HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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COVID-19 Pandemic Changes Nation While Hospitals and Case Managers Cope

Case managers should not forget self-care

By Melinda Young

It started in the United States with an infection outbreak on the West Coast. Soon after, America's way of life shut down, and infections and deaths escalated because of the COVID-19 pandemic.

By mid-March, only a few hospitals began receiving a surge of patients critically ill from the coronavirus. Infectious disease physicians and epidemiologists predicted that by May, many cities would experience surges of severely ill patients from COVID-19.

> "WE ARE FACING A SITUATION IN THIS COUNTRY THAT THE VAST MAJORITY OF US HAVE NEVER EXPERIENCED BEFORE, AND IT'S AT A LEVEL WE HAVE NO EXPERIENCE WITH."

"What happened in China and what is happening before our eyes in Italy is a tsunami of critical cases coming to medical systems. They cannot handle them, and the mortality rate is skyrocketing," says **Greg Poland**, MD, professor of medicine and infectious diseases at the Mayo Clinic. Poland also is the director of the Mayo Vaccine Research Group. "In countries that do not have that overwhelming demand, the mortality rate is very low."

"America has not gotten the memo," he adds. "I'm going

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out now, and people are crowded into a restaurant with the assumption they won't have a serious illness, based on their age. They may or may not be correct."

But it is a false assumption, Poland says. "We're a selfish culture and do not understand the effect on other people and those who have very high risk," he adds.

If there is a silver lining in the pandemic, it is that it hit the United States at the tail end of the flu season instead of during its peak, says **Kathleen Fraser**, MSN, MHA, RN-BC, fellow of the American Academy of Nursing and executive director of the Case Management Society of America (CMSA). Fraser also is chief executive officer of Fraser Imagineers in Houston.

The 2019-2020 flu season was the worst in 30 years in terms of its effect on children. Usually, influenza A dominates. But, this season, influenza B spread, which hits children harder than does influenza A, Fraser notes.

"Flu season hit earlier than it has in the past three decades, and it hit more kids this year than it has in 30 years," she adds. "It was a very different and difficult flu season."

Then, starting in January or February, COVID-19 began to spread in the United States. This novel viral infection typically presents with a cough, fever, and shortness of breath.

This particular virus infectious for a long time while the patient is asymptomatic, said **Dawn Bowdish**, PhD, assistant professor at McMaster University in Hamilton, Ontario. Bowdish spoke at a March 16 video conference on COVID-19. *(The recording is available at: http://bit.ly/2Ql7b6U.)*

Unprecedented Situation

When people begin to feel symptoms, it means their immune response is dealing with that virus. As a result, most people will limit their public activity. But when a virus has a long incubation period, it can spread easily and infect more people.

"Most people display symptoms five to seven days after they're infected," Bowdish said.

Public health officials have called for 14-day (or longer) quarantine periods because of evidence the virus stays infectious longer, she added.

"We are facing a situation in this country that the vast majority of us have never experienced before, and it's at a level we have no experience

EXECUTIVE SUMMARY

The COVID-19 pandemic has disrupted American life and threatens to inundate hospitals with critically ill patients through the spring. Hospitals and case managers can use phone and video conferencing when feasible. Also, they can follow all infectious disease prevention measures.

- A surge of critically ill patients is expected by May in hospitals across the United States.
- The 2019-2020 flu season was the worst in 30 years in terms of its effect on children, but it was ending before COVID-19 hit the United States.
- Even with widespread social distancing and closed businesses and venues, communities and hospitals are not prepared for peak outbreaks.

with," said **R. Sean Morrison**, MD, co-director of the Patty and Jay Baker National Palliative Care Center and an Ellen and Howard C. Katz professor and chair, Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai in New York City. Morrison spoke about COVID-19 at a March 18 webinar from the Center to Advance Palliative Care (CAPC). CAPC has made several COVID-19 response toolkits and resources available at no charge to the public at: http://bit.ly/2Qp2VTN.

"Everyone in this country with serious illness will need to be cared for. We need a workforce with knowledge about palliative care, and we need it right now," Morrison said.

Case managers and palliative care professionals can support patients through phone calls and, when possible, video conferencing. "Complex patients with the highest symptoms may need bedside consultation," Morrison explained. "But most of our work will be through telemedicine and telephone support. That's critical for a number of reasons, including because it allows us to keep our workforce, which is very scarce, healthy."

If closings and social distancing measures work as planned — slowing and stretching out infection clusters — then healthcare facilities have time to prepare for expected surges in viral outbreaks. This is where case managers can help. Hospital case managers can continue to perform their discharge and transition planning duties as well as they can, Fraser suggests.

"Case managers are making sure they can get patients out of the hospital when they don't need to be there," she says. "They make certain patients are ready to be discharged safely."

Case managers and other healthcare professionals can learn more about the pandemic and ethical issues through a recent framework report for healthcare institutions, available at: http://bit.ly/2x9M14Q.

Ebola Experience Helped Preparation

The Ebola outbreak of 2014-2015 helped prepare U.S. hospitals for an epidemic, said **Paul Biddinger**, MD, MGH endowed chair in emergency preparedness, director of the Center for Disaster Medicine, and vice chairman for emergency preparedness in the department of emergency medicine at Massachusetts General Hospital. Biddinger spoke to journalists and others at a web conference on March 13.

"Many hospitals and healthcare systems felt unprepared in 2015 for Ebola," Biddinger explained. "As serious a disease as it is in a nation with a significantly developed healthcare system, it's much less of a threat [than COVID-19] because it only spreads with symptoms and by contact, so we're grateful that disease outbreak didn't spread further."

A national Ebola education center was developed to help health systems deal with outbreaks and epidemics involving unusual infectious diseases, he said. "We've been preparing for something like this coronavirus," he added.

The University of Nebraska Medical Center, Emory University, and New York Health and Hospitals established the National Ebola Training and Education Center (NETEC). NETEC's goal is to increase the U.S. public health system's capability to effectively manage cases with suspected and confirmed infection by special pathogens. *(More information is available at: https://netec.org/about/.)*

Proper PPE Usage Is Critical

Biddinger is involved with NETEC through Massachusetts General Hospital. Through the Ebola experience, public health and emergency preparedness experts learned the importance of wearing personal protective equipment (PPE) and doffing properly, he said.

"The importance of donning and doffing PPE is one of our most important lessons learned," Biddinger explained. "How you take off PPE is one of the most important things a healthcare organization can focus on."

Healthcare workers who doff PPE incorrectly, or in the wrong sequence, can release droplets in the air and breathe them in, he noted.

Hospital patients with lung disease, diabetes, and compromised immune conditions are at greatest risk of critical illness from COVID-19. Healthcare providers should keep in mind that geriatric patients might not have as high of a fever with the disease as do younger adults and children, said **XinQi Dong**, MD, a researcher in epidemiology at Rutgers University in New Brunswick, NJ. Dong spoke at a March 12 video conference.

The most vulnerable patients also might include those with ongoing pulmonary disease, emphysema, asthma, hepatitis, lupus, and those taking medication that suppresses the immune system, Dong added. "Elderly patients are in most need of care," he said.

Despite the United States' efforts to slow COVID-19 and hospitals' more recent efforts to acquire additional PPE, ventilators, and

other necessary supplies, the public health sector is not prepared for multiple outbreaks and surges in hospitalized, critically ill patients, noted **Ali Khan**, MD, PhD, professor in the department of epidemiology at the University of Nebraska Medical Center. Khan also spoke at the March 12 video conference about COVID-19.

"During a really bad flu year, we see emergency room and hospital diversions [of resources] because we can't handle a bad flu year in the United States, let alone this pandemic," Khan says. "How do we take care of patients coming in the door, making sure we do it safely?"

Also, how do hospitals ensure their staff and non-COVID-19 patients remain safe from infection? How do they handle dozens of patients being admitted on one day with the viral infection?

"Now, ERs are screening people outside and quickly triaging them based on where they need to go, so they're less likely to infect other people," Khan says. "There is drive-through testing of healthcare workers."

As cities, states, businesses, and others stopped most in-person commerce and gatherings across the United States through March, hospitals in some areas were experiencing an influx of patients in need of a bed because of viral infection.

Elective surgeries ground to a halt, and hospitals geared up for a change that was expected to require more equipment and PPE. If a hospital experiences an outbreak, RN case managers are ready to take on frontline tasks, Fraser says.

"Most of us are registered nurses, and we were trained so heavily on isolation techniques and wearing masks, gloves, and isolation gowns," she says. "We're first and foremost RNs."

What case managers and RNs might need from management are self-care reminders, Fraser says.

"Case managers need to remember to take care of themselves," Fraser adds. "Watch out, use all the precautionary tactics with isolation techniques, and make sure you are eating healthy and taking lots of vitamin C. Don't forget about yourself, especially if you are working long hours." ■

Focusing on Social Determinants of Health Can Reduce ED Revisit Rates

Rates dropped 50%

By Melinda Young

A health system's ED reduced revisits through a focused program to help patients with their social determinants of health.

"Our emergency room [serves] a huge refugee population," says **Lené Hudson**, MSN, RN, CCM, director of care management at Valleywise Health in Phoenix.

Patients often present with chronic medical and behavioral health needs, along with two or more social determinants of health issues. These put patients at risk for returning to the ED.

At the health system's level 1 trauma care campus, more than 60% of patients have significant behavioral health problems, Hudson says.

The ED's revisit rate is 6%, which the health system decided to improve through case management-type services. The revisit rate was cut in half, Hudson says.

"We looked at throughput, observational data, and avoidable admits," Hudson explains. "We focused on avoidable observations, rather than inpatient admissions."

For instance, patients were placed in observation care when they did not meet the criteria. When this occurs, the real issue might be social determinants of health, she says. "We didn't have good mechanisms for tracking social determinants of health, and we wanted to know how to look at that," she adds.

Also, they reviewed ED visit volume and found it would be beneficial to place a care coordinator in the ED. There already was a social worker, who was available to handle inner-city trauma cases, including burns, stabbings, and gun violence.

As part of the research, Hudson and a nurse reviewed data on frequent ED visitors and found a way to see what was happening in real time.

"We created a little system where every time a person came back to the ED, a little boomerang appeared," Hudson says. "That would be a target for a staff person to say, 'This person came in more often.'"

Then, someone would talk with the patient and perform a high-

level screening. "We asked the basic elements about transportation, money, access to care, and other basic screening questions," Hudson explains.

"We have a large population that will use our ED for primary care," she adds. "But there are other patients that we can help access care and connect them to our clinic. We can do specialty referrals and work with them to get those visits scheduled."

The care coordinator can follow up with those patients to ensure they visited the clinic. "They can break down barriers of why they couldn't get there, or why they're coming back to the ED," Hudson says.

After a pilot period, they found that two major barriers were care access and a cultural component. "We had patients who were refugees, a Hispanic population, and a lot of people who just didn't know how to connect to care," Hudson explains. "We had a transitional care coordinator who would make this follow-up call within the time frame to make sure they got care."

Once patients from the ED were connected with a clinic, they could be helped by ambulatory care coordinators.

This is how the ED care management program works:

• **Obtain stakeholder buy-in.** "You need the right stakeholders to buy in," Hudson says. "You want to build a trusting relationship."

Case managers can do this by following their words with actions. "We worked closely with the medical director in the ED as a physician champion and talked about the benefits of connecting patients to care," she explains. "One physician championed this to all providers, helping us."

When providers asked for something, such as obtaining a specialty referral for a particular patient, the care coordinator helped build a referral process for them.

"We had the physician champion be part of those discussions, asking, 'What do you want to see, and how do you want to see it?'" Hudson says.

• **Know the population.** "Know your population that is vulnerable and comes into the emergency department," she says. "We look for those frequent flyers — anyone with two or more visits into our system and at least one inpatient readmission within 30 days."

The program does not focus on medical diagnoses, but does look at barriers and social determinants of health.

"What we found is if we break down the barriers, the diagnosis is not the problem. The problem is access to care," Hudson explains. "The issues are medication, transportation, access to care, and cultural problems."

• **Create the intervention.** Creating a care plan is the easy part. Obtaining the patient's buy-in is the biggest challenge, Hudson says.

For example, Hudson saw a patient who returned often to the ED because of fatigue, nausea, and vomiting. The person had visited the ED four times, resulting in a boomerang alert.

"I went to interview the patient, introduce myself, and explain my role," Hudson says. "I asked about the person coming into the ER to see what we needed to do to connect them to care and get a medical history."

Using active listening skills, Hudson learned that the patient was diabetic and had no money to pay for insulin. Plus, the patient lost the glucometer and could not refill medications. Transportation to a primary care clinic also was an issue.

"Right there, I have four potential interventions," Hudson says. "I asked about the living situation to see what's been done and what needs to be done."

Sometimes, a patient needs to be connected with behavioral health partners in the community, she adds. "We can get all the interventions completed during the ED visit," Hudson says. "We can get providers to help get that patient's medications filled."

Some health plans provide transportation assistance. For patients without insurance, the case manager could help them find transportation assistance or develop a transportation plan that could include bus passes or taxi rides.

• **Determine criteria.** The main social determinants of health are problems with transportation, food, and poverty, Hudson says.

Other criteria for ED case management assistance include patients

EXECUTIVE SUMMARY

A case management program that focuses on social determinants of health helped a hospital system reduce revisit rates in its ED.

- The ED's re-visit rate dropped from 6% to 3%.
- The hospital placed a care coordinator in the ED to focus on frequent visitors and help patients with medicine and chronic care barriers.
- Focusing on transportation and access to care issues, the care coordinator helps patients schedule appointments with community providers.

who have visited the ED three or four times within the previous six months, and any patient with an unscheduled, 30-day readmission to the hospital within the past six months, she says.

Patients who take five or more medications, or record an admission risk score of five or greater, meet case management criteria.

• **Form partnerships.** "One key nugget is your community partnerships," Hudson says. "You have to know who to call to say, 'I have this patient. Can you take him?'"

It is important the person in this role has a good sense of clinical decision-making, and a good network relationship with community partners and their care coordinators, she says.

"If I am trying to schedule a patient in the primary care provider clinic, and it's totally full for tomorrow, how do I get that patient in?" she says. "You need to know those escalation processes of how to get that patient in."

• **Provide weekend help.** Social workers are in the ED continuously, but the care coordinator role is limited to Monday through Friday, working hours.

"When we're here, we meet with patients," Hudson says. "Say a provider at 8 p.m. wants someone to follow up with a patient. It goes to our work queue."

When Hudson arrives in the morning, she sees referrals from the previous night and can handle them that day.

"They can do telephonic help at night and on weekends," Hudson says. ■

How to Provide Culturally Competent Care

By Jeanie Davis

Are your international patients struggling to adapt to life in a U.S. hospital? Have you experienced difficulty interpreting their needs? Do you believe that their care has suffered due to these difficulties? It is imperative that case managers take extra care to help them adapt.

With the increased diversity among today's hospital patients, case managers must be careful to understand each patient's culture, says **Victoria Showunmi**, RN, MSN, MBA, CCM, who emigrated from Nigeria 17 years ago. She has worked as a case manager at the MD Anderson Cancer Center in Houston for the past five years — a hospital with a large international patient population.

Showunmi has been instrumental in coordinating programs to help fellow case managers become culturally competent, she says. "People coming from different worlds have different expectations of the healthcare system."

Her own experience in making the transition to U.S. culture is a great example. "There are terms that do not exist in my culture, such as 'hospice,'" she says. "It's the same challenge for our patients, and we need to understand that to meet their needs."

Showunmi explains that culturally competent care provides many benefits, including:

• Potential to improve health outcomes;

• Effective use of healthcare resources;

• Increased patient satisfaction;

• Increased efficiency and effectiveness of staff;

• Reduction in medical errors and lawsuits.

She defines "culture" as all integrated patterns of human behavior that include language, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Communication, courtesies, rituals, roles, customs, relationships, practices, expected behaviors, values, thoughts, and manners of interacting all are reflected in culture, she explains.

Cultural competence, Showunmi says, is "having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs in order to deliver the best care."

She advises that in healthcare, certain cultural practices often cause concerns, including:

• Language and communications;

• Religious beliefs;

• Healing practices and preferences;

• Family involvement;

• Pain management;

• End-of-life care.

Case managers are obligated to respect the rights and inherent dignity of their patients, Showunmi says. "They must also act with integrity and fidelity with patients," she explains. While this is not always easy, especially when there are language differences, case managers must accept each patient's differences, she explains.

Showunmi gives this advice for cultural communication:

• **Listen, engage, and educate.** A translator should be a priority, when necessary. Then, start the conversation with simply asking

the patient or family member how people from their culture view things related to healthcare. For example, some cultures believe one must tolerate pain and should not need pain medications. But other cultures have low tolerance for pain and can buy pain medications over the counter. "You can explain that pain medications are not bad, that they can help you do things you need to do," Showunmi explains.

• **Assess and acknowledge a request.** This shows respect. For example, in some cultures, the entire extended family will gather at the hospital to care for a loved one. In the Hispanic population, the entire family is involved in the care of the patient. "It's not uncommon to see 15 to 20 people in the room," Showunmi says. "Grandparents, grandchildren, everyone."

Negotiate a middle ground where everyone is comfortable. She advises case managers to accommodate the big family group. "Make the effort to accommodate them as much as possible when discussing plan of care or goals of care," she says. "But also negotiate the visiting hours and the number of guests that can stay overnight." Also, she advises using a translator so they can understand.

• **Approach each patient with an open mind.** The case manager must be open to the patient's culture, advises Showunmi. It helps to ask about the family's expectations at various milestones in the patient's care. "In the Chinese culture, when the patient is about to pass, they must lay on something [personal mattress or bed] from their home," she explains. "They should be allowed to bring things to the hospital like a comforter or a pillow to accommodate their culture. This shows you acknowledge their culture."

Another example: "In some cultures, the male makes all the decisions. The female will say, 'Whatever my husband says.' You can explain that in this country, you have your own right to make a decision about your medical care. Explain why the test or treatment is necessary, so we can provide you with the best care," she advises.

• **Recognize that direct eye contact can be interpreted in different ways.** "Not making eye contact can be a sign of respect," Showunmi says. "Don't think they are not listening." Ask patients questions to ensure good communication.

Touching another person is restricted in some cultures, she says. "Some religions do not allow a male to touch a woman," she says. "Most people understand that holding someone's hand can be a sign of comfort, if you do it in a way that shows you care about them."

• **"Yes" and "No" can be misinterpreted.** "In some cultures, it is customary to say 'yes' to everything," says Showunmi. "They don't want to sound disrespectful." When asking a question, phrase it so another response is required, she advises. "Don't ask them if they feel pain; ask what level of pain are they tolerating."

• **Respect religious beliefs.** For example, it may go against some religious beliefs to receive a blood transfusion. Or, visitors may be prevented from seeing some patients. Her advice: "Ask each patient, 'What are your preferences?' You don't want to generalize about any religion, but do what you can to respect their wishes."

For instance, Christians may request a priest; Jewish people may want a rabbi for prayers and blessings before a major procedure. For Muslims, make accommodations for daily prayer, five times per day.

Showunmi advises training staff in cultural awareness. Staff members and others can provide presentations about their cultures. "Our diversity in the U.S. will continue to increase, so we must prepare to meet our patients' needs as much as we can."

Case managers may invite people from outside their organizations to provide education on specific cultures, she adds. "There are several local groups in the community who cater for specific populations. They may be a very good resource." ■

Ethics, Case Managers, and the Value Proposition

By Jeanie Davis

The pressures case managers face are a reality in a value-based healthcare system. Cost of care and penalties for readmissions are the bottom line in every institution, and that pressure will affect how well case managers perform in their everyday duties, says **Ellen Fink-Samnick**, MSW, ACSW, LCSW, CCM, CRP, principal at EFS Supervision Strategies.

To uphold their ethical tenets, and advocate in the best interests of their patients, a case manager must be prepared to handle these pressures. They must be leaders in their teams, with a strong sense of self and self-confidence.

Leadership is difficult for many case managers to grapple with, she says, but they must rise to the challenge. "Case managers are front and center in the care coordination process," Fink-Samnick says. "Whether they are in a formal leadership position or not, they have to act as a leader."

Self-confidence is essential in coordinating a team and managing the dynamics, Fink-Samnick says. "That is complicated by a backdrop of workplace bullying and lateral violence," she adds.

Bullying Aimed at Case Managers

Healthcare institutions must recognize the pressures on case managers, she explains. "Too often, case managers are pushed to follow discharge templates, don't ask questions, don't advocate, and move the patient along. The result is the case manager is not set up to practice ethically and legally."

Workplace bullying is defined as a persistent pattern of mistreatment from others in the workplace that causes either physical or emotional harm. Lateral violence is a co-worker exhibiting harmful, hostile, or aggressive behavior toward other co-workers.

"There has been a dramatic uptick in these behaviors, with the highest surge in hospitals," says Fink-Samnick. "For close to the past decade, healthcare professions have seen the highest levels of workplace bullying. Seventy-five percent of workers are impacted by bullying, whether target or witness, while $200 billion annually is spent on lost productivity from bullying alone; for example, increased sick days, medical claims, legal costs, and staff turnover," she explains.

> "FOR CLOSE TO THE PAST DECADE, HEALTHCARE PROFESSIONS HAVE SEEN THE HIGHEST LEVELS OF WORKPLACE BULLYING."

Example 1: A case manager is discussing a patient with a physician, acute care nurse practitioner, physician advisor, or hospitalist. "The case manager asks whether the patient needs to stay at the current level of care," says Fink-Samnick. "They simply want clarification of the treatment plan or code status."

The response they get is often "a biting, devaluing comment from anyone in that discussion — typically the physician, but often another team member," she says.

Example 2: The case manager is working with an elderly couple, Mr. and Mrs. Smith. He is 75 years old and underwent a hip replacement. The plan is to transfer him to a subacute rehabilitation nursing home.

When the physician comes into the room, Mrs. Smith says Mr. Smith is complaining of pain, and mentions she saw drainage from the wound. Mrs. Smith then says, "But you know better, doctor, shouldn't we do something?"

The case manager approaches the doctor outside of the patient's room to inquire about the drainage. The doctor's words to the case manager: "What's the big deal? You know Mrs. Smith is a complainer." Then, the doctor aims a series of comments berating the case manager, who is left feeling defeated.

"At that point, the case manager gives up, issues the discharge order, gets the transfer order signed, and the patient goes to the nursing home," Fink-Samnick explains. "In 48 hours, the patient spikes a fever, blood test shows an infection, and the patient is readmitted."

Disruption Drives Readmission Rates

A 2017 study revealed hospitals that employ surgeons with high numbers of patient complaints experience higher readmission rates.[1] "It's arrogance that costs hospitals the

big bucks in readmission penalties," Fink-Samnick explains. "If a case manager cannot talk to a physician, that's a big problem." There is a ripple effect, she says, as that case manager will be more inclined to leave the workplace due to bullying.

Workplace bullying is especially prevalent in healthcare, Fink-Samnick says. As a result, patient care suffers because communication is fragmented, she adds.

Frustration is at the heart of this bullying and bad behavior, she explains. "All over the country, hospitals are struggling. Hospitals have been acquired by bigger hospitals, and this leaves hospital systems in turmoil. Along with the focus on value-based care and penalties for readmissions, people are under a lot of pressure."

In some situations, one case manager might be handling the job of two people, working a full schedule plus one weekend every month. The hospital cannot justify hiring two case managers. The case manager gets frustrated with being overworked, and it shows.

"That's when a nice team with good communication deteriorates," says Fink-Samnick. "People begin placing blame on each other. That's the definition of lateral violence."

One study revealed the healthcare industry experiences the highest incidence of workplace bullying for any industry sector. "I was shocked when I saw that," says Fink-Samnick.

Typically, a hospital case manager earns $85,000 annually; if that case manager leaves due to bullying, the cost of replacing that person is estimated at more than $120,000 per employee. The cost of employee turnover from workplace bullying is calculated by multiplying the combined salaries of departed workers by 1.5, she explains.

Readmissions are affected when the case manager feels bullied, says Fink-Samnick. "Their attitude and behavior changes," she explains. "Their decisions degenerate, becoming less ethical, less competent, especially if they are not mature professionals. They will be less accountable in their actions. That's when we see poor outcomes related to care coordination, handoffs, and readmissions."

Research over the past decade shows consistently that 70% of all patient handoffs are flawed, says Fink-Samnick. A Joint Commission 2017 alert highlighted ineffective communication during patient handoffs as a major contributing factor to more than 1,700 deaths and $1.7 billion in additional costs for the healthcare system.[2]

"That means all those readmissions are preventable," Fink-Samnick adds. The readmissions are due to incidences like Mr. and Mrs. Smith — and the doctor who brushed away their concerns.

If case managers are not comfortable and confident in their role, and if they are not trained properly, there will be trouble, she says. In that situation, the patient may file a lawsuit against the case manager for unethical behavior, as they did not advocate on the patient's behalf.

Serious Repercussions for Case Managers

When a case manager does not advocate for a patient, it could prompt a hospital readmission, says Fink-Samnick. "The family is furious, and files a grievance against the CCMC or National Board for Case Managers against the case manager's credentials," she explains. "If they find that the case manager did not advocate for the patient appropriately, it goes against the values of the profession, and is potentially sanctionable. You could lose your license; you could lose your credentials."

A complaint is filed with the case management credentialing entity claiming the case manager did not perform due diligence, knew of a conflict of interest, or knew ethical standards were being violated. The stakes are higher when a patient is set up for harm — especially when the case manager did not advocate for the patient to experience a safe discharge or transfer, whether to home or another facility.

Core Ethical Behaviors

All ethical behavior can be distilled into what Fink-Samnick calls the 3 Cs and 2 Ds:

- Competence;
- Confidentiality;
- Conflict of interest;
- Dishonesty;
- Dual relationship.

"Conflict of interest" and "Dual relationship" must be understood clearly, she explains.

Dual relationship is a nurse giving a patient the name of a lawyer he or she used for personal matters, which could affect the impartiality of the professional relationship. Conflict of interest is a set of circumstances that clash between self-interest and professional or public interest, like recommending a home care agency owned by a friend.

At the heart of the issue, says Fink-Samnick, is whether the case manager is adequately informed, credentialed, and trained.

Also key: "Does the case

manager know they are ethically accountable to follow through in reporting abuse and exploitation?" she asks. "They are responsible for advocating on behalf of the patient in any situation with a physician, staff member, facility, or healthcare agency. Advocacy is the primary ethical tenet of a professional case manager."

Workplace bullying can be endemic to the culture of an organization, especially in healthcare, says Fink-Samnick. "However, healthcare organizations are recognizing the impact on patient safety and care quality, as well as the dramatic toll it is taking on the workforce. Organizations can no longer afford the financial and human toll of this disruptor."

On the personal level, Fink-Samnick is a fan of Eleanor Roosevelt, who said: "No one can make you feel inferior without your consent." Fink-Samnick adds: "You don't handle these situations initially through direct confrontation but by discussion."

Fink-Samnick advises those targeted by bullying to follow these steps:

- Perform a self-check to assess how you came across;
- Approach the person who allegedly bullied, to check in. Perhaps he or she experienced a tough day, or are stressed.

She also recommends following these five steps:

- Address the bullying behavior, perhaps with a witness;
- Seek employer resolution (use all available resolution routes; e.g., leadership, human resources);
- Consider filing a complaint with a credentialing body if no other resolution can be reached;
- Seek an independent legal consultation;
- Obtain an independent mental health consultation.

Leadership training can help case managers cope with bullying, says Fink-Samnick, adding that many hospital leaders could benefit from training to change their bullying behaviors. "It's part of a larger conversation, but too often, their negative behavior is their response to pressures they experience." ■

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ICU to Long-Term Acute Care: Seamless Transition, Fewer Readmissions

By Jeanie Davis

When a seriously ill patient has not stabilized in the ICU, the next step may be a long-term acute care hospital (LTACH) like Spaulding Hospital Cambridge (MA) — which often is a difficult transition, says **Caitlin Ryan**, MPH, LICSW, CCM, manager of case management at Spaulding Hospital.

"Very often, these are patients who have a tracheostomy and haven't been able to come off a ventilator, or they may have end-stage cancer, organ transplants, major neurological diagnosis, or traumatic injury," Ryan explains. "These patients tend to have multiple comorbid conditions requiring extensive rehabilitation and medication management."

Patients and their families often are anxious about moving to an unfamiliar facility. "They are worried the staff won't understand their needs as well as the ICU team," she notes. "They miss the one on one with the ICU physician, and that loss can be terrifying for many patients."

Transition Coaching Eases Anxiety

Six years ago, Spaulding joined nearby Brigham and Women's Hospital (BWH) in creating the Integrated Patient Centered Care in Chronic Critical Illness program to provide a seamless transition of care for these patients and their families.

Transition coaching for patients and families is the first step in dispelling anxiety, Ryan adds. Treatment teams from both hospitals, including the patient's pulmonary physicians, meet with the patient and family to discuss expectations and goals of care.

"Communication is an essential component of the program," Ryan says. "Patients wonder, 'How will they know I'm OK? Will they check on me enough? Will I get my labs quickly enough?'"

When the Brigham team stays in contact with the patient, family, and Spaulding team, the anxiety level decreases dramatically, she adds.

A weekly conference call — typically a video call — helps the family feel in close contact with physicians from both hospitals, says Ryan. "This is especially necessary as the treatment progresses so the families can think about whether to continue treatment."

The case manager or social worker often participate in the calls. "This provides a really nice connection between everyone involved," she explains.

The pulmonologists at BWH retain close communication with the Spaulding team, Ryan adds. "We can page them if the patient becomes acutely ill, which helps avoid emergency room visits. These patients are so complicated that if they show up at an ED, they will get admitted. We can avoid all that by consulting with the BWH physician and putting interventions in place."

If admission is unavoidable, the team can set up a direct admission rather than going through the ED, and avoid the waiting room. If there only is need for an MRI or CT scan, the team can arrange the tests through the BWH ED without admission. Then, the patient can return to the Spaulding LTACH.

Also, the two hospital teams arrange consult appointments so they are timely and appropriate, she adds. "We reduce unnecessary appointments and make sure patients are seen for urgent issues in a timely manner."

Case Studies

The following are two program success stories:

• One patient, a young woman, had many medical comorbidities throughout her life. As she aged, she was admitted more frequently for respiratory failure, and ultimately required a tracheostomy. At that point, she was doing well enough to go back home — but later developed problems with the tracheostomy and required readmission to Spaulding.

During the six months the patient was at Spaulding, the weekly meetings were integral in discussing the treatment plan, arranging for the BWH pulmonologist to consult on-site at Spaulding and soliciting input from the Spaulding team members. The decision was to switch to a special type of tracheostomy with a design that solved a leakage problem so the patient could go home.

"The family was incredibly scared, and there were a couple of close calls during admission when we thought she might pass away," says Ryan. "We held weekly conference call meetings with the family and the Brigham team, using video as much as possible for the human element, as it made the family feel more comfortable."

This patient experiences fewer readmissions than in the past, Ryan reports. "The new tracheostomy and the conferencing made the difference."

• A patient chronically on ventilator support and dialysis was admitted to Spaulding to resolve one of the issues. In Massachusetts, no facility has the capability for outpatient or skilled nursing care to manage both those conditions. Therefore, he needed inpatient care long term, Ryan explains.

"The family was not ready to give up on this patient, and wanted the patient to come home," Ryan says. "The team discussed various options, like an outpatient dialysis center and private duty nurse to manage the tracheostomy at home."

But over time, the family realized the patient was not going to improve, and did not have quality of life. "The family had to see all the options, then over time they began to realize the right decision was palliative care," she explains. "The patient passed away peacefully."

"It's very rewarding when we can help patients and families cope a little bit better and access services that are a little less traditional," Ryan adds. "Both hospitals get very nice letters from grateful family members."

Continuity of care is a priority, she adds. "When patients are discharged to a skilled nursing facility or home, the pulmonologist will continue to follow those patients on an outpatient basis to ensure they have the provider they trust the most, which helps avoid unnecessary readmissions." ■

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.

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CE QUESTIONS

1. **Which group is the most vulnerable to COVID-19 illness?**

   a. People with blood disorders
   b. People with emphysema, asthma, hepatitis, lupus, and pulmonary diseases
   c. Children younger than age 12 years
   d. People with opioid addiction

2. **Which did investigators find in a 2019 study of more than 6 million Medicare admissions and 30-day hospital readmissions from 2009 to 2014?**

   a. Hospital 30-day readmissions increased at the same time hospital admissions decreased.
   b. Hospital readmissions fell, and evidence showed its decline was entirely due to the Hospital Readmissions Reduction Program.
   c. Hospital readmission increased at the same rate that hospital admissions increased.
   d. The 30-day readmissions rate fell at a rate that was similar to a declining hospital admission rate.

3. **What is cultural competence, according to Victoria Showunmi, RN, MSN, MBA, CCM?**

   a. Learning about other cultures by taking an organizationwide diversity training course.
   b. The capacity to function effectively within the context of the cultural beliefs, behaviors, and needs to deliver the best care.
   c. Showing empathy and carefully listening to patients to accommodate their requests.
   d. Allowing patients to observe religious traditions while in the hospital.

4. **What are the 3 Cs of core ethical behavior described by Ellen Fink-Samnick, MSW, ACSW, LCSW, CCM, CRP?**

   a. Competence, care plans, confidentiality
   b. Confidentiality, core beliefs, conflicts of interest
   c. Competence, confidentiality, conflicts of interest
   d. Complaints, competence, coaching