HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Case Managers Face Risk of PTSD During Pandemic

PTSD can affect non-frontline staff

By Melinda Young

Mental health professionals are warning hospitals that staff could face emotional challenges as the COVID-19 pandemic increases their susceptibility to anxiety, depression, moral distress, and helplessness.

"Hospital staff are starting to experience the cumulative grief of this pandemic. The uncertainty of its conclusion is only making things worse," says **Gaila Palo**, MN, ARNP-CNS, AGCNS, CWON-AP, travel wound nurse at Kindred Hospital in Seattle. "The need for emotional support is starting to show itself as strongly as for physical needs."

> "HOSPITAL STAFF ARE STARTING TO EXPERIENCE THE CUMULATIVE GRIEF OF THIS PANDEMIC. THE UNCERTAINTY OF ITS CONCLUSION IS ONLY MAKING THINGS WORSE."

While hospitals and cities are in crisis mode, hospital nurses, physicians, case managers, and others stay focused on their daily work. But as the crisis period ends and the post-crisis period begins, they face the possibility of post-traumatic stress disorder (PTSD) symptoms.

"PTSD is a real thing. We used to think of it as just affecting soldiers coming home from battle, but we now think about nurses and case managers, who see the very same thing: gunshot wounds, people dying every day, and it has a lasting impact on the staff," says **Garrett P. Salmon**, DNP, RN, APN, CRNA, assistant professor

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AUTHOR: Melinda Young
AUTHOR: Jeanie Davis
EDITOR: Jill Drachenberg
EDITOR: Jonathan Springston
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS DIRECTOR: Amy M. Johnson, MSN, RN, CPN

EDITORIAL QUESTIONS
For questions or comments, call Jill Drachenberg at (404) 262-5508.

at Middle Tennessee State University School of Nursing.

Salmon's research outlined PTSD's complex, debilitating effect on nurses, leaving them anxious, depressed, burned out, and with compassion fatigue.[1]

Before COVID-19, PTSD symptoms were on the rise in healthcare workers because of the growing intensity of hospital care. Hospitalized patients are sicker, and there is increasing comorbidity, Salmon notes.

"If we don't take care of our workers, we can't take care of patients," he adds. "We can't just say, 'Suck it up and get over it.'"

Offer Staff Social, Emotional Support

Case management and other leaders need to support their staff and invest time and energy into preventing PTSD. For instance, they can create a social network, where employees can talk with one another outside of work, Salmon says. *(See tactics for preventing PTSD in this issue.)*

"We have to realize that even before the pandemic hit, burnout among physicians, nurses, and pharmacists was averaging about 50%," says **Bernadette Melnyk**, PhD, APRN-CNP, vice president for health promotion, chief wellness officer, and dean of the College of Nursing at The Ohio State University. Melnyk has researched clinician mental health, including a recent paper on the mental health of healthcare workers during the global pandemic.[2]

Research shows that about one in four nurses reported depression before the pandemic, Melnyk says. "My prediction is we're going to have a tsunami of mental health problems in our healthcare providers during the rest of the pandemic, and in the months following."

Without intervention, these issues could culminate in PTSD, moral distress, and suicide, she adds.

Hospitals have focused on the emotional health of their frontline staff during the pandemic, but others — including case managers — also can be affected, says **Maureen Brogan**, LPC, ACS, DRCC, statewide program manager of Traumatic Loss Coalitions for Youth at Rutgers University Behavioral Health Care.

For instance, some case managers were trained during the crisis to become frontline staff in the event of a surge of COVID-19 patients. Even if they never were called to work in the critical care units or provide direct care to infected patients, they might experience symptoms of PTSD because the uncertainty and job

EXECUTIVE SUMMARY

Healthcare workers, including case managers, face the risk of post-traumatic stress disorder (PTSD) during the COVID-19 pandemic.

- Hospital staff experience cumulative grief and a great deal of uncertainty as the pandemic continues with no set end in sight.
- Even before the pandemic, about half of nurses experienced burnout.
- Case managers are vulnerable to PTSD as they have seen their jobs changed to help frontline nurses.

changes can lead to increased anxiety and depression, she says.

"We may see more symptoms where people do not meet the entire diagnostic criteria for post-traumatic stress disorder," Brogan says. "We may see more symptoms when people are pulled out of their area of expertise and into an area where they do not feel 100% competent. They may be willing to help or want to help, but there's self-doubt."

When people feel uncertain and are not confident in their work, they are prone to more anxiety and mental health issues, she adds.

Case Managers Exposed to Trauma

Case managers who remained in their roles also can experience PTSD from working in hospitals where so many patients are sick and dying from the novel disease. It is a secondary exposure to trauma.

"Case managers are still exposed to it," Brogan says. "They're still hearing the stories, and they have colleagues who have been exposed."

It is similar to when a town is ravaged by a tornado and some houses are left standing among the houses that are destroyed. The people who still have their homes can be traumatized by the devastation that did not touch them personally, but is all around them.

"Even if you're in case management, you're hearing the details of the losses," Brogan explains. "It's quite normal to feel a little anxious, depressed, and to have some insomnia at this time because we're dealing with so much uncertainty."

There are aspects of the pandemic that make the situation more difficult to handle than the more common disasters of fires, tornados, hurricanes, and earthquakes that can strike hospitals and cause similar levels of upheaval and emotional distress.

One important difference is the uncertainty about how this crisis will unfold. With other disasters, there is a predictable pattern and course of action. The disaster occurs, and everyone goes through a period of grief and anxiety as they work to help their patients under trying circumstances. But they know this difficult time will end in weeks or months, and they will eventually regain a sense of normalcy. No one knows when the pandemic will end because there are no exact parallels to other natural disasters. This uncertainty contributes to emotional distress and PTSD symptoms, Brogan explains.

"In the world of trauma, we assess the length of exposure and the intensity of exposure," she says. "In this pandemic, we have had heightened length and intensity."

A second difference involves typical human coping mechanisms. During other crises, hospital workers will pull together and support each other with hugs, sharing meals, and helping those who have lost their homes.

"When we work with people exposed to trauma, we tell them to support themselves and each other," Brogan says. "The pandemic is interfering with that."

Social connectedness is vital, but everyone in the hospital must maintain physical distancing. Some staff members will go into isolation because of their exposure to the disease, she adds.

"This pandemic is putting a wrench into the coping mechanisms we have developed," Brogan says. ■

REFERENCES

1. Salmon G, Morehead A. Posttraumatic stress syndrome and implications for practice in critical care nurses. *Crit Care Nurs Clin North Am* 2019;31:517-526.
2. Jun J, Tucker S, Melnyk BM. Clinician mental health and well-being during global healthcare crises: Evidence learned from prior epidemics for COVID-19 pandemic. *Worldviews Evid Based Nurs* 2020. doi: 10.1111/wvn.12439.

With PTSD, Prevention Is a Cure

Leaders can screen employees for symptoms

By Melinda Young

Natural disasters, pandemics, and other crises can lead to more hospital staff experiencing post-traumatic stress disorder (PTSD) symptoms. Case management directors and other leaders need to screen employees for signs of PTSD and create a prevention plan.

"I think it's critical that hospitals implement screening programs to assess levels of anxiety, depression, and PTSD so they can identify providers who are experiencing issues and get them support and help," says **Bernadette Melnyk**, PhD, APRN-CNP, vice president for health promotion, chief wellness officer, and dean of the College of Nursing at The Ohio State University.

"We know when providers are depressed or burned out, more medical errors are made. That's a major issue because medical errors are the third-leading cause of death in this country," Melnyk says. "We should shift our paradigm from crisis intervention to prevention."

Hospital leaders need to help their staff grieve, says **Alexander Wolf**, DNP, RN, APRN, nurse practitioner at TriHealth in Cincinnati.

Understand Ethical Dilemmas

In hospitals where personal protective equipment (PPE) is scarce or where providers must decide how to use limited resources, such as experimental treatments and ventilators, nurses and other staff might experience ethical concerns and regret. These issues have been on everyone's minds during the COVID-19 pandemic.

"We have to help them understand the nuanced ethical issues that play into this pandemic," Wolf says. "There are whole different ethical concepts that go into those decisions, and it requires a conversation."

Hospital employees will give everything they have to helping their patients, leaving little time or emotional energy for themselves. One example Wolf witnessed involved an intensive care unit (ICU) physician who had spent 30 hours in the ICU. "He was dog-tired, but he went out of his way to do a daily meeting with us, over the phone," Wolf says. "We took time to remind him of what he's doing and to make sure, in the course of being tired and completely overwhelmed, that he needs to remember that he is fulfilling his mission and is making an impact."

Highlight All the Short-Term Wins

One way to help staff during a difficult period is to acknowledge short-term wins.

"Short-term wins are not necessarily predictable and they may look different from day to day," says **Michelle Sanchez**, MSN, RN, Beacon Program manager with the American Association of Critical-Care Nurses (AACN). "A win might be completing a shift without any additional admissions, discharging a patient with COVID-19 to a lower level of care, or implementing an innovative change to typical care processes in the face of challenges presented by COVID-19. It's important for leaders to celebrate these wins, whether through recognition at the shift huddle, a note of appreciation or encouragement, or a simple cup of coffee."

Leaders can teach themselves and their staff how to develop a positive outlook, which is an important shield against depression and PTSD.

"A positive outlook can apply to any circumstance. No matter how bad something gets, there's always something good that comes out from it," says **Garrett P. Salmon**, DNP, RN, APN, CRNA, assistant professor at Middle Tennessee State University School of Nursing.

Case managers and other healthcare staff should ask themselves what they did well that day, as well as what they could have done better, Salmon says.

"Look at what you did wrong and how you can get better, and look for positives that come out of that situation," he adds.

Another tactic is to teach staff to focus on what they can control in their lives and let go of the things they cannot control, such as the amount of PPE or understaffed shifts. "Control your own behavior and how you react," Salmon says.

Organizations should have wellness support in place, Melnyk says.

"Our work has shown that if clinicians believe they are getting wellness support, their outcomes are better," she says. ■

Nurses Offer Advice for Case Managers to Help Frontline COVID-19 Staff

By Melinda Young

Case managers, social workers, and nurses from other areas of the hospital have been the back-up support to critical care nurses during the COVID-19 crisis.

Many underwent training to assist frontline staff during COVID-19 critical care peaks. They provided help with restocking personal protective equipment (PPE), and offered emotional and mental health support.

"Nurses without critical care experience can support critical care nurses with a variety of tasks," says **Michelle Sanchez**, MSN, RN, Beacon Program manager with the American Association of Critical-Care Nurses.

Support nurses assisted critical care nurses with doffing, refilling coffee and water bottles, and cleaning equipment and high-touch areas, says **Gaila Palo**, MN, ARNP-CNS, AGCNS, CWON-AP, travel wound nurse at Kindred Hospital in Seattle. In addition to their new tasks, nurses provide emotional support to the professionals on the frontlines, she adds.

"They give smiles and words of encouragement to nurses, as soon as they come out of a room, checking in with staff and being available to lend an ear," Palo says. "As one colleague from labor and delivery said, 'I'm a nurse for the nurses. I know how to do that.'"

There are many creative ways case managers and other hospital staff can provide support to one another, including these examples:

• **Care closet.** "One unit designated an old supply room as the care closet, where nurses can go to escape for a few minutes if they need an emotional break," Palo says. "The helping nurses keep this room stocked with chocolate, tissues, and notes of appreciation and empathy on the walls."

> SUPPORT NURSES ASSISTED CRITICAL CARE NURSES WITH DOFFING, REFILLING COFFEE AND WATER BOTTLES, AND CLEANING EQUIPMENT AND HIGH-TOUCH AREAS.

Anyone using the care closet can write an anonymous note about their feelings on a sticky note and post it to the wall. Other staff draw a heart or star on the note to show they feel it, too.

"It's sort of like giving a love symbol to a post on social media," Palo says. "Many of the activities for emotional support have been spearheaded by the spiritual care/chaplain departments."

Another unit held a Secret Santa-style exchange in which staff left one another notes, treats, and little surprises for two weeks, Palo says.

• **Healthy competition.** Nurses in an eight-story facility held a stair-climbing competition for the COVID-19 unit, Palo says.

"The nurses were bemoaning their gyms being closed, so they decided to time each other running up the stairs and back during their breaks," Palo explains. "They even had a little trophy for the Stairmaster of the Week."

This is an example of team-building and a healthy activity in which hospital staff can have fun and camaraderie, she adds.

• **Sitcom parties.** "There's a general theme of staff avoiding many sources of negativity because of the emotional burden of life right now," Palo says. "They are reaching out for light in a dark space, and being more contentious about not letting more darkness in. One unit has some of its nurses holding watch parties for sitcoms."

Some hospital professionals stopped telling people to "Stay safe," and instead say "Be well" in emails.

"It has the broader connotation of wishing someone health and wellness in all areas — not just around COVID," Palo says. "It's a subtle difference, but I believe in the power of language. We have to use every tool we can to support each other during this time."

• **Community support.** Hospitals have experienced public support and appreciation. In one hospital, a cellist played a concert in the parking garage as staff were coming out from their night shift, Palo recalls.

"The community bangs pots and pans, and yells and claps all over Seattle every night at 8 p.m. to thank the healthcare workers," she says. "People with apartments facing a hospital put up banners

of support and thank-you signs in their windows for staff to see during patient care."

All these things help, but they are not enough to prevent emotional distress among hospital staff during the pandemic, Palo notes.

"Nothing can make this OK or safe or peaceful, but it does make it tolerable for another day," she says. "It makes it survivable in the hard moments, and it reminds us that it is worth the cost, that our sacrifices — though never fully understood — are appreciated."

Managers can send staff weekly tips on mindfulness and other ways to protect their emotional and physical health, says **Maureen Brogan**, LPC, ACS, DRCC, statewide program manager of Traumatic Loss Coalitions for Youth at Rutgers University Behavioral Health Care.

Virtual support meetings also can help, Brogan says.

"There are always good things going on, and sometimes people are not sharing the good things because we're inundated with so many negative things," she says. "We can't fix everything, but we can validate and support each other." ■

Researchers Offer Guidelines for Providing Psychological Support

Pandemic can lead to moral injury, more

By Melinda Young

Healthcare workers need psychological support during and after the pandemic as they cope with moral injury, acute stress reactions, burnout, depression, anxiety, and post-traumatic stress disorder (PTSD). A group of researchers published pragmatic recommendations for organizations about how to support their workers during the COVID-19 crisis.[1]

Hospital Case Management asked the investigators about moral injury and their recommendations in this question-and-answer story. The researchers, who sent their answers via email as a group, are as follows:

• **Michael D. Christian**, MD, MSc, FRCPC, research and clinical effectiveness lead, London's Air Ambulance, Bart's Health Trust, London

• **Esther Murray**, CPsychol, AFBPsS, SFHEA, senior lecturer in health psychology, Centre for Medical Education, Barts and the London School of Medicine and Dentistry, Queen Mary University of London

• **Matthew Walton**, MA, MB, BChir, DiMM, foundation year 2 doctor of accident and emergency and intensive care unit, National Health Service, London.

Hospital Case Management: What is moral injury in the context of healthcare workers and the pandemic? Why are healthcare workers more likely to experience moral injury during the COVID-19 pandemic than during other crises?

Christian, Murray, Walton: Moral injury is present when there is a betrayal of what is right, either by the self or by someone in legitimate authority, in a high-stakes situation. While the coronavirus we are currently dealing with is a sort of natural disaster, the reactions of those in legitimate authority have, in many cases, involved a betrayal of what's right. At an individual level, clinical decisions will have to be made — and will continue to be made — that contravene the morals of those making them. These decisions are supported by protocol, but they differ from usual practice and guidelines pre-COVID-19. In many countries, governments have been slow to act, and there have not been coordinated plans to encourage as many citizens as possible to shelter in place. Equipment has been lacking, and testing inadequate. Healthcare workers across the world have been watching this pandemic unfold and calling out for something to be done to protect populations. They have not been listened to, which is a form of betrayal.

We do not know that staff would be more likely to suffer moral injury in the COVID-19 pandemic than any other crisis, but what we will see now is far more people experiencing it, as so many more are exposed. What the pandemic has done is to deliver a threat on a huge scale. Because of the time scale and the fact that we have been able to watch it spread, it is much clearer that there has been a betrayal of what's right, in a high-stakes situation, by people in legitimate authority.

Hospital Case Management: Your paper notes that PTSD might

affect frontline staff at a higher rate than usual during the pandemic. Why is PTSD a particular danger for people dealing with COVID-19 patients? When is it most important that leaders screen and assist staff at risk of or experiencing PTSD?

Christian, Murray, Walton: PTSD can be caused by being involved in a traumatic event, witnessing it, or hearing about it from someone who was there. There is a dose-response effect. If you take all this in combination, you can see how there will be an increased risk with so many adverse events, both at work and in the personal sphere, repeatedly and over time.

Leaders should be aware of the mental well-being of all members of their team, whether directly or indirectly. If not by screening for a specific illness, staff can be made aware of prolonged and extreme stress reactions in themselves and their colleagues, and they could be encouraged to complete self-tests and take up offers of support if there are any concerns.

Most people will ultimately be OK, even though many people will suffer acute stress responses — some of which can be quite profound. The most likely outcome is that these [responses] will resolve by themselves over time, especially where staff have access to good peer support, wider social support, and effective, containing leadership.

What leaders can remember here is that while they can't address the primary stressor — that is, the pandemic itself — they are in a good position to address the secondary stressors that compound staff distress in a crisis. Secondary stressors include those stressors that arise as a result of the crisis itself. In the current situation, leaders can help ensure [schedules] allow for sufficient rest and that housing and occupational health issues can be swiftly and efficiently resolved.

In terms of when leaders should intervene, there should be plans in place to safeguard staff well-being at all times. It also should be noted that social support is one of the most powerful tools we can use to prevent traumatic experiences from making people ill. Strong relationships within teams; provision of appropriate services; and clear, concise, and transparent communication all improve the individual's sense of safety and value at work, which in turn helps them to recover from traumatic experiences.

> "LEADERS SHOULD BE AWARE OF THE MENTAL WELL-BEING OF ALL MEMBERS OF THEIR TEAM, WHETHER DIRECTLY OR INDIRECTLY."

Hospital Case Management: In your paper, you suggest drop-in sessions with psychologists/psychiatrists and providing support to staff in isolation. How might hospitals best provide these interventions during and after the crisis?

Christian, Murray, Walton: There is no one-size-fits-all model of psychological support, in a crisis or in more peaceful times. There have been some lovely examples of spaces created where peers can meet, offload, and decompress, such as Project Wingman, recently run by British Airways. *(Details are available at: https://bit.ly/2TvjwqE.)* Other organizations have set up more formal systems, such as confidential phone support staffed by inpatient psychiatric nurses, or even weekly psychology sessions. *(Find out more at: https://bit.ly/2zYacoo.)* Informal support networks also should be encouraged; for example, mutual phone support networks for those in quarantine.

It is extremely important that the culture of the workplace supports staff in accessing psychological support. That means senior staff need to be modeling the use of psychological support services and bringing others with them. They need to discuss the importance of psychological support for everyone who needs or wants it, and share their own strategies for maintaining their well-being.

The organization can reduce barriers to attendance, too. For example, they can create paid and protected time slots in staff work schedules. Improved utilization may actually improve cost-effectiveness of such services.

It will be useful to inform staff of the usual reactions to traumatic events, what they might expect, and how they might deal with it. It also is important to make clear to staff that systems in place now will continue when the immediate crisis has passed. In this way, institutions can ensure support not only to see staff through what might be a prolonged recovery/processing period, but also that these systems form part of the culture of the hospital or primary care facility. ■

REFERENCE

1. Walton M, Murray E, Christian MD. Mental health care for medical staff and affiliated healthcare workers during the COVID-19 pandemic. *Eur Heart J Acute Cardiovasc Care* 2020;2048872620922795.

Helping COVID-19 Patients Through Recovery and Rehabilitation

By Jeanie Davis

For hospitalized COVID-19 patients, surviving the infection is the first major hurdle — but it may not be the last. Their recovery may involve rehabilitation, depending on complications from ventilator-related immobility or damage from blood clots.

Rehabilitation facilities have updated their processes to accommodate these patients' special needs, says **Dina Walker**, RN, MSN, ACM, RN-BC, National Director of Case Management for Encompass Health in Birmingham, AL.

"Patients may require inpatient rehabilitation as time spent immobile on ventilators or during a long acute care hospital stay leads to profound muscle weakness and deconditioning," Walker explains. "If patients develop blood clots as a result of COVID-19, they may suffer a stroke or heart attack, potentially requiring physical, occupational, and even speech therapy."

At Encompass Health's inpatient rehab facilities, the electronic medical record was adapted to include COVID-19-related diagnoses, symptoms, and test results, including pending results. "We also updated our communication of COVID-related results and information to the post-discharge provider," Walker says.

Weekly interdisciplinary conferences were relocated to accommodate social distancing. With limited visitation, larger spaces like the cafeteria and lobbies are available for these meetings. Staff members can also call in via WebEx, if necessary. A COVID-19 task force was created at Encompass Health's main office to provide education and assistance to their 135 hospitals. They also published a frequently asked questions sheet and a regularly updated COVID-19 plan. Centers for Disease Control and Prevention (CDC) recommendations are followed closely.

Hospitals have had to adjust their therapy staffing, including staggering schedules, to accommodate smaller therapy groups among inpatients, maintaining social distancing and masking.

Leadership increased the frequency of cleaning in the facilities to ensure surfaces that patients and providers touch, including therapy gyms and equipment, are in compliance with CDC recommendations.

COVID-19 Discharge Planning Checklist

Walker advises Encompass Health's case managers to refer to CDC guidance when preparing these patients for discharge home or for transfer to an assisted living or skilled nursing facility, available at: https://bit.ly/2WUzFrS.

Other points to consider in discharge planning:

• Address the patient's quarantine isolation level and personal protective equipment (PPE) needs. Some patients go home and are not required to isolate; others are asymptomatic. Most patients require a mask, and the caregiver requires mask and gloves for some time.

• Provide patients with discharge prescriptions for a 14-day supply or greater to allow for delay in primary care appointments or quarantine/isolation time.

• Ensure the patient's physician is available for follow-up appointment. "The biggest barrier we're seeing is setting up follow-up visits with physicians in a timely manner," Walker says. "Some have cut office hours or closed offices, cut back service lines, haven't developed telehealth, or staff hasn't come in, or they don't have safe practices like distancing."

She advises case managers to call physicians well in advance of discharge. "If the clinic is taking patients, are they using telehealth? If so, what platform are they using? Make sure the patient has the correct technology and the skills for a telehealth visit."

This requires case managers to learn more about remote communications for patient engagement. "They will need to help patients and caregivers with the technology," says Walker.

Also, assess PPE-related discharge needs for patient, caregiver, and family members:

• Can the patient procure his or her own PPE?

• Will the hospital provide PPE? What type, and how much?

• How long will the patient and caregiver need to use PPE at home?

Identifying a facility to accept these patients has become increasingly difficult, Walker says. "Skilled nursing facilities [SNFs] and assisted living facilities [ALFs] are refusing to accept patients, even if the patient hasn't been infected," she says. "If

they have been infected, it's even more difficult."

To simplify the transfer process, the Centers for Medicare & Medicaid Services waived patient choice of transfer facility as well as quality metrics of facilities.

However, the result has not been optimal for patients. "Sometimes, patients will only get accepted by one facility, even if it's not their choice or preference," Walker explains. "In some cases, we're having to hold onto patients in the hospital, which increases their length of stay."

In handling these difficult situations, case managers must educate patients and families about the options. "Inform them of each facility's policies regarding accepting COVID-related patients," she says. "Then, be prepared to translate that information to the patient and their caregiver."

Walker's team also has worked with SNFs and ALFs to dispel myths about COVID-19 infection. "We're finding that some facilities require a patient to receive COVID-19 testing before they consider accepting the patient, and will only accept a negative test result," Walker explains. "However, the COVID tests are so sensitive they're detecting the viral RNA, which doesn't necessarily mean the patient is infectious. We try to educate them as much as possible, but if that is their policy, there's nothing else we can do."

If the patient is discharged home, ask the physician to determine level of isolation, length of isolation/quarantine, and any PPE needs.

Identifying a home care agency has become difficult, Walker says. "Some home health agencies are experiencing staff shortages and may be limited in the services they are providing. We're also seeing more families refusing to allow home health caregivers come into the home because they perceive risk of infection. If the patient has just gotten over COVID or hasn't even contracted it, they don't want someone bringing it in to their home."

Case managers must learn what home health agencies are doing to prevent infection, she advises. Also, learn about a durable medical equipment provider's protocols and communicate that to patients and families to alleviate those fears.

The hospital team should work closely to keep family members engaged remotely. Walker advises case managers to use whatever device or platform that works best for the family or caregiver, including WebEx, FaceTime, or Skype.

"We are providing our hospital care teams with iPads for that purpose, as FaceTime on a cellphone screen was just too small to be effective for remote education or training," she says. "We provide teletraining for family caregivers using the iPads. We train them how to don and doff protective equipment. We provide them with gloves and masks to last during their remaining quarantine time."

Home evaluations are necessary to determine if home modifications are needed to accommodate a patient's functional limitations. These can be done by working with the family to take photos, measurements, and provide video e-tours of the home, says Walker.

"It's certainly made us increase our technological knowledge and think outside the box to meet the needs of this special patient population," says Walker.

Remember Non-COVID-19 Patients

As admissions to acute care facilities are slowly declining, this means that more post-acute services are being accessed, says **Toni Cesta**, PhD, RN, FAAN, owner and consultant with Case Management Concepts. "This is good news. Patients are moving out of hospitals, and fewer are being admitted. After a period, the same pattern should transition to the post-acute world, and the need for these levels also will begin to drop."

Creative solutions are paramount, Cesta says. For example, some hospital systems are creating special temporary facilities to house the overflow of post-acute care patients. The most important thing to remember is that, as discharge planners, case managers must transfer patients to the least restrictive level of care possible. For example, patients who can manage at home should not be sent to a sub-acute unit.

"Things are improving overall, but we must remain diligent," Cesta explains. "Do not forget the non-COVID-19 patients as you progress your patients through the acute care continuum. Keep lengths of stay as short as possible and move patients as quickly as possible." ■

COMING IN FUTURE MONTHS

- Plan of care rounds can improve patient communication
- Case managers can benefit from video visits
- Case managers wear many hats during pandemic
- Post-pandemic stress should be addressed

Keep Emergency Patients Calm in the Face of COVID-19

By Jeanie Davis

A dramatic dip in emergency department (ED) volume has been a concern for hospital providers across the country. People experiencing stroke, heart attack, and other serious symptoms have been avoiding hospitals, fearing coronavirus, according to reports.

How can a nurse case manager calm fears in new patients? In Nashville, one nurse practitioner has been on the front lines with this situation.

As the region's only Level 1 trauma center, it is critical to reassure people, says **Jessica Van Meter**, DNP, MSN, RN, APN-BC, CCRN, A-EMT, an emergency and Life Flight nurse with Vanderbilt University Medical Center.

"We've always had sympathy for patients coming into a hospital filled with sick people, especially at peak times like flu season," Van Meter says. "This unprecedented pandemic has really given us greater perspective on how patients may feel and the fear embedded in them about coming to the emergency department."

In the regional media, Vanderbilt took proactive steps to educate the public via multiple news stories. "We wanted to reassure people in our area that we remain open and are here to meet critical needs despite the COVID-19 crisis," says Van Meter.

A hotline staffed by nurses helped with patient triage so patients would know if an emergency visit was necessary or if their symptoms could be managed at home. Telehealth calls also are available to connect providers with patients to add reassurance that emergency staff are ready to care for them.

Vanderbilt has long provided limited telehealth services, especially in assessing stroke symptoms. The pandemic vastly increased the range of services telehealth can provide, as the Centers for Medicare & Medicaid Services lifted many restrictions on these services.

"If you're at home and have health concerns, you can chat with a nurse practitioner or physician via FaceTime or Zoom, walk through the symptoms, and determine whether you should be seen in urgent care, a primary care clinic, or the ED," Van Meter says. "We hope this trend is sustainable. This could really change healthcare in a positive way going forward."

The ED is triaging patients in two locations: one for respiratory and/or COVID-19 symptoms, another location for non-COVID-19 patients, including cardiac, stroke, and trauma patients. All healthcare providers are screened for symptoms every day to ensure a healthy workforce. Limited visitation also has kept patient care areas safe.

"Communicating all these measures to patients has helped relieve anxiety," says Van Meter.

Despite these precautions, patients still express COVID-19 fears. In some instances, delays in treatment of stroke symptoms has led to "really devastating" results, she says. "There have been a few sad situations where the family waited outside the window for tPA or necessary interventions. It's been difficult wondering if circumstances would have been different if they would have come in right away."

Some patients think symptoms may resolve if they wait it out. For example, diverticulitis is a common problem seen in the ED. "We educate patients that it can be managed at home with antibiotics and a telehealth call with their

primary care provider," says Van Meter. "They can even have the local pharmacy deliver medication to avoid coming into the pharmacy. There really is no need for an emergency visit."

Many media reports focused on protecting vulnerable populations, especially the elderly and children, by keeping them at home instead of the ED. However, Van Meter says Vanderbilt's media messages have focused on explaining the vulnerability and the need for treatment in a timely manner, "or face the risk of worse outcomes."

Vanderbilt's media message also applies to abuse, she explains, as both adults and children are at greater risk for abuse during this time due to stress and social isolation. Children are at high risk as they are isolated from people who can help them, like neighbors and teachers.

Crisis lines can provide guidance and resources. Emergency services and police always are options for those in threatening situations at home, Van Meter adds.

In calming a patient's anxieties, the most critical factor is separation from family caused by limited visitation. "We ensure that patients have their cellphone and charger so they can stay in touch," Van Meter says. "Even though we previously discouraged patients from using cellphones in certain hospital areas, we've relaxed that rule. It's much more important that they have contact with their families."

Families and patients receive iPads so they can FaceTime with family members, she adds. "The whole situation is stressful, and anyone coming to the ED will have to be alone without family during admission — which adds an extra layer of anxiety," Van Meter says. "The ED nurses have really tried to step up and be reassuring to meet the patient's needs, including emotional needs, as best we can, and facilitated communication with loved ones."

Her Life Flight team also has taken steps to ensure more communication with families about medical transport patients. "We always have called to inform them we've arrived safely," she says. "Now, those calls last a little longer because visitation is limited."

One positive aspect of the situation, she says, is the decline in automobile-related trauma cases. "Because of the stay-at-home orders and the focus on working from home, we've had far fewer commuters — resulting in 65% decrease in trauma cases from a year ago. We attribute it to the drop in road-related accidents," she explains.

There also has been a drop in primary care issues treated in the ED, she reports. "This gives us a bit more time to talk with patients and decrease their anxiety in a much more therapeutic way than is usually possible." ■

Group Issues Guidance on PPE Pressure Injuries

The bruised faces of healthcare workers have become a badge of courage, the price they are willing to pay for wearing respirators, masks, and other personal protective equipment (PPE) over long work shifts caring for COVID-19 patients.

The National Pressure Injury Advisory Panel (NPIAP), an independent, not-for-profit professional organization, has issued some general guidance to help healthcare workers — with the caveat that PPE effectiveness must not be compromised.

"The same mechanical forces (i.e., pressure and shear) that cause pressure injuries in our patients are now causing pressure injuries in fellow healthcare providers wearing PPE masks, face shields, and goggles for long periods of time," the NPIAP stated. "N95 respirator masks have a particularly high risk for injury due to requirements for a tight fit. Skin injury can also occur as a result of friction and the accumulation of moisture under the mask." *(The guidance can be found at: https://bit.ly/34UKe0m.)*

Using a liquid skin protectant may help prevent friction injuries without interfering with the fit of the N95 mask. "The NPIAP does not recommend the use of petroleum jelly, mineral oil, or any other compound that could enhance slippage and affect the function of the mask," the guidance stated.

Another helpful measure is periodically relieving the pressure of the mask, washing hands before and after.

"Reduce pressure by removing the mask from your face for 15 minutes every two hours outside of areas of patient contact," the NPIAP recommended. "If this time frame is not practical, attempt to lift the mask by the sides for five minutes every two hours. Any pressure relief will be helpful. Wash hands before and after touching mask."

Skin abrasions can be treated with topical moisturizers, and "thin occlusive dressings may be used to protect open wounds if they do not interfere with the mask seal," the panel concluded. ■

HOSPITAL
CASE MANAGEMENT

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CE QUESTIONS

1. **How has the COVID-19 pandemic increased risk of post-traumatic stress disorder (PTSD) in ways that the more common natural disasters have not?**

   a. The pandemic is more indiscriminate in who is affected.
   b. Healthcare workers experience more mental health challenges if they are infected.
   c. There is more uncertainty because no one knows when the pandemic will end, and social distancing prevents people from receiving physical social support.
   d. Healthcare workers are not receiving the usual types of emotional support they receive during hurricanes, tornadoes, and other natural disasters.

2. **According to Bernadette Melnyk, PhD, APRN-CNP, hospitals should implement new screening programs to assess their staff's levels of:**

   a. anxiety, depression, and PTSD.
   b. anger and obsessive-compulsive behavior.
   c. physical complaints, including gastrointestinal disorders.
   d. homelessness, food security, and transportation challenges.

3. **According to Dina Walker, RN, MSN, ACM, RN-BC, what should case managers consider when discharging or transferring patients?**

   a. The amount of food in the patient's home
   b. Obstacles in the patient's home
   c. The patient's isolation and personal protective equipment needs
   d. Access to videoconferencing software

4. **What is one way in which staff at Vanderbilt Medical Center calm the fears of emergency department patients?**

   a. Providing patients with plenty of water
   b. Relaxing cellphone rules to allow isolated patients to contact family
   c. Providing patients with warm blankets
   d. More frequent checks from nurses

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

The Case Manager's Toolbox: The Essential Skills of an Effective Case Manager, Part 3

By Toni Cesta, PhD, RN, FAAN

Introduction

This month, we continue our discussion of the skills case managers need to perform at the highest level of quality. This issue includes information about additional communication issues and techniques that you can use to enhance your conversations with patients, families, and all members of the interdisciplinary care team.

Organizational Structural Barriers

A hospital's organizational structure can affect the quality of communication, leading to barriers. These barriers can affect the case manager's patients, peers, other members of the multidisciplinary team, payers, and senior administrative management.

The risk of message interruption increases with the number of people involved in the chain of communication. As in the old game of Telephone, the initial message is substantially changed by the time the message reaches the last person. Important details such as times, dates, and names are unclear. It is always more effective — and efficient — to relay the message to the entire group at once.

Defensive Communication

Defensiveness also is a barrier to effective communication. This occurs when a person attempts to protect himself or herself from a real or perceived threat. The threat could be related to the sender or receiver of the message, or it could be present in the message itself. Defensive communication can occur when there is a lack of trust, such as when a person is distrustful or suspicious of the sender's motives. Often, the sent message contains challenging content or disregard for the receiver's values, beliefs, or feelings.

Differences in status, such as job titles or seniority, can cause poor-quality communication. This is known as information processing or filtering. Simply being aware of and sensitive to this communication barrier can aid in overcoming it. This is common when physicians are speaking to patients, or sometimes between less experienced nurses and physicians.

> ESTABLISHING A TRUSTING RELATIONSHIP AND KNOWING HOW AND WHEN TO USE POWER APPROPRIATELY WILL LEAD TO BETTER OUTCOMES.

Generally, there are two types of power:

- **Directive power.** This often is used to affect the behavior of others to satisfy personal needs.
- **Synergistic power.** This rallies the creative energies to benefit all participants.

Establishing a trusting relationship and knowing how and when to use power appropriately will lead to better outcomes. Case managers must share expertise, issue directives, follow up on compliance issues, and attempt to influence when necessary.

Case Study: Appropriate Use of Power on a Patient's Behalf

Mrs. Smith, a Florida resident, was hospitalized while visiting her elderly sister in New York. After 20 days in the hospital, she is ready to be discharged. While in

the hospital, her functional status deteriorated. She required oxygen and a wheelchair, presenting a potentially unsafe home situation. Mrs. Smith refused nursing home placement, wanting only to return to Florida where her friends could help her. Many contacts and more hospital days later, it became clear that it was cheaper to arrange for medical air transport to Florida than to continue her hospitalization.

The case manager in this scenario can affect the outcome of this patient's hospitalization by using directive power and educating the hospital's administration. Soon, it was obvious that it was financially prudent to send the patient back to Florida rather than keep her hospitalized indefinitely. The case manager's responsibility is to communicate to hospital administration the cost-benefit of a few days in the hospital vs. the cost of an ambulance and medical air transport.

Power and Communication

Stay focused on communication goals. Do not be intimidated by the power status of the person with whom you are communicating when care quality is at stake. Seeking feedback and verifying the information conveyed will help you maintain power.

Trust

Stress and lack of trust can interfere with accurate, clear communication. Both affect the ability to express needs and share information openly and honestly. Building rapport and a trusting relationship can reduce stress, increasing the likelihood of accurate communication.

The following are four basic qualities needed for a successful patient-case manager or case manager-colleague relationship:

• **Warmth.** Treating others with warmth can help them feel accepted. Nurses who exhibit openness rather than cold, expressionless, disapproving behavior will gain trust faster. Warmth reflects self-respect, self-acceptance, and genuine concern for others. Patients will respond favorably.

• **Respect.** This encompasses the Golden Rule: Treat others as you would like to be treated. Consider the person's personality, culture, opinions, customs, values, and beliefs. Case managers still must value and accept the patient and his or her family when their decisions about a discharge plan are not in full agreement with the case manager's recommendations. Keeping patients informed about their care gives them the feeling they are respected as individuals, not just seen as a bed number or a disease entity.

• **Empathy.** This is essential to establishing a trusting relationship with a patient and family. Empathy helps people feel understood. Case managers should tune into the patient's feelings and thoughts, and let go of stereotypes and prejudices. Case managers must hear the person without demanding he or she feel a certain way in a given situation.

• **Genuineness.** This component enhances the trust relationship. Remaining open and acting genuinely allows people to feel they are interacting with a real person who is interested in their well-being. Consistency often is a factor in genuineness; if a patient discovers inconsistency between verbal and nonverbal behavior, communication will break down. Remember that people who already are stressed are more sensitive to false behavior and inconsistent communication.

In addition to avoiding or minimizing the many barriers to effective communication, case managers should become attuned to communication channels that effectively transmit the message.

Communication Paths

Communication paths can be formal or informal — and both can profoundly affect the end message. There are two types of formal communication: downward and upward. Downward communication explains what to do, how to do it, and when to complete it. This communication is common when supervisors delegate tasks to subordinates. Upward communication occurs as requests from subordinates to supervisors; for example, when a case manager speaks with a chief financial officer to request financial approval, when we decided to fly Mrs. Smith home to Florida rather than pay for her continued hospital stay. The result is a more accurate managerial process and wider participation.

Informal communication usually takes place between smaller groups, such as the case manager and the social worker. Managers in these departments might hold a formal meeting to discuss policy matters between their departments. This communication is based on mutual trust, or a more formal communication will need to follow.

In addition to reducing communication barriers, case managers can improve their communication competency. How colleagues work together as a team can determine the success or failure of any work environment. Good relationships are fostered when colleagues respect and understand each other's responsibilities.

Teams

Generally, there are 10 elements to effective teamwork. There is a big difference between an effective team and a group of people who have been thrown together with no clear goals or expectations. While reviewing these elements, think about the members of your team, including RN case managers, social workers, discharge planners, utilization reviewers, nurse managers, payers, or physicians. Rate your team's effort toward a productive case management program and better patient outcomes.

SUCCESSFUL CONFLICT MANAGEMENT IS AN IMPORTANT SKILL FOR CASE MANAGERS AND SOCIAL WORKERS TO ENCOURAGE CREATIVITY AND INNOVATION, INCREASE PRODUCTIVITY, AND ACHIEVE GOALS.

- Open, honest, and understanding communication;
- Common goals and clear understanding of the mission;
- Team member support;
- Pride in the team's work and results;
- Seek and offer guidance on decision-making;
- Express ideas and opinions;
- Develop new skills;
- Use unique skills and talents;
- Engage in healthy debate and work out differences with new points of view and creativity;
- Increase openness, enthusiasm, and energy with appropriate humor.

These 10 elements require respect, compromise, and conflict resolution.

Conflict

Administrative pressures for cost control while still providing safe and quality care influence case managers in their daily decision-making activities. It is more important than ever for case managers to collaborate with the interdisciplinary team to meet the pressures and demands of healthcare delivery. Case managers should remember that conflict is inevitable and need not be a negative experience. Conflict is merely a difference in views, goals, facts, or values that place them at opposite ends of an issue.

Generally, conflict falls into one of these three categories:

- **Perceived conflict:** The belief that a conflict exists;
- **Felt conflict:** The conflict causes feelings of hostility, fear, or mistrust;
- **Expressed conflict:** The conflict spurs debate, assertion, competition, or problem-solving.

The most widely used conflict resolution method is the collaborative win/win, where participants work toward solutions to maintain their goals and create a resolution with which everyone can live. Successful conflict management is an important skill for case managers and social workers to encourage creativity and innovation, increase productivity, and achieve goals..

The physician is a vital communication source. Patient care will suffer if there are conflicts or barriers to the case manager-physician communication. Establishing up-front communication regarding the case manager's role is a good place to start in build-

ing an effective team among the disciplines. Case managers must initiate positive dialogue with physicians and address the stereotypes and stresses of a shifting healthcare system.

Despite sharing the common goal of delivering quality patient care, physicians and case managers can become adversaries if there is distrust of the case manager's intentions. Comments such as "Case managers are the police who work with the insurance payers to deny care" can mean physicians perceive case managers as a threat to their medical judgment. Because of the changing working relationship between case managers, physicians, and other staff, establishing a cooperative and collaborative relationship can be awkward and frustrating.

Case managers should remember the care team is here for the patient and remain focused on that goal. Case managers should be clear their interest is in ensuring the high-quality care and the best possible outcomes for the patient and the organization. The physicians, social workers, utilization coordinators, and discharge planners should know the case managers are not there to control or dictate practice, but to foster effective, quality communication between members of the interdisciplinary care team.

Tactics for Conflict Resolution

These five tactics provide a framework for resolving conflicts:

• **Competing.** An assertive tactic in which an individual's concerns are satisfied at the expense of another's. This is useful in a situation in which the solution is urgently needed, and there is no time to try another solution.

• **Collaborating.** Individuals work together to find mutually satisfying solutions. This is useful when a solution is complex and requires all parties involved be satisfied with the outcome.

• **Compromising.** Everyone must give something up to resolve the conflict. This can be used when the goals of one individual are somewhat important or not important enough compared with the goals of other.

• **Avoiding.** This is a passive tactic in which an individual postpones or sidesteps the conflict. This can be used when one party holds more power, and the risk of confrontation outweighs the benefits or the solution.

• **Accommodating.** This occurs when an individual focuses on the concerns of others and neglects his or her own concerns. This is useful when one individual has a vested interest in the issue, while the issue is unimportant to the other.[1]

Summary

Communication is a key tactic that should be in every RN case manager and social worker's toolbox. It is a skill set for success and should never be underestimated. This month, we reviewed many of the techniques that you can incorporate into your daily practice. ■

REFERENCE

1. Barton A. Conflict resolution by nurse managers. *Nurs Manage* 1991;22:83-84, 86.