **Elizabeth Hogue, Esq., says all patients, including Medicare beneficiaries and Medicaid recipients, have a common law right, based on court decisions, to control the care provided to them, including who renders it.**

   a. True
   b. False

3. **Which is *not* one of the goals of recent CMS proposals to expand Medicare-covered telehealth services reimbursement?**

   a. Paying clinicians for virtual check-ins
   b. Paying clinicians to evaluate patient-submitted photos
   c. Expanding Medicare-covered telehealth services to include social media platforms
   d. Expanding Medicare-covered telehealth services to include prolonged preventive services

4. **UMC Health System in Lubbock, Texas, opened a new 34-bed observation unit in June 2018 to solve which major problem?**

   a. Delays testing and treating patients
   b. Bed shortages
   c. Financial loss
   d. All of the above

# 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.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

# Case Management Leaders: Without You, We're Nothing, Part 1

*By Toni Cesta, PhD, RN, FAAN*

## Introduction

In my opinion, the role of the case management leader is one of the hardest roles in any healthcare setting. The attractive things about a leadership position in case management also make it one of the most challenging. Case management leaders are expected to have a skill set that ranges from clinical knowledge and expertise, to knowledge of healthcare finances, to leadership and management skills. The case management leader also must possess strong leadership and management skills, as they are responsible for managing the staff, the departmental budget, and staff development.

Most case management department leaders have the title "director." While some leaders may have other titles, "director" is the one most commonly used. The role of a director is considered middle management, and success in the role requires that the director cultivate good working relationships with staff and senior leaders of the organization. Most directors, if asked, would admit they simply don't have enough staff to get the job done. Other resources they may lack include data support staff, clerical staff, office space, space on the nursing units, and laptops or similar devices.

The combination of limited resources with a middle management role and a requirement of a wide range of skills and knowledge adds up to a complex and often difficult job. The director also must stay current in all issues related to case management, and often works for senior leaders who do not completely understand the roles of case management or the value that it brings to the organization. It is no wonder that directors are difficult to find — and that there often is a great amount of turnover. This month, we will discuss why case management leaders continue to be so challenged and how they can cope with this ever-growing and demanding job.

MOST CASE MANAGEMENT DIRECTORS, IF ASKED, WOULD ADMIT THEY SIMPLY DON'T HAVE ENOUGH STAFF TO GET THE JOB DONE.

## What Is Leadership?

Titles aside, it often is said that we lead others but manage ourselves. So, what is the difference then between a leader and a manager? It certainly is more than just a title. The differences often can mean success or failure for the director of a case management department.

According to author Warren Bennis, the following list of examples illustrate the differences. As you read through the list, consider whether you fit into one or the other. If you fall more often on the manager side, that may just mean that you are still growing in your position. Be as honest with yourself as you can be.

- A leader continually develops; a manager stays consistent.
- The manager's eye is on the system; a leader is focused on people.
- A leader creates trust; a manager controls.
- The manager sees things in the short-term, while a leader has far-seeing perspective.
- Leaders question why; managers ask how and when.
- The manager's eye is on the bottom line; the leader watches the horizon.
- A manager imitates ideas; leaders are original.

• Leaders challenge the status quo while managers simply accept it.

• A leader is his or her own person; a manager is a soldier.

• A manager can do things correctly; the leader can do the right thing.

There may have been a time and place where leadership and management might have been interchanged. For example, if a supervisor worked in a car factory, he might be managing the processes of car-making in the factory but not have much concern for the product being made or who might be buying it. In this case, he is truly a manager — he wanted things to be efficient, but that is all.

## No Longer Cogs in a Wheel

Times have changed and in today's economic climate, this approach does not always achieve desired outcomes. Employees are no longer considered cogs in a wheel, but rather, they are important in the quality management and improvement processes. Managers also must lead their teams to improve their skills, inspire results, and identify areas for improvement whenever they arise.

The question for case management leaders is: Are you are really leading, or are you strictly managing your staff and your department? The answer to this question may be affected by myriad issues that are common in many case management departments.

For example, you may want to manage your data and share it with your staff, but you simply don't have the resources or the time to do so. Sharing the data with your staff will help to improve the outcomes of the case management department, but most days you are swamped with work and higher-level activities fall to the side.

If you have been called a "status quo" leader, you are probably actually functioning as a manager. You may not want to rock the boat or make any significant changes. You may actually fear change. Your fear of change may be due to a lack of knowledge or confidence. It might be because your boss has made it clear that things need to stay as they are.

EMPLOYEES ARE NO LONGER CONSIDERED COGS IN A WHEEL, BUT RATHER, THEY ARE IMPORTANT IN THE QUALITY MANAGEMENT AND IMPROVEMENT PROCESSES.

Whatever the reason, today's case management department cannot stay stagnant. As the healthcare environment evolves, so must the case management department. This evolution includes the staff, the departmental resources, and the expected outcomes.

You may want to give some staff development lectures, but you don't have the time to create the lecture, never mind give the lecture. You spend time with budgets, meetings, and other management activities that leave little time for staff development. You understand your need to lead the staff, but leadership activities just don't fit into your day as other priorities prevail.

You may not have enough staff, but also quite common is a lack of leadership staff needed to manage today's case management departments. Departments have become much more complicated as they attempt to integrate many roles and functions, including utilization and resource management, discharge planning, patient flow, denials and appeals, and psychosocial management and support, among others.

Under these circumstances, your challenges will be many. However, running a case management department isn't what it used to be. The pace is quicker and there are many more demands. It is well understood that the most successful leaders possess certain traits. If you can integrate these traits into your daily routine, they will provide you with a firm leadership foundation and a higher probability of success. Let's begin our review of these top 10 major leadership traits.

## Trait 1: Be Results-oriented

As a leader of a department in today's healthcare world, you must be results-oriented. I often am amazed by how many case management leaders do not have any sort of tracking system, such as a case management report card or dashboard, that can show where the department is doing well and where it needs to improve. The old phrase "work smarter, not harder" applies here. If you are leading your department, you must exert the department's resources and energy in ways that improve the outcomes

for the staff, the department, and the organization. By monitoring and managing your data, you will know where to exert the most energy.

While certain core activities must always be accomplished, how will you best know if the staff are functioning optimally if you are not outcomes-oriented? For case management departments, this means more than just completing those clinical reviews or getting those discharges out the door. What are the *outcomes* of those activities? Are you reducing denials? Is your length of stay down? Do you have fewer avoidable days? The difference between tasks and outcomes is huge for a case management department and for a leader. The best strategy is to be action-oriented, but don't be just busy — be effective. You also may need these data to demonstrate your value to the organization and to justify additional resources when needed.

To use data to your advantage, be sure to have some form of a case management scorecard. Select the outcomes you want to track and identify the benchmarks. From there, determine the metrics you want to achieve in each of these for your own department and track them monthly. The data will help you understand where you are doing well and where you may need improvement.

## Trait 2: Be Customer-focused

To be customer-oriented is a broad challenge for case management department leaders. If you are in a middle-management position, you are accountable to those above you as well those who report to you. You probably have additional responsibilities to the patients and families, physician staff, the finance department, the department of nursing, and others. The list encompasses most of the departments and disciplines in the hospital. Your customers extend to those external to the hospital, including post-acute care providers, patients and families post-discharge, and primary care providers. There is a lot to navigate.

Your job as a leader is to ensure that you are meeting the needs of your customers. This requires constant vigilance in looking past your own department walls so that you don't ever assume you know what your customers need. The only way to truly know is to ask your customers. You can do this via a questionnaire or in person, such as during a committee meeting. For example, while you are meeting with your post-acute providers, you can ask them if the transfer process is smooth and efficient on their end. These actions can do a lot to forge great working relationships, and they will serve you well as department leader.

## Trait 3: Have a Vision

Having a vision means looking beyond today's work. It means looking toward next month, next year, and maybe even five years ahead. To have a vision, you must understand what your goals are and be able to create a vision for the future that is clear to you, your staff, and the organization. You may want to consider writing a 'vision' statement for your department.

A vision statement is one sentence that describes the clear and inspirational long-term desired change resulting from your department's work. Design your vision statement to clearly communicate what you are doing to positively achieve in a way that people within and outside your department can remember and communicate to others.

In your statement, succinctly describe your vision as a guide to action for your department and ensure that each and every staff member embraces it as their guide and personal call to action. The best vision statements are inspirational, clear, memorable, and concise. They don't need to be long — they can be as short as 10 or 15 words. It is likely that your organization has a



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vision statement, so be sure that yours complements it but is strictly focused on what is unique about case management and its contributions to the hospital's outcomes, both financially and clinically. Finally, don't keep your vision statement a secret. Be proud of it and share it whenever possible.

## Trait 4: Strategic Focus

It was once said to me that one should never go into a meeting without knowing what the outcome will be. This means that before you attend any meeting where an important decision has to be made, you should negotiate for what you want. You shouldn't even hold the meeting until you are sure that the outcome will be in the direction that you are looking for.

To be a strategic leader means that you must think carefully and thoughtfully about what you do and how you do it. Being strategic is defined as relating to the identification of long-term or overall aims and interests and the means of achieving them. You may think of this as being political, but it is much more than that.

As you navigate through issues with other departments and disciplines, you will need to be able to articulate that vision to them and engage with them in ways that ensure that you get what you need and want for your department. Being strategic means being able to negotiate and advocate for your department's needs. You need to think at a higher level in order to be strategically successful.

You should look to the future and be able to adjust as things change. The future might be tomorrow, next week, or next year. You should cultivate good negotiation skills as you work with other disciplines, your boss, and outside agencies in pursuit of attaining all the best you can for the department and organization. It is said that a good leader spends at least 15% of his or her time strategizing. While this may seem like a lot, it will be an investment in the future of your department and save time down the road.

## Trait 5: Delegate Effectively

Some directors may try to do everything themselves, seeing delegation as a form of weakness or incompetence. In fact, the opposite is true.

A good leader must use the human resources of his or her department optimally and to the department's advantage. If you try to do everything yourself, you will never get it all done nor will you ever make improvements. You will always be stuck in the minutia of the work and lose sight of the big picture.

Start off by understanding what you must do versus what can be done by others in the department. Be sure that each and every staff member is working at the top of their skill sets, not at the bottom — and that includes you. Delegating doesn't mean dumping on others.

If you are thinking that it would not be done right unless you do it yourself, stop and think. Look at the work you are doing objectively and ask yourself: "Is this something I can ask another person to do? Can I teach him or her how to do it? Is it within his or her scope of practice and/or job description?" If the answer is yes, then it is well worth the time to teach the task and hold him or her accountable for it going forward.

Manage the process by setting deadlines and meeting with the person to review the work completed. You will become more effective in your role, and the employee probably will value the faith that you have put in him or her. This is leadership at its best.

## Summary

This month, we began our discussion of leadership and the role of the case management leader and reviewed some of the most successful traits. Next month will complete our discussion on leadership by continuing our review of leadership traits and how to apply them to your daily practice. ■

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