HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Plan of Care Rounds Improve Communication

By Melinda Young

Interdisciplinary plan of care rounds, attended by nurse case managers, social workers, and others, can help improve communication within the collaborative care team.

Plan of care rounds are instrumental for case management, says **Ashley Cannady**, BSN, RN, CCM, manager of case management at Cleveland Clinic.

"We have interdisciplinary plan of care rounds — collaboration between the case management department, nursing staff, and usually a nurse case manager and social worker, bedside nurse, nurse practitioner, and the patient," Cannady explains. "We're able to see the patient day to day. We have continuity and the ability to stay on that particular floor."

> INTERDISCIPLINARY PLAN OF CARE ROUNDS, ATTENDED BY NURSE CASE MANAGERS, SOCIAL WORKERS, AND OTHERS, CAN HELP IMPROVE COMMUNICATION WITHIN THE COLLABORATIVE CARE TEAM.

With rounding, case managers watch patients progress and can answer any patient concerns. "It gives us a heads-up on any issues they have at home," Cannady says.

For example, a patient might ask questions about medication. With plan of care rounds, case managers can suggest a pharmacy consult to address those concerns.

"It allows us to put together various pieces of the puzzle and have smooth transitions home," Cannady says.

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There is evidence to suggest the rounds have helped increase communication scores on the patient satisfaction survey, she notes.

"Patients see team members communicate. The rounds allow them to provide feedback on what they need at home," Cannady explains. "It provides for a smoother transition home or to the next level of care."

Cannady explains how the plan of care rounds work:

• **Make an introduction.** The case manager's introduction to patients might follow a script similar to this:

"Hi, Sally. My name is Ashley, your case manager. We're here for your bedside rounds. Our social worker Kristen is here, along with the rest of the team. We're here to review your plan of care for today," Cannady explains. "I see you were admitted with chronic obstructive pulmonary disease. We have our pulmonary team, and the plan is for you to go home with home care. Do you have any questions about what is going on with your care?"

The patient then has a little time to ask questions or make a comment.

"It's collaborative and gives each team member the potential to voice their goals and what input they may have as far as medical care," Cannady says.

The bedside round ends with a brief comment, such as: "Thank you for your time. If there's anything you can think of going forward, please let us know. We're here," she says.

• **Provide consistency.** "Every floor has the same team," Cannady says. "We start the rounds at 10 a.m. for most floors, although some floors vary. Typically, the case manager or bedside nurse leads the round. Each member goes to each patient room. We identify ourselves, introduce ourselves, and discuss the plan of care for the day."

Each bedside meeting takes around three minutes. The plan of care team visits each patient, every day.

"It's very important to do this every day, for every patient," Cannady stresses.

Each time the team visits a patient during the plan of care round, they can reinforce the previous day's discharge information.

"We round on patients the same day as discharge," Cannady explains. "We might say, 'This is the plan: The nurse will come in, and we have home care set up for you. We also have a follow-up appointment set for you on this day.'"

This reinforces everything the team has discussed with the patient.

• **Include patients.** The plan of care round team gives patients time

EXECUTIVE SUMMARY

Collaborative care teams can use interdisciplinary plan of care rounds to improve communication and facilitate smooth transitions.

- The plan of care round team can give patients a brief overview and answer patients' questions or concerns.
- Consistency is essential to success. These rounds can be conducted at the same time each day for every floor of a hospital.
- Another method is to keep the patient bedside visits brief and time them to maintain efficiency.

to provide feedback, ask questions, and plan goals.

"The nurse or case manager gives a brief overview of what the patient is hospitalized for and what is going on with treatment," Cannady says. "If they're confused about what's going on with their plan of care or have any questions about what medications they might need at discharge, they can ask."

When patients need more time with their case manager, he or she can return later to sit with the patient and troubleshoot issues, she adds.

• **Adjust on day two.** The second day of rounding serves as reinforcement of the patient's education and plan of care.

"We provide an update on what is going on today, as opposed to yesterday," Cannady says. "If the patient needs a higher oxygen level or additional medication, that's the time to discuss any differences between the days and any differences in the care."

The second day is an update in the care plan, she adds.

• **Maintain efficiency.** The bedside rounds are timed to keep them quick and efficient. Nurses provide clear-cut instructions for follow-up care, Cannady says.

"Patients shouldn't have any delays with discharge," she notes. "The bedside rounds are not meant to hold up discharge. If patients are unable to leave and are medically cleared, then they will leave the hospital — as long as nurses have provided them with discharge instructions."

The plan of care round team does not carry devices with them. At the most, someone might have a clipboard with the patient's name and notes, she says.

"Sometimes, when patients have a higher acuity or additional questions, then the plan of care team might stay longer — up to six minutes in the room," Cannady says. "If the patient requires longer plan of care rounds or explanation, then we continue on and stop back at the patient's room when we complete the rest of the rounds. This provides more one-on-one time with that patient."

The scripting for rounding is flexible, but efficient. A case manager might say, "I see you have additional questions. These are our bedside rounds. As soon as we get done with the remainder of the patients, we'll circle back to have one-on-one with you and answer your remaining questions," Cannady says.

When caregivers are present, the team encourages them to be part of the plan of care round.

Physicians are not part of the rounds, but a nurse practitioner is available on the floor to participate, she notes. "There is someone from the medical team there to answer questions and provide feedback on any medical issues," Cannady says. ■

Mandates for Discharging Homeless Patients Take Effect in California

Hospitals handle it with no additional funding

By Melinda Young

Hospitalizations among homeless people are on the rise, driven largely by mental illness and substance use issues.[1]

Homeless patients can fall through the cracks as they often do not carry healthcare coverage. Also, these populations can cost hospitals millions each year in unreimbursed care.

California recently enacted a law that addresses this issue by requiring hospitals to follow a prescribed plan for identifying and safely discharging homeless patients. SB 1152 outlines specific discharge planning measures for homeless patients in acute care hospitals. *(Text of the bill is available at: https://bit.ly/2BeZgDZ.)*

As one report notes, "Helping people plan a successful transition from institutions like hospitals and jails is critical to preventing and ending homelessness." *(View the report at: https://bit.ly/30swEPX.)*

"The first blush of the bill's requirements was on Jan. 1, 2019. The next blush of requirements was approximately six months later," says **Todd McClure Cook**, MBA, MSW, EdD, vice president of integrated care management at Sharp HealthCare in San Diego.

Health systems quickly adjusted to the requirements. "At first, it was a mad scramble," Cook says.

One requirement is for hospitals to offer homeless patients food and clothing that is appropriate for the climate, he says.

"They must ask about infectious disease and provide appropriate

vaccinations," Cook says. "You have to provide the individual with a list of available resources, including different shelter possibilities in the area. We were required to provide full prescriptions for the individuals." Before the law was passed, hospitals had to provide homeless patients with a minimal amount of medication to carry them over until they could visit a federally qualified health center, Cook explains.

The law also requires the health system to transport homeless patients up to 30 miles or 30 minutes.

"There were a lot of gray areas surrounding all of this, which gives organizations like mine — and we consider ourselves to be well ahead of the curve — a great challenge," Cook says.

Challenging Requirements

One of the bill's more challenging requirements involves on-demand, real-time reporting of a hospital's compliance with the regulation. Case managers perform most of the work required by the bill.

"It involves two critical areas in the hospital: the inpatient side of the hospital, when someone is admitted, and the outpatient side, which includes all of those patients seen through our emergency department," Cook explains. "For the inpatient cases, I would say the case management my team provides largely drives the satisfactory completion of the requirements. In the emergency department, we have a combination of the physician, the nurse, and my team, including a nurse case manager and a social work case manager."

To educate case management and other staff on these changes to the homeless discharge process, the health system relied on the California Hospital Association's user manual.

"It gave a brief distillation of the act and its requirements," Cook says. "It explains how they perceive the requirements should be met."

Using the association's manual, Sharp leveraged its technology to improve compliance.

"We're not in a position where we can bring on more full-time equivalents just because of a new state law," Cook says. "This reality challenges organizations like us to be at our very best and to demonstrate our ability to think differently by building technology that will make the load easier."

For example, the health system built an electronic health record that includes information about documents and steps needed to plan the discharge of a homeless patient, he says.

"The case manager and the emergency department nurses see this technology," Cook says. "There is an automatic prompt or automatic fill. If I'm doing an assessment as a clinician and I answer questions about the patient's housing status, it could automatically populate this case into the homeless tracking."

Unexpected Outcomes

The bill gives the health system a lens for observing distinct populations, an unexpected outcome.

"It began to broaden the 'a-ha' moments of 'This is how you look at it and stratify different populations for true healthcare management,'" Cook explains. "Everything is not just a big old elephant anymore, sitting in the middle of the room. It gives you some insight and comfort level that, yes, you can break down things and they can be made meaningful. You can do a lot in a short order that will make an impactful difference."

The downside to the bill is that it includes many complex parts. Health system staff may not buy into the change and processes.

"One of the things we found immediately is that we always ask patients about appropriate clothing, especially when they don't have it or are going without shoes," Cook says. "We hardly ever documented that before because we didn't see it as necessary."

Documentation required by the new law is one of the more challenging aspects, he notes. Nurses take the time to ask homeless patients if they want something to eat, whether it is 5 p.m. to 1 a.m. But when the patient says, "no," nurses

EXECUTIVE SUMMARY

A California law that mandates discharge planning measures for homeless patients could be replicated in other states as homeless populations create major healthcare issues.

- Hospitals had to scramble to meet the mandate's specific rules, but have adjusted to procedural changes and more documentation.
- Case managers can leverage technology to save staff time on fulfilling some of the requirements.
- Hospitals are required to ask about infectious disease and to provide vaccinations, as needed.

now have to document that they asked. Before, they would move on to the next task.

"We found there were a number of items like that — things we naturally did that we did not think to document, or our clinicians did not document," Cook says. "Then this bill passes, and you have to write it down. We're still learning new ways to ensure maximum compliance."

The discharge planning law also requires screening for infectious diseases. COVID-19 has added a new challenge.

"Not long ago, we had an outbreak of hepatitis that was distinct to the homeless population in San Diego," Cook says. "We had to check for hepatitis and indicate our findings."

The bill's intentions overlap with what large metropolitan health systems largely already do for their homeless patients, he notes.

"We expect there will be more and more of these bills," he says. "Beyond social determinants of health, homelessness should be treated as a comorbidity."

Beyond state legislation, if medical professionals treated homelessness as a comorbidity, it could make a big difference in how the public viewed the homeless. It would resemble how public views of smoking changed after smoking was identified as a public health problem, Cook says.

"My hypothesis is we want to stop homelessness, so treat it like a comorbidity," he adds. ■

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Case Management Leaders Should Identify Sustainable Solutions

By Melinda Young

Hospital case management leaders have found their departments evolving in recent years, often to include practices and models that focus on population health goals. As care coordinators and case managers move toward transitions that incorporate these goals, one challenge is sustainability.

New research provides a model for sustaining a collaborative practice model that advances population health. Investigators determined engaged patients are highly satisfied with their care, including improved physical and mental health outcomes at a cost savings for the health system.[1,2]

"This research focuses on model sustainability," says **Maria Shirey**, PhD, MBA, RN, NEA-BC, ANEF, FACHE, FAAN, professor and associate dean of the University of Alabama at Birmingham (UAB) School of Nursing. "We present a sustainability framework, showing the different elements in sustainability you need to keep it going."

The Four Rights

The interprofessional collaborative practice (ICP) model includes Smooth Care Transitions for Diverse and Underserved Populations (STAND-UP). The ICP uses the Four Rights model: the right team with the right patient population with the right provider at the right time for care.[2]

Population health programs sometimes start with grants. If they are successful, it is important to find ways to make the programs sustainable for health systems.

"Look at the sustainability model: It identifies all the different things you have to consider to be able to continue. That is something you have to go into these efforts with," she adds. "These include things like how to line up political support and partners to see the value of this work and how to sustain funding."

For example, Shirey and colleagues built a business plan, using rich data and demonstrating a business case.

"When our grant was ending, we spoke with health system leadership at the hospital," Shirey explains. "The outcomes we were producing were so superior that it didn't make sense for them to stop the program. They needed to continue to fund us."

The program focused on an underserved population that was using the emergency department (ED) extensively and in ways that were unnecessary if they received the ongoing care they needed, she says.

The UAB health system runs a heart failure and a diabetes clinic, which can keep patients healthier and help to avoid ED visits. "Both clinics follow a model of care that is an interprofessional theme, under

one roof. We take care of the total patient," Shirey notes. "We do primary care and specialty care focus, and we take care of comorbid conditions to the extent we can."

The clinics will provide care to people who do not carry adequate health insurance or the income to pay for copays and medication.

"We can prescribe medications, but if patients don't have money, they don't take medicine and they won't improve," Shirey says. "We have a patient assistance program that provides medication, and we have a Dispensary of Hope affiliation with a pharmacy." The Dispensary of Hope distributes medications to pharmacies and safety-net clinics for low-income, chronically ill patients. *(For more information, visit: https://bit.ly/39eMzFP.)*

UAB uses a bundle in which patients receive care coordination from a social worker and a clinical nurse leader. Patients are monitored continuously. Staff know if patients are home, hospitalized, or receiving treatment in the clinic or ED. "Our goal is to keep them home with their families, functional to the best possible in their disease state, and to keep them out of the ED," Shirey explains

This is accomplished through evidence-based guidelines, patient activation, and care coordination, Shirey notes.

Integrate Behavioral Health

Behavioral health integration also is part of the program. "A lot of these patients have mental health issues and substance abuse," Shirey says. "It's very difficult to take care of them if you don't take into consideration those other aspects."

For example, some patients are depressed and do not take care of themselves because of untreated depression. "They don't take their meds or eat right, and they get into a vicious cycle," Shirey says. "If we see a patient is depressed in our protocol, we have services to offer them in our clinic: psychiatric mental health, psychologist, and others."

Patients are prescribed antidepressants and connected with support groups, as needed. "If you can improve the depression, then you can improve their ability to better care for themselves," Shirey adds.

The program's care coordination function is led by a clinical nurse leader. "She keeps track of where each patient is in the continuum of care, and she knows what that patient's plan of care is," Shirey says.

The care model includes medication reconciliation with patients at each visit. "Our patients keep journals. so The clinical nurse leader reviews their journals and makes assessments of where the patient is relative to their plan of care and feeds this information to the nurse practitioner, who will see the patient for that visit," Shirey says. "The other aspect of the clinical nurse leader role is they're not only involved in the actual care component, but also are good at analytics, keeping data, and monitoring outcomes."

The bulk of the program's funding comes from the hospital because of what it saves the health system, Shirey notes. "The quality of our care is exceptional. Our outcomes show we improve physical and mental health and improve access to care."

Patients' lengths of stay are shortened, and they are admitted to the hospital only when medically necessary.

"In our clinic, we can see patients in less than seven days, and there are times when we can see a patient on the day we receive a provider referral," Shirey says. ■

EXECUTIVE SUMMARY

Case management leaders can learn from population health programs that successfully steer chronically ill patients to affordable clinics to help them manage their disease and stay out of the hospital and emergency department (ED).

- Research shows these programs can save money and increase patient engagement.
- One model used is STAND-UP, which stands for Smooth Care Transitions for Diverse and Underserved Populations.
- Population health programs might begin with grants, but leaders can make the case for hospitals funding these sustainably to reduce unnecessary hospitalizations and ED visits.

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Ethical Considerations for Complex Discharges

By Jeanie Davis

What will you do if a patient refuses prescribed treatment? If the patient does not follow doctor's orders, how will you advise them? If adult children will not let you tell the patient his diagnosis, what will you do?

These are common situations in healthcare. Each raises an ethical dilemma for hospital case managers.

"Clinicians want to do good, but what about the patient's right of self-determination?" asks **Eileen Zenker**, LCSW, CCM, regional clinical supervisor at SeniorBridge in New York City. "We as clinicians think we're not making bad decisions. How can anyone not listen to us when we know what's best? And yet we have to keep the principles of bioethics in mind at all times. Those principles make our decisions more complicated."

Look for Hidden Issues

Zenker offers a reminder of the four basic principles in bioethics:

- **Autonomy:** The patient's right to choose is the basis for informed consent and decision-making.
- **Nonmaleficence:** Do no harm; harm should not be disproportionate to the benefit.
- **Beneficence:** Balance the risks and benefits of treatment against risks and costs.
- **Justice:** Be fair to everyone (access to care).

"Healthcare is such a complicated landscape. Things move quickly, so we don't always get the whole story," says Zenker. "That requires an in-depth discussion, and there's rarely much time. We don't want to make the decision for the individual, but we do want to understand what's going on."

A patient may be noncompliant, but the reason may be hidden. "In today's world, there is so much to worry about, which can lead to noncompliance," she explains. "A patient may be afraid to tell his boss he's sick because he's concerned he will lose his job."

> "HEALTHCARE IS SUCH A COMPLICATED LANDSCAPE. THINGS MOVE QUICKLY, SO WE DON'T ALWAYS GET THE WHOLE STORY."

For the same reason, the patient may not want to file with his health insurance company, which results in no coverage for the medications.

Finances often are an issue for patients, explains Zenker. A patient may be taking care of a seriously ill family member, and using the family's money to cover that person's medication instead of her own. She may frequently end up in the emergency department because her condition is uncontrolled.

"Instead of labeling people, let's try to understand them," says Zenker. "Ask yourself, 'What's going on here? How can I help this person? How can I get help to his wife or family member? How can I show the team the big picture about this person?'"

She adds: "We must look at the larger picture, beyond the fact that they're taking up a bed in emergency. Try to understand their rights but look at the bioethics principles that interplay."

When Values Compete

When studying competing values, the patient's right to choose and doing no harm can collide, Zenker says. "The question becomes, how can we balance that out? It's in no one's best interest if the patient is noncompliant, but what would make them do that?"

If a patient refuses a procedure, why? If the patient leaves the hospital earlier than recommended, what should be done? Can you understand their actions?

For example, a patient refuses dialysis. The case manager takes time for a heartfelt discussion, asking why the patient refuses. "The patient is depressed, that's why," says Zenker. "We can treat the depression and that can lead to dialysis treatment. We must understand the full scope."

She adds: "We understand the risks and benefits of our decisions. I eat potato chips knowing they're bad for me. But it's harder with patients when we want to respect the patient's autonomy, yet do the right thing and not harm anybody."

Zenker also advocates for escalating issues to the hospital's medical ethics team, when warranted. "When there are competing values, when someone is making a decision that is not in his or her best interests, these can be escalated to an ethical consult. We need a discussion to understand this person. A medical ethics team can be effective in helping resolve these conflicts."

The patient's autonomy becomes a delicate issue when his or her decision-making capacity starts to decline. Likewise, if the patient cannot understand the financial issues, he or she may need a financial proxy.

"We must recognize each individual's capacity to make their own decisions," Zenker says. "We must understand who that person is. The biggest issue is, what constitutes what's good for the patient? Who decides that?"

Case managers are key in escalating these issues, she adds. "Very often, the case manager and social worker will be able to see the situation holistically, which is why their expertise is so important. They can determine whether it's necessary to bring in a psychiatrist to evaluate the patient's capacity."

End-of-life care often triggers these difficult discussions regarding whether to continue treatment, Zenker says. "An interdisciplinary team can discuss that, taking into account the patient's values, judgment, and capacity," she explains. "They can analyze and understand what's happening, and help resolve issues."

Creating Rapport Is Key

In resolving these ethical issues, the case manager must have be self-aware, Zenker says. "You must be able to establish rapport to get information from the patient so they'll talk to you. People are afraid to share information these days. They worry about what it means."

Clinicians believe they know best, but even they admit they do not always know, she adds. "We have to be aware of ourselves because of how quickly patients are moving through the system. The ability to develop rapport with patients and family members is so important to understand."

The case manager can trigger the discussions. "Case managers have to be the patient's advocate; it's what we do so well. We're the ones who see these patients."

Even with "drive-thru patients," the case manager is key in identifying issues that complicate patient treatment. "A good case manager helps everyone. They may be the one person who realizes this patient doesn't have sufficient mental capacity and may need a court-appointed proxy."

Cultural awareness often is a concern. "If adult children don't approve of us speaking with their father, we must consider the cultural sensitivity, and respect their values," says Zenker. "But we must also be respectful of the patient and speak up for patient autonomy. We must give the patient the opportunity to understand their own condition and their own treatment. That is their right, and the children must be able to understand that."

Handling these delicate discussions with patients and family members is not always easy, Zenker admits. "The case manager must have an awareness of self and of other cultures to make that connection with patients." ■

Medical Marijuana and Patient Treatment

By Jeanie Davis

If a patient asks about medical marijuana, how will you respond? Are you familiar with the legalities and science to advise your patient?

The legalities are complex, but the bottom line is this: medical marijuana is gaining support nationwide.

"Case managers are getting questions about medical marijuana," says **Patricia Carothers**, BSN, RN, MS, CCM, president of Colorado-based My NetRN, Inc. "No matter what your view is, there's no hiding from this. You've got to be prepared to answer patients' questions." Case managers must understand the logistical, medical, and ethical implications of medical cannabis if they are to guide clients.

Marijuana was as common as aspirin in the 19th century, used to treat multiple health problems. In the 1930s, the United States government started restricting access. Today, marijuana is illegal on the federal level, classified like heroin as a Schedule I drug.

But times are changing. Recreational marijuana has been legalized in 11 states. Medical marijuana is legal in 33 states and Washington, D.C. Guam, Puerto Rico and the U.S. Virgin Islands have approved medical marijuana for "qualifying conditions," and more states are taking steps toward legalization.

In fact, marijuana remains the most popular drug that is illegal under federal law, reports the Harvard Health Letter. A 2014 survey suggests that about 10% of marijuana consumers — more than 2 million — may use it exclusively for medical reasons.

However, medical marijuana is only FDA-approved for treatment of two rare, severe forms of epilepsy: Dravet syndrome and Lennox-Gastaut syndrome. Many more people use medical marijuana to alleviate chronic pain, anxiety, epileptic seizures, decreased appetite, and many other conditions.

Case Managers Field Questions

Healthcare providers are trying to sort out the issue, says Carothers. Even in "legal" states like Colorado, some physicians refuse to recommend medical marijuana to patients, so they cannot obtain it from a dispensary.

The doctor's decision compromises patient autonomy and, perhaps, safety. "Healthcare professionals should honor and respect freedom of choice for their patients," Carothers says.

In non-legal states, some people are self-medicating with recreational marijuana. "What is our response going to be?" Carothers notes that most adverse effects occur in cannabis-naïve patients who ingest high amounts of THC. This is much more likely to happen when they take the recreational route.

"All of your clients should be made aware of these potential risks," Carothers adds.

She advises: "People often have a complicated relationship with medical marijuana. They're interested, heard about it from a friend who used it, but don't know where to start. We need to be their source of information."

Medical marijuana is the marijuana plant used to treat medical conditions. It is basically the same plant as recreational marijuana. However, cannabis plants bred for medical purposes will vary, depending on the strain, in levels of chemicals that create a "high." Yet all strains are rich in chemicals that affect pain and other bodily functions.

How Does It Work?

Cannabis contains hundreds of chemicals, called cannabinoids, each affecting the body differently.

Marijuana mimics our own natural endocannabinoids, Carothers explains. The endocannabinoid system is involved in a wide variety of functions, including pain, mood, appetite, memory, stress, sleep, metabolism, and immunity.

Delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) are the primary chemicals with medical applications. THC produces the "high" people feel when they smoke marijuana or eat foods containing it. CBD1 binds with receptors in the brain and central nervous system. CBD2 receptors are in the immune system.

"The receptors in our body are ready to bind with the compounds in cannabis for activating responses," she explains.

Cannabis used for fiber contains usually less than 1% of THC, but medical marijuana contains varying amounts of THC, Carothers says. "Patients with medical marijuana access can sometimes obtain higher levels of a THC product vs. a recreational product," she says. "It certainly depends upon their condition and need."

How Is It Administered?

Medical marijuana can be smoked, inhaled through a vaporizer, ingested (gummies, lollipops, brownie), or applied topically in a lotion, spray, oil, or cream. In liquid form, a few drops can be placed under the tongue. Reports of detrimental issues with vaping involved people using non-cannabis substances, Carothers says.

The body processes the substance differently based on how it is administered, she explains. With oral ingestion, the substance must pass through the stomach and liver, so there is delayed onset and longer duration. "Oral doses are difficult to titrate for that reason."

This variability of absorption and potency can be difficult to judge regardless of how it is administered, says Carothers. Inhalation is the easiest to titrate, and is the most common route. Although considered safe, inhalation can lead to respiratory irritation, she adds.

She strongly recommends microdosing — using between 2 and 2.5 milligrams of either THC or CBD. She recommends the "start low and go slow approach" for everyone, but especially seniors and those using marijuana for the first time.

What Does It Treat?

Most people take medical marijuana to reduce chronic pain, nausea, and vomiting due to chemotherapy, and muscle spasticity related to multiple sclerosis or epilepsy seizures. While research of medical marijuana is limited due to federal laws, most existing evidence supports using medical marijuana for the above conditions, says Carothers.

Medical marijuana also can be taken for Alzheimer's disease, anorexia, appetite loss, Crohn's disease, epilepsy, glaucoma, schizophrenia, post-traumatic stress disorder, muscle spasms, and Wasting Syndrome.

Research in a Tel Aviv laboratory is addressing many questions, including whether cannabis kills cancer cells; and, if it does, which types of cancer; and which cannabis strains are effective. The "which strains" question is crucial.

One study involved children with autism given a low THC/high CBD compound; that study had a 78% success rate on various endpoints including anxiety, violence, sleep, and communications.

However, the effect may be strain-specific, as a similar study involved a low THC/high CBD strain, but provided by a different grower. The children experienced no effect at all, Carothers reports.

As medical marijuana is not scientifically standardized, she knows case managers struggle to advise patients. "Start low, go slow," she suggests.

How Can Patients Obtain a Prescription?

The patient must have a medical condition that qualifies for medical marijuana use. If they live in a legal state, they must check the list of qualifying conditions. The state also may require a medical marijuana ID card to buy it at a dispensary.

To obtain the ID card, a physician with an active Drug Enforcement Administration certification must recommend it for the patient. If the doctor will not make a recommendation, the next step is to visit a medical cannabis specialist. Medical marijuana dispensaries typically will offer this type of specialist.

Patients who live in a non-legal state cannot obtain medical marijuana from a legal state without risking serious criminal charges for illegal possession, trafficking, or both.

Patients who live in a legal state can obtain medical marijuana from another legal state if they are visiting. Some states accept out-of-state authorizations. It is important to note the acceptance of an out-of-state medical card is entirely up to the dispensary owner's discretion.

A medical cannabis dispensary should employ an experienced provider. A medical background is a plus, but not always a given, says Carothers. Ideally, the person dispensing has taken a certification course. The dispensary should provide a separate room for discussing the patient's complete medical history as well as the current medications, activities, and desired outcomes.

Each patient should receive a customized product unique to his or her condition, she explains. Through a medical marijuana dispensary, patients receive more education, pay less, get higher CBD potency, and receive a higher-quality product than if they purchased cannabis through a recreational dispensary, she adds.

"Nurse case managers are on the front lines, in the trenches on every health topic," says Carothers. "People feel comfortable talking to nurses; they come to us for information. It's important for case managers to have ready resources that are peer-reviewed, clear, and true."

The Case Manager's Role

Hopefully, case managers and physicians will honor and respect their patients' freedom of choice, says Carothers. "Is it ethical to refuse a request for medical marijuana based on personal views?" she asks. "Surely, compassion is a crucial component of our ethical behavior."

Case managers should be able to explain the science of medical marijuana, she says, including the risks and benefits of cannabinoids. "We should be able to provide our patients with resources to inform and educate them."

Also, case managers must be realistic, as patients may self-medicate if they cannot obtain a doctor's permission. "What is our response going to be? Typically, the adverse effects occur in cannabis-naïve patients who ingest high amounts of THC when taking recreational marijuana. All patients should be made aware of this risk," she says.

If the patient is pregnant, that risk is higher, Carothers adds. The American Medical Association does not support using cannabis during pregnancy. The patient's physician should be brought into the conversation.

Examine Biases

It is important to not be judgmental, which is not always easy, says **Vivian Campagna**, MSN, RN-BC, CCM, chief industry relations officer for The Commission for Case Manager Certification.

"Think about your personal biases, because that is an important aspect of your response to patients," she says. "Can you be objective and helpful in discussing it with a patient? If you do have a bias, that will inherently override your objectivity and may skew your response toward inaccuracies."

You must respond to patients' questions, she advises, with this caveat: "If you feel you can't objectively answer questions, advise that a co-worker or other knowledgeable person discuss it with the patient."

Also, learn how the provider feels before entering any conversation

with the patient. If the provider is not on board, you risk harming the client-physician relationship, says Campagna. "You have to tread very carefully, as people do have strong feelings about medical marijuana."

She advises discussing it hypothetically with the physician, without mentioning the patient's name. "This will help preserve your patient's relationship with the physician, as well as your own relationship with that physician," she explains. "We need to have teamwork with providers to be effective, and don't want to risk alienating the provider or creating an adversarial relationship. It's a very fine line we have to walk."

If medical marijuana is illegal in your state, and a patient asks, you have to discuss the laws. "Keep in mind, medical marijuana is still not legal on the federal level. If the patient buys it in a neighboring state, they could face legal action," says Campagna. "Even if they're taking a road trip and carrying their legally purchased medical marijuana, there can be legal ramifications. The same holds true with CBD products as well, since they are not allowed in all states." ■

Simulation Can Improve Staff PPE Safety

It is important for healthcare workers to learn and practice the correct way to wear personal protective equipment (PPE). One helpful technique is to use medical simulation.

"You want to be confident in your personal protective equipment when you go to work, enter a room, and intubate a patient," says **Patrick Hughes**, DO, MEHP, FACEP, FACOEP, emergency medicine residency assistant program director, assistant professor of integrated medical science, and director of the emergency simulation program at Florida Atlantic University's Schmidt College of Medicine.

Hughes led a team that developed a simulation that is inexpensive, easy to create, and effective. "We developed a solution with the inside of a highlighter. You put the highlighter refills into warm water," Hughes explains. "It leaks into the warm water, and then we spray the water on a mannequin."

The highlighter creates a fluorescent solution, which can be put in a spray bottle. After soaking, the solution can sit for a few minutes. Hughes' simulation lab typically sprays a mannequin within five minutes of starting the simulation. It does not matter whether the spray is wet or dry when the simulation starts, he notes.

The staff don their PPE and perform a simulation of a common operating room task or nebulizing treatment. Then, the surgery center's infectious disease leader can turn on a black light to show how the simulated contagion spread.

"We have them go out and see if there is any contagion on them after they took off their PPE, and 25% of participants might have some fluorescents on their forehead or face that they touched while contaminated," Hughes reports.

For a hospital environment, the simulation scenario goes like this: A member of the staff roleplays a patient in respiratory distress. "They do a history and physical exam, and then the patient needs an airway intervention," Hughes says. "They do a nebulizer treatment on the patient."

This shows how using the nebulizer can put viruses like the SARS-CoV-2 into the air. "The person finished the procedure, and we have them care for the patient. At the end, we turn off the light in the room and shine the UV light on participants to show them all of the contagion," Hughes explains. "Then, we turn the light back on and have them take off their PPE in the manner they were taught. We reuse the UV light to see if anything was left on them."

Seeing the visual impact of their PPE mistakes allows managers and staff to correct their use of PPE in real time. "For instance, one person had some left on their cheek," Hughes recalls. "When they had taken off their outer gloves, they had touched the under glove with the contaminated outer glove. Then, they touched the side of their face with their contaminated glove and left some of the solution on their face."

Healthcare facilities can create a simulation that more closely reflects an operating room, presurgery procedure. The materials cost less than $25, and the mannequin can be anything that might work with the equipment used in the simulation.

"This is something that can be done in any hospital or surgery center. You don't necessarily need a high-fidelity simulator," Hughes says. "We found that people liked the extra training and refresher course on using personal protective equipment. They liked the fact that we showed them how contaminated they were at the end of the scenario." ■

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. **An interdisciplinary plan of care round team, consisting of case managers, nurses, and a social worker, round for three minutes at each patient's bedside. This team can:**

   a. teach the patient about medication, healthy eating, and exercise.
   b. give patients an overview of their status and care, answer questions, and create goals.
   c. educate interns rounding that day on the patient's status and prognosis.
   d. tell patients about the referrals for that day and their current prognosis.

2. **The four principles of bioethics are:**

   a. justice, care, autonomy, patience.
   b. autonomy, nonmaleficence, beneficence, justice.
   c. beneficence, justice, treatment, decision-making.
   d. justice, autonomy, treatment, good decisions.

3. **The Four Rights of interprofessional collaborative practice are:**

   a. the right diagnosis from the right physician in the right hospital at the right time.
   b. the right plan of care with the right patient at the right hospital with the right treatment.
   c. the right patient with the right care team in the right hospital at the right time.
   d. the right team with the right patient population with the right provider at the right time.

4. **California's SB 1152 law mandates specific discharge planning measures for which population of patients in acute care hospitals?**

   a. Women
   b. Mentally ill
   c. Homeless
   d. Children

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

The Case Manager's Toolbox: The Essential Skills of an Effective Case Manager, Part 4

By Toni Cesta, PhD, RN, FAAN

Introduction

This month, we will end our discussion on case management skills, tools, and techniques with an in-depth review of the concept of communication, particularly in the role of the case management professional.

Communicating with Diverse Groups

Today's case managers and social workers face the challenge of communicating with diverse groups, including patients, families, physicians, and insurance companies. Case managers should use communication techniques and skills we reviewed in previous issues. Our lines of communication go well beyond the walls of the hospital and include post-acute providers, primary care providers, community-based case managers, navigators, and others.

For example, case managers must listen closely to what the payer is requesting and clarify any vague information as soon as possible. Do not assume the third-party payer receiving the necessary information about the discharge plan. As educator and advocate, case managers must clearly communicate the patient's needs to the third-party payer. Remember, you are a problem-solver and should not simply accept a "No" or "We don't do that." Take risks when advocating for patients. Sometimes, these conversations can be difficult or unpleasant. However, communication with external members of the interdisciplinary team (e.g., payers, community resources, family members) becomes just as important to the success of the patient's outcomes as the communication with internal members.

> TODAY'S CASE MANAGERS AND SOCIAL WORKERS FACE THE CHALLENGE OF COMMUNICATING WITH DIVERSE GROUPS, INCLUDING PATIENTS, FAMILIES, PHYSICIANS, AND INSURANCE COMPANIES.

Well-managed conflict can increase the effectiveness of an organization. The assertive style of communication can work best when applied to the case management process, but psychological, physical, and structural barriers can interrupt the flow of communication. Case managers must work to overcome these barriers to make high-quality care decisions.

Communication Styles and Characteristics

1. Assertive
- Pushing hard without attacking;
- Expressive and self-enhancing;
- Influencing results/outcomes.

2. Aggressive
- Taking advantage of others;
- Self-enhancing at others' expense;
- Intimidating.

3. Nonassertive
- Inhibited;
- Self-denying;
- Passive.

Data Management

High-quality data are important for case managers to

make care decisions. We identify, collect, and analyze data when assessing patients; creating and implementing the care plan; and monitoring the outcomes. Case managers should know how to manage and interpret data using tracking and collection tools, such as:

- administrative logs and databases;
- documentation tools;
- variance data collection;
- quality assessment, insurance, and improvement tools;
- managed care review;
- information systems and electronic medical records.

It is critical to learn and understand methods of data collection and management (retrospective, prospective, and concurrent) and appropriate use of these methods, including advantages and disadvantages. It also is important to understand data analysis measures, including:

- **Numbers:** Descriptive statistics;
- **Rates:** Incidence and occurrence;
- **Attributes:** Demographics;
- **Perceptions:** Patient and staff satisfaction;
- **Composites:** Case mix index.

With automation and technology becoming increasingly ubiquitous, case managers must know how to access databases, run special reports, prepare graphic reports, conduct statistical analyses, and export or download data. Case managers with these skills are the most desirable and successful. The ability to write succinctly, clearly, and concisely is another crucial skill. Know how to accurately summarize important findings in reports, and understand when to seek out more data for better decision-making or to draw more accurate conclusions.

Do not focus solely on reading, writing, listening, and speaking. Case managers also can practice effective communication by withholding judgment, avoiding inconsistencies, and valuing all members of the team, including the patient and family.

Big Picture/ Systems Thinking

Systems thinking can be defined as a problem-solving language that guides the understanding of complex issues within organizations that include parts of interaction. The complexity of case management models requires a systems approach to care delivery because of its interdependence on the various disciplines involved in care processes. Pay careful attention to the work environment and its many inputs, throughputs, and outputs, and the degree to which they interact. Inputs, throughputs, and outputs comprise the various functions of case management such as resource utilization, discharge planning, transitional planning, roles and job descriptions, goals, objectives, performance, productivity, and outcomes.

It is important to understand the services provided in the varied settings across the continuum of care. If we are not systems-focused in our thinking and approach to care delivery and management, communication will be ineffective if we are not systems-focused in our approach to care delivery. Case management requires understanding the patient's level of care. We also must coordinate, facilitate, and arrange post-discharge services and transitions to the next level of care, which requires communication with community agencies or managed care organizations for authorization of services. Regardless of the setting, case managers are expected to employ a systems-thinking framework and approach to case management care delivery. This framework ensures success and improved outcomes.

Think of hospitals and healthcare organizations as systems in which staff members interact and function in interdependent teams to accomplish common goals. This includes case management systems. Case managers must be able to work in teams to achieve cost-effective,

quality outcomes. Systems-thinking is the desired approach for achieving such results.

Systems-thinking is a powerful problem-solving technique that focuses on the essential interrelationships of the case management model. It helps case managers see the big picture and the interconnectedness of the system or organization. Systems-thinking can help case managers by:

- managing multiple tasks and functions;
- managing change;
- managing decision-making;
- motivating others;
- handling conflict;
- facilitating negotiations.

Emotional Intelligence

Emotional intelligence has emerged as a necessary leadership skill, particularly in healthcare.

Emotions serve as information in decision-making and communication. They also influence how case managers may connect with others and establish relationships, using:

- awareness of one's emotions;
- awareness of other people's emotions;
- the effects of emotions on the situation or event.

Well-managed emotions can act as a source of power, motivation, feedback, information, influence, innovation, creativity, success, and freedom. Emotional intelligence can improve a case managers' abilities by:

- making careful decisions;
- resolving conflict effectively;
- communicating openly and honestly;
- establishing trust with patients; families, and co-workers;
- building rapport with patients and families;
- creating a patient-centered, teamwork-focused environment of care.

The desired qualities of case managers are not limited to their technical, clinical, and interpersonal skills. These qualities are most effective when case managers can recognize, understand, manage, and appropriately respond to emotions. Responsibilities and services require case managers who are astute and emotionally intelligent; otherwise, they cannot provide efficient, effective, safe, cost-effective, ethical, quality care.

Qualities of Emotional Intelligence

Successful leaders possess extensive skills. This is especially true of case management leaders. These skills include:

1. Know your emotions

- Identify the information influencing your perception.
- Recognize what influences your moods.
- Know when you are thinking negatively.
- Recognize when you are becoming angry or feel frustrated.
- Know when you are becoming defensive.
- Recognize when your verbal and nonverbal communications are conflicting.
- Know which senses you are using.
- Communicate your feelings.

2. Managing emotions

- Learn to de-stress when under pressure.
- Act productively, especially when angry, frustrated, or anxious.
- Take a moment to calm thoughts before making decisions or responding to unpleasant situations.
- Understand the relationship between your physiological and emotional states.
- Remain calm when you are the target of anger or criticism from others.
- Take some time out.
- Resort to humor.

3. Motivating oneself

- Regroup quickly after a setback or stressful experience.
- Change or break ineffective habits.
- Develop productive, rewarding habits.
- Follow words with actions.
- Keep your promises.
- Be persistent.
- Do not give up.
- Always do your best.
- Finish your responsibilities/duties within the designated time frames.

4. Recognizing others' emotions

- Clarify misunderstandings.
- Ask others how they feel.
- Validate your perceptions of others.
- Validate your perceptions of how others think of you.
- Recognize when people are distressed, anxious, or distraught.
- Engage in meaningful conversations with others.
- Manage group emotions appropriately.
- Help others manage their emotions.
- Show empathy.
- Let others express their feelings honestly.
- Establish common goals.

5. Handling relationships

- Resolve conflicts.
- Approach problem resolution as a group.
- Encourage team-building behaviors.
- Exhibit effective communication skills.
- Be honest and sincere.

• Build trust.
• Build a sense of community.
• Influence others and allow others to influence you.
• Make people feel welcome.
• Seek support and advice.
• Avail yourself to others when they need you.
• Be approachable.

Successful case managers excel in areas such as peer relationships, leading subordinates, resolving conflicts, making complex decisions, resource allocation (including their own time), and innovation. Successful case managers are leaders, not managers. Leadership skills are more desired in case managers than management skills. Management is more narrowly focused ("How can I accomplish certain things?"), while leadership is broader ("What do I need to accomplish?") In other words, management is doing things right, while leadership is doing the right things.

Management is efficiency in climbing the ladder of success; leadership determines whether the ladder is leaning against the correct wall.

Imagine a group of new graduate nurses cutting their way through a jungle. The workers will be clearing the path in the front. The potential managers will be behind them, sharpening their machetes, creating policies and procedures, and setting work schedules. The potential leader will climb the tree, assess the situation, and say, "Wrong jungle!"

Changes in the healthcare industry require professional leadership first and management second. Although the title generally is associated with management, leadership more fully and accurately defines the role of the case manager. Efficient management without effective leadership is "like straightening deck chairs on the Titanic."

Effectiveness depends on whether energy is expended in the right place on the right things. It is irrelevant if a case manager spends days on a discharge plan only to discover the plan was not right for the patient due to poor vision.

The pressure for change within our healthcare industry will intensify in the coming years. This pressure will require case management professionals to respond with new dynamic transformational leadership to cope with future changes. The transformational leader approaches leadership from an entirely different perspective or level of awareness. The transformational leader:

• draws attention to important goals or actions;
• encourages team members to forgo self-interests for the good of the team.

Transformational leaders:
• are role models;
• build an image;
• set goals;
• set high expectations.

The case manager of the twenty-first century characteristically has all of these qualities. Any organization interested in building a solid case management program should consider them.

Summary

When other professionals study the work of case managers and social workers, they may not recognize its complexities and challenges. So much of what we do is invisible to others, and may not be appreciated. We may help eliminate problems or barriers affecting our patients before others even know such barriers exist. Because our work is so complex, we must continuously grow and hone all the skills we have discussed during this series. Pick two or three skills that you want to work on for your own professional growth and development. Evaluate your effectiveness as you deal with real-life situations. The more skills in your toolbox, the better your work as a case manager will be. ■