HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

Gaps in care occur between ICU and acute care unit 76

Hospitals Without Walls transitions reach new level. 78

How case managers can use data to improve care delivery 79

Helping patients with Alzheimer's disease and dementia. 81

Case Management Insider: The Role of the Social Work Case Manager Across the Continuum of Care

Relias Media
From Relias

JULY 2021 Vol. 29, No. 7; p. 73-84

International Nursing Group Sounds Alarm Over Interrupted Nursing Pipeline

Retirements and burnout are increasing

By Melinda Young

Emerging data and reports suggest long-term stress and burnout among nurses has escalated since the COVID-19 pandemic began — which might contribute to increasing numbers of nurses leaving the workforce.[1-3]

The pandemic also affected nurse training in 2020 as nursing students experienced delays in graduation and training opportunities.[4]

The International Council of Nurses issued a policy brief in April 2021, stating most of its associations believe student nursing education was disrupted by the pandemic. These disruptions could affect the development of the nursing workforce.[4] These findings suggest potential workforce shortages in coming years.

> MORE THAN HALF OF RESPONDING NURSES REPORTED FEELINGS OF EXHAUSTION WITHIN THE PREVIOUS 14 DAYS.

The American Nurses Foundation conducted a survey between Jan. 19 and Feb. 16, asking nurses about their overall mental health and well-being. More than half of responding nurses reported feelings of exhaustion within the previous 14 days. The survey also revealed 28% of nurses said they want to quit their jobs, and 18% intended to leave their

Financial Disclosure: None of the planners or authors for this educational activity have relevant financial relationships to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

HOSPITAL CASE MANAGEMENT

***Hospital Case Management™*, ISSN 1087-0652, is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Hospital Case Management*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.**

GST Registration Number: R128870672.

SUBSCRIBER INFORMATION:
(800) 688-2421
customerservice@relias.com
ReliasMedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at groups@reliasmedia.com or 866-213-0844.

Back issues: $78. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, Relias LLC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

1.5 ANCC contact hours will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791. It is in effect for 36 months from the date of publication.

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers.

TARGET AUDIENCE: The target audience is hospital-based case managers.

This activity is valid 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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

position within the next six months. More than 50% of nurses who said they would leave the nursing profession in 2021 are retiring, and 47% said the work was negatively affecting their health and well-being. Forty-one percent cited insufficient staffing.[1]

The authors of a different study found that even before the pandemic, more than 50% of clinicians experienced some level of burnout, which was defined as long-term exposure to stress and high emotional exhaustion, high depersonalization, and a low sense of accomplishment.[2]

The pandemic had a big effect on nurses' stress and burnout, says **Ellen Fink-Samnick**, LCSW, CCM, CRP, DBH-C, principal of EFS Supervision Strategies, LLC, in Burke, VA.

"When you look at the numbers of people who died in the pandemic, nurses and physicians took the biggest brunt," she says. "Think about what that did to the workforce when over 3,600 members of the healthcare workforce died."

Hundreds of health systems furloughed nurses and other workers during the early months of the pandemic, which added to stress and to many nurses' desire to leave the profession, Fink-Samnick says.

Anecdotal evidence suggests some nurses who left bedside nursing jobs in hospitals decided to switch to case management. "You had all of these new folks ending up in the case management world," she says.

Reports of this career switch partially come from a Facebook group for case managers. "You've got all of these people who joined the group, saying, 'I am a nurse, and I am done with nursing,'" she adds. "Case management recruiting firms are very big, very busy right now, recruiting people who were nurses to do case management."

Nursing Supply in Peril

The influx of new case managers can create short-term challenges in training and onboarding. It is likely temporary, as long-term nursing shortfalls could negatively affect every field dominated by registered nurses.

The nursing supply problem is complex, and the pandemic has accelerated the retirement of highly seasoned nurses, says **Rhonda Maneval**, EdD, RN, senior associate dean of the College of Health Professions and the Lienhard School of Nursing at Pace University in New York City.

EXECUTIVE SUMMARY

The coronavirus pandemic has increased stress, burnout, and mental health issues among case managers and other healthcare workers, according to emerging research.

- The American Nurses Foundation surveyed nurses in early 2021, finding that more than half felt exhausted within the previous two weeks.
- Adding to nursing stress were furloughs during the pandemic and workforce disruptions.
- It was difficult for nursing colleges to find clinical positions for nursing students, as hospitals were overwhelmed and had less time to work with student nurses.

"We have a supply problem of not enough nurses, and we're heading into another nursing shortage," Maneval warns. "You add on top of it an already critical need for nurses, and then you have more retirement than you anticipated, so the need becomes greater."

The shortage is not caused by a lack of young people interested in nursing. Nursing schools reported a large influx of applicants during the pandemic. The problem was schools did not have the faculty and clinical opportunities needed to enroll more nursing students.[5]

The American Association of Colleges of Nursing reported 80,521 qualified applications were not accepted at nursing schools in the United States because of a shortage of clinical sites, faculty, and resources.[5]

Educating new nurses at a time when nurses are in critical demand creates a vicious cycle, says **Crissy Hunter**, DNP, RN, CHSE, CNE, clinical nursing faculty and COURSE coordinator for the nursing education track at Southern New Hampshire University in Manchester.

Healthcare systems, particularly in rural areas, might be short on nurses and patient beds because of the nursing shortage, she says. Then, they have to limit the number of nursing students who can receive clinical hours and supervision because they do not employ enough faculty to handle all the nursing students who need the clinical training. With fewer student nurses receiving training in the local hospital, fewer will stay in the area to work, thus creating the vicious cycle that perpetuates the nursing shortage.

Not just any experienced nurse can become faculty at a nursing school or in the clinical setting. Clinical faculty need at least a master's degree for the evaluation of the student.

"It's tough because if you have a bachelor's-prepared nurse as clinical faculty, they can't evaluate," Hunter explains. "The facility has to have the manpower of a master's-level nurse to be present to evaluate the student."

The two main reasons nursing schools are not admitting enough qualified candidates are because of the shortage of qualified faculty and lack of sites for clinical practice. "Most states have a cap on how many students can be safely at a clinical site that has one faculty member," Hunter adds. This means even in cities and larger health systems, there is limited capacity to admit students.

Nurse case managers and other working RNs can help nursing schools admit more students by earning master's degrees in nursing education, Hunter says. Nursing schools that educate and train pre-RN licensure staff have more challenging faculty staffing needs than do schools that train nurse educators.

"There's a difference between nursing students who don't have an RN license," Hunter says. "The amount of structure and faculty [ratio] to students is a different requirement than for those with post-licensure."

Hunter teaches nurses in a post-licensure online college program. "I have hands-on time with 100 students and can teach 25 at a time in a certain course," she explains.

Prelicensure nursing education programs need a smaller faculty-student ratio. The clinical faculty might be limited to eight or 10 students per faculty member.

Experienced nurses who may consider becoming a college or clinical faculty instructor should consider earning a master's degree from a nursing education program. Programs might accommodate students who also work in the field, and some are virtual and asynchronous, which means that students can complete course instruction and work at any time that works with their schedule.

"There is a federal grant that reimburses you if you go into a nursing education field at a place that has a deficit," Hunter notes. "That's highlighting the role of the nurse educator, and it's such an amazing profession."

If experienced nurses and case managers go back to college to become nurse educators, it could help address the nurse shortage and help in the long run, Hunter says. ■

REFERENCES

1. American Nurses Foundation. Pulse on the Nation's Nurses COVID-19 survey series: Year one COVID-19 impact assessment. February 2021. https://bit.ly/3orhx4Q
2. Norful AA, Rosenfeld A, Schroeder K, et al. Primary drivers and psychological manifestations of stress in frontline healthcare workforce during the initial COVID-19 outbreak in the United States. *Gen Hosp Psychiatry* 2021;69:20-26.
3. Berlinger N, Wynia M, Powell T, et al. Ethical framework for health care institutions & guidelines for institutional ethics services responding to the coronavirus pandemic. The Hastings Center. March 16, 2020. https://bit.ly/3f49Kat
4. International Council of Nurses Policy Brief. Nursing education and the emerging nursing workforce in COVID-19 pandemic. April 2021. https://bit.ly/3eWDSnU
5. American Association of Colleges of Nursing. Student enrollment surged in U.S. schools of nursing in 2020 despite challenges presented by the pandemic. April 1, 2021. https://bit.ly/3ov3Xxm

Gaps in Care Occur Between ICU and Acute Care Unit

ICU patients need careful follow-up

By Melinda Young

Patients who received ICU care experience problems that need to be resolved before they are discharged. These can include delirium, debility, and dysphagia, researchers say.[1]

Investigators studied the period before patients were discharged to identify gaps in their care, says **Eileen Kim**, MD, assistant professor in the division of hospital medicine at Hofstra/Northwell in Manhasset, NY. They found after patients were transitioned from the ICU to hospital beds, many still experienced persistent delirium, functional decline, and dysphagia. Hospital practices, including bed rest and dietary restrictions, led to these syndromes, worsening these conditions.

This post-acute ICU syndrome (PICS) affected a large proportion of ICU patients. For instance, up to 80% of ICU patients experience delirium while in the ICU. Researchers found nearly one-quarter of patients transferred out of ICU received constant observation, physical restraints, and/or antipsychotic medications, all of which suggest persistent delirium after they were transitioned to acute medical care units.

This suggests a gap in care. PICS patients need treatment of their syndrome before they are discharged.

Specific Care Needed

Once patients leave the ICU, they need care specific for their health issues, but their care typically is the same as other hospitalized patients. For instance, a patient with problems related to an ICU stay is treated similarly to patients admitted for pneumonia. The nursing ratio is the same, which creates a gap in care.

"Think about the patients who spend four days in the ICU, but 10 days on the medical ward," Kim says. "We thought there must be a gap and unmet need of ICU patients on the medical ward."

> AFTER PATIENTS WERE TRANSITIONED FROM THE ICU TO HOSPITAL BEDS, MANY STILL EXPERIENCED PERSISTENT DELIRIUM, FUNCTIONAL DECLINE, AND DYSPHAGIA.

Nurses and case managers can be a solution to this problem. "Nurses and case managers have their own communication and may have a better appreciation of care complexity for ICU survivors," Kim explains. "For case management — essential in transition from hospital to home — these patients may have interim skill needs."

They may need additional help at home with physical therapy and activities of daily living. "The case management is essential in communication with patient and family, and communication could start in the ICU," Kim says. "The syndrome of delirium, functional decline, and dysphagia is so common that all patients may need speech and swallowing examination on discharge."

This first study was a needs assessment to find out what was happening on the floor. Investigators also are working on a second study, surveying nurses, nurse practitioners, and others who receive ICU survivors to study their perceptions.

"Now that we know there is a care gap, our next step is to see what is the perception of the receiver," Kim explains. "Our goal is to improve the quality of care for ICU survivors."

Kim and colleagues also want to build evidence-based guidelines, like bundles, protocols, and curricula that nurses and case managers can use to improve quality of care and minimize poor outcomes associated with the ICU stay.

Gaps in Care Fuel Readmissions

From a health system's perspective, the gap in care for ICU survivors results in higher ICU readmission rates. "Twenty-five percent of patients still had an indwelling bladder catheter, and that was associated with higher ICU readmission rates," Kim notes.

This suggests patients would benefit from a bladder scan. The

results would make it clear whether the catheter should be removed. "In our hospital, when people come out of the ICU with a Foley catheter, we initially start with a bladder scan to make sure they don't retain too much urine," Kim explains. "We take out the Foley and give them eight hours."

Nurses can help patients cope with becoming ambulatory to quicken their need to urinate without a catheter. After eight hours, they can perform another bladder scan to see if the patient is retaining or not producing urine.

"If they're retaining too much urine in the bladder, then we do a straight catheterization, putting in a little catheter and draining whatever is in the bladder to relieve the pressure and to make sure urine is coming out of the body," Kim says. "This is temporary, and the risk of infection is much less than an indwelling catheter, especially for elderly men who may have prostate problems."

When patients still struggle to urinate after several trials, and the bladder scan suggests urine standing in the bladder, the Foley catheter can be reinserted. "This requires a lot of communication and protocols with the nursing staff," Kim says. "Nursing has to do the bladder scan, straight catheterization, put in an active order, and start medications. It takes a multidisciplinary effort to reduce complications."

Nurse case managers and social workers also are needed to help patients and family members cope with the fear of going home with a Foley catheter, if necessary. "Case managers and social workers can play a major role, saying, 'Even though we do keep you on a Foley and catheter bag, when you are ready for discharge, we can connect a leg bag to wear next to your thigh,'" Kim explains. Patients can go out in public with the thigh bag without anyone noticing.

Case managers also can reassure patients that after a few weeks, the Foley catheter likely will be removed. "Case managers can give hope to patients and family members," Kim says.

Another role for case managers is to help patients and families with expectations. Family members may not have noticed the patient's cognitive decline before the hospitalization. From the clinician's perspective, the hospitalization worsened an underlying condition and caused a rapid decline.

"There are some cases where ICU survivors go through so much and get transient delirium," Kim adds. "In those cases, case managers can set expectations for family members."

For example, case managers can introduce the idea of sending the patient to the rehabilitation unit after ICU, she says. Rehab can serve as a bridge before the patient is discharged.

"A lot of family members have guilt of sending their loved ones to rehab; they feel pressured to bring them home because they love them so much," Kim explains. "Case managers can introduce the idea that rehab is not neglecting, but is only a bridge until they get out of acute illness."

Case managers also can introduce the idea of palliative care, hospice care, or home visits to families of patients with worsened dementia. ■

REFERENCE

1. Kim E, Kast C, Afroz-Hossain A, et al. Bridging the gap between the intensive care unit and the acute medical care unit. *Am J Crit Care* 2021;30:193-200.

Hospitals Without Walls Transitions Reach New Level

By Melinda Young

As the pandemic continues, some healthcare facilities worldwide are providing acute care to patients in their homes. This is a necessity in places where the health systems have been overwhelmed. In other places, it is a way to provide care that might even be safer for certain medically stable patients.

"The Centers for Medicare & Medicaid Services calls it Hospitals Without Walls," explains **Chrissy Finn**, RN, BSN, MSN, director of InterQual Content Products at Change Healthcare in Nashville, TN. "It was something that was initially trialed in the United Kingdom. They looked at cardiac heart attack patients initially, and it's something that quickly gained traction."

Australia implemented a hospital at home program that affects a small proportion of its overall hospital days, she adds.

Screen for Eligibility

Physicians, nurses, case managers, and other team members can screen patients for hospital at home eligibility and handle transitions of care. "Hospital in the home is just starting to gain traction here in the United States," Finn says.

Early research showed this acute care model can increase patient satisfaction and decrease nosocomial infections.

The pandemic has played a role in bringing this model to more people's attention. "In the COVID-19 pandemic, hospitals are looking at how to manage keeping older and sicker, frail patients out of the hospital, where they could come into contact with COVID," Finn says.

Managing them in the safety of their homes is an option that has been explored by hospitals around the world. "And how do we manage COVID patients who have a longer length of stay [LOS]?" she asks.

Once a COVID-19 patient is stabilized, but perhaps needs a longer course of intravenous treatment, they could be managed at home, as long as they are stable. "People are looking at hospital in the home as a LOS reduction tool," she adds.

When patients are sick with the disease, they need the hospital's acute care setting. But once they are stable, they could be a candidate for hospital at home with its close monitoring and intermittent nursing visits. Some organizations have moved in that direction.

"Certainly, the pandemic has forced us all to think creatively about how to best manage patients and where we're at from a technology standpoint," Finn says. "It's opening doors and making a lot of things possible that were not possible before."

Post-baby boom populations also are more interested in alternative models for acute care. "I think people in my generation, and I'm in my 40s, really don't want to go to the hospital," Finn says. "I want to stay in the comfort of my own home with my bathroom. It's promising that healthcare is trending in this direction."

Funding this type of care model is one crucial issue. "The biggest barrier is the payment component. We need a reimbursement model for it," Finn adds.

Patients who would traditionally be managed on an acute care floor in a hospital are provided the same level of care in their home. Typically, patients have presented to the emergency department or a primary care provider with a medical complaint. Then, based on their clinical stability, the suitability of their home setting, and their condition, they could be triaged into the hospital at home model.

"Do they have electricity, a caregiver? How easily can we get them set up with this technology?" Finn asks. "[Providers] make sure patients have adequate bandwidth to hook up to remote monitoring, and they arrange nursing visits, physical therapy visits, lab draws, medications, linen, and a bed."

Even meals can be provided in the home setting. "Some of our local customers were starting a hospital-in-the-home pilot program in 2017," Finn says. "They were utilizing the level-of-care screening guidelines we have to support their pilot to make sure they were truly admitting acute-level patients to the pilot program."

They wanted to compare outcomes, and used InterQual's criteria to support the pilot's screening process, she adds.

"We released hospital in the home screening guidelines in 2018," Finn says. "Our content is to look at who belongs in the hospital and who doesn't, and to make sure we are admitting patients on severity of how ill they are and the intensity of services we provided as part of their hospital stay. We provide guidance or a framework to make sure they look at all these components," Finn

says. "Did they appropriately screen the patient? Is the patient stable enough to be managed in the home setting? Does the patient agree to participate?"

They also ensure the patient's level of service is appropriate for a home setting, based on clinical findings and the physician's orders.

"The future of hospital in the home will be based on setting up programs and protocols and following those steps to make sure you're admitting the right patients to your program," Finn says. "You have to follow discharge protocols to see when patients might be ready to enroll in a hospital in the home program, or when they are ready to be discharged from the program once they're in one."

It is not a fit for every patient who meets the criteria. "If you have a patient who lives alone and is highly anxious, they might not want to sign up for this program," Finn says. "The best way to describe it is that you have the ability to be in your own home, be comfortable sleeping in your home with your own pillow, have your own private bathroom, and being with your family on a day-to-day basis." ■

How Case Managers Can Use Data to Improve Care Delivery

By Jeni Miller

What good are data if they are not used? Many case management departments collect data and report trends, but the information is only as good as how the hospital uses it. The extra effort is worth it. Case managers and their departments who use data in meaningful ways experience better outcomes — but the decision to be resourceful often starts higher up.

"Case managers must depend on their leadership to share data and information related to their roles, particularly around denials and appeals, discharge planning, length of stay, readmission rates, and value-based purchasing," explains **Toni Cesta**, PhD, RN, FAAN, owner and consultant with Case Management Concepts in North Bellmore, NY.

For many hospitals, data consumption is not just helpful — it is required.

"Hospital case managers and case management leaders have an obligation to consume data," said **Jeffrey Echternach**, MBA, AS, NRP, DSC, technology officer at the Center for Case Management. "The data imperative is equally important for all leadership levels within case management, as this department is frequently viewed as the clinical arm of the revenue cycle and influences a number of essential metrics for hospital operations."

A Data Treasure Trove

Echternach notes each level of staffing can glean different, helpful information from the collection. Frontline staff can learn about key trends affecting their patients and the hospital. Leaders can share top impact metrics and their relative influence with staff, in addition to key actions that will shift these metrics in a positive way. Both can leverage data and business intelligence tools to drive positive changes through performance improvement initiatives that drive efficiency and better patient care.

What kind of information is out there?

"[The kinds of data available] vary widely depending on the case manager job role — frontline staff vs. leadership — and the maturity of the business intelligence tools and curated metrics that are made available by the organization," Echternach says.

Generally, case managers respond to data per encounter while leadership is more concerned with analyzing trends for a particular unit or division of the hospital, or the entire hospital. With that in mind, case managers might be accessing data more frequently, perhaps daily or even hourly. Echternach explains their data considerations usually include:

- length of stay (LOS);
- LOS variance from expected LOS;
- status (such as inpatient vs. observation);
- insurance information;
- approvals and authorizations;
- use of healthcare services (including past hospitalizations or emergency department visits);
- problem list and current or active diagnosis;
- social determinants of health (SDOH) and support systems;
- assessments, missing assessments, or gaps;
- medications, coverage (insurance), accessibility;

• hospital bed availability, hospital bed demand;

• readmission risk (calculations and artificial intelligence tool predictions);

• post-acute destination availability;

• denials of continued stay or admission coverage from insurance;

• medical necessity;

• charges.

"The case manager is an advocate for the patient, balancing benefits, patient interests, and hospital utilization," Echternach says. "As such, they are evaluating length of stay, appropriate testing and test setting, [and more]. Embracing and maximizing the use of data and/or technical tools to augment the practice serves the best interests of the patient and hospital."

For those in leadership roles, the most useful data when analyzed for trends, leading to opportunities for improvement, include:

• LOS (observed to expected);

• case mix index;

• status changes and patient mix;

• observation with excess LOS;

• use of target or appropriate bed space;

• approved days vs. total, denied days vs. total, percentage of denied days overturned;

• avoidable days, stratified by reason;

• readmission rate, readmission interventions, post-discharge compliance for high-risk cases;

• population portion with a positive SDOH finding;

• SDOH population with one or more referral or active/documented community support;

• time to first assessment;

• time to first medical necessity appraisal;

• discharges by post-acute destination;

• patient choice turnaround time;

• referral to post-acute turnaround time;

• discharge processing turnaround time;

• long stay cases;

• high-dollar cases;

• clinical denials, concurrent denied trends by reason;

• high utilizer rates, high utilizer interventions, and response rates.

From Treasures to Tangibles

Taking the data to the next level and turning it into tangible opportunities for change is the most valuable part of the process.

"Case managers can see how their interventions are having an effect on the department, the organization, and their patients," Cesta notes. "These data allow for continuous quality improvement. Without feedback, staff do not know where they are doing well or where they may need improvement."

According to Cesta, improvements made because of data can have a positive effect on quality of patient care as well as hospital finances.

"Constant improvement can result in both financial as well as quality gains," she explains. "On the financial side, denials can be reduced, and length of stay can be shortened. Value-based purchasing scores can alert the staff to areas needing improvement around cost and length of stay as well as readmission rates. Most of the case management outcomes can be calculated in terms of dollars."

Case managers also should be sure to track their "saved days," which are those days taken off the LOS following a case management intervention that resulted in an earlier discharge for the patient, Cesta says. When case management prevents an unnecessary admission or readmission, these interventions are tied to cost savings, and should be quantified as such.

In situations like those seen during the height of COVID-19, when some hospitals were beyond full, case managers who use data well can help make a deep impact in helping the hospital function under stress.

"In some cases, when hospital capacity is stretched to its limits, the case manager's keen focus on utilization and level of care supports the greater good by helping clinicians with earlier identification of discharge options, downgrade options, and the creation of bed capacity to make room for additional demand," Echternach adds.

Knowing how to translate the data and trends into deliverables can involve a steep learning curve. According to Echternach, many hospitals that are actively engaged with their data and make subsequent efforts to improve performance have:

• **Cost savings per case.**

• **Wider access.** By shortening LOS, hospitals can expand bed access, leading to more admissions, shorter wait times for existing admissions, and lower variable costs when admission demands are low or fulfilled.

• **Cut readmissions with like causes.** Preventing these situations can improve hospital margins and lead to improvements in disease management and compliance. Overall, reducing readmissions will contribute to favorable evaluation on value-based purchasing scores.

• **Improved efficiency.** Evaluating trends in reaction time or processing time and prioritizing improvements leads to time savings.

But to achieve these goals, case managers and leaders need to commit to engage with their data regularly, with an eye toward using it for performance improvement and cost savings.

"For case managers and social workers to see how they are doing, both good and bad, they need to see these data on a regular basis," Cesta shares. "Data sets can be aggregated in a case management dashboard that is populated on a monthly basis and shared at a staff meeting. In this way, trends can be analyzed, and areas for improvement can be identified. This data collection falls under the responsibility of the director or manager of the department."

Echternach shares the example of a hospital in Massachusetts that evaluated historical discharge data compared to bed capacity and identified a target and minimum number of discharges per day.

"This 'magic number' became a cornerstone of daily operations, stimulating action-oriented conversations when the morning bed huddle review demonstrated that predicted plus confirmed discharges for the day did not meet demand," he explains. "Discussion moved from hypothetical and weak to action-oriented and objective. 'If we need 83 discharges today, and have a combined total of 67, then ….'"

About That Learning Curve

Since it takes time, trial, and error to turn data analysis into meaningful action, it is wise for case managers and leadership to employ the help of professionals, including an in-house analyst, and seek resources to guide discovery.

"Some departments have a data analyst embedded in the department, but many do not," Cesta notes. "Some hospitals have support staff who will run the data for the departmental leadership in a decision support department, or the like. In other instances, specialized case management software will populate a dashboard for the users. The director of the department should be sure to report the data in a format that is understandable to all, both within the department itself, but also for others in the organization."

Echternach advises case managers to "learn from each other," including tips and tricks they have learned in small group forum. Similarly, he says, "leaders can inform the staff on interpretation of data. Further engaging with subject matter experts from other departments in different types of learning events can enrich the learning experience."

Other learning opportunities in data literacy are available through organizations and consultants, like the Center for Case Management, who can help leaders explore case management metrics, productivity, payer trends, denials, hospital capacity, and support case management department leaders in connecting case management practice to the influence of outcomes. Groups like these also publish articles, blog posts, video-based education, and direct training.

Case management departments are a powerful force for the hospital's performance, both in quality of patient care and finances. Bringing in powerful data tools and knowing how to use them can set the case manager and leadership up for success — and the results often are priceless. ■

Helping Patients with Alzheimer's Disease and Dementia

By Jeni Miller

Regardless of whether they realize it, case managers have likely worked with patients who are living with Alzheimer's disease or dementia. The diagnosis rate is relatively low, says **Michelle Cornelius**, LMSW, EdM, director of memory care programs at Cypress HomeCare Solutions, as "typically only 50% of people with dementia are actually diagnosed with the disease." Researchers with the DelpHi Trial found a formal diagnosis of dementia is between 50% and 80%, even in wealthy countries with advanced medical care.[1]

"People are often afraid to go to the doctor and get a diagnosis, or they think that nothing can be done anyway, or that it's a normal part of aging, which it's not," Cornelius explains. "Other people worry that if they get a diagnosis, they'll have to change how they're living. When people do talk with their doctor, sometimes they take a 'wait-and-see' approach, so they don't get diagnosed as early as they should."

Even when a formal diagnosis is made, treatment is not necessarily

offered — and for many patients, the diagnosis largely is overlooked. When people with dementia are admitted to the hospital (with or without a formal diagnosis), staff and case managers may be unaware of the unique care this population requires.

"People are interacting with patients with dementia, and no one knows it," Cornelius says. "When patients living with a form of dementia enter the hospital, case managers may notice language deficits, holes in their social mores, difficult interactions, and more. Many understand dementia to be just about memory loss, but it's so much more than that."

Under the Surface

Cornelius describes dementia as a largely hidden disease, one that can surface at times and seem to recede at others. "Sometimes, a person with dementia can act as if everything is fine and normal, so case managers and others may take their words at face value, which leads to recording things that are incorrect."

A case manager may choose to keep the possibility in mind during assessments and other interactions, even when the patient's chart does not indicate a dementia diagnosis. If the patient seems particularly forgetful, asks the same question repeatedly, or is asking where they are, it might be wise to consider dementia. Listening carefully can help shed some light on what might be going on beneath the surface.

"I've had people with dementia sit next to me and tell the nurse that XYZ happened, when nothing of the sort actually happened," Cornelius shares. "The brain fills in gaps. The patient isn't trying to lie or speak untruths. Their brain is just trying to carry the conversation so that they don't appear as though they don't know the answer. Sometimes, it's just the brain's truth. There is no point in trying to argue or correct them. That's simply not going to work."

Detecting and Connecting

Since case managers are experienced in serving a variety of patients and are accustomed to gathering detail, they likely will be successful when asking leading questions and paying close attention to behavior, which is a particularly high form of communication for people living with dementia.

When entering the patient's room, Cornelius explains, "introduce yourself to [the patient], even if you've already been there. Talk with them, find out the names of their family members, and above all, use validation practices to validate their experience."

For example, Cornelius suggests when a patient is adamant he or she wants to go home, the case manager can respond in kind by repeating, "You want to go home." Another recommendation is to diffuse the situation by providing a comforting food or drink and asking the patient to talk about his or her home. "Here is a glass of apple juice. Tell me more about your home," or "Here is a cookie. I bet you've had these kinds of cookies at your home, too."

Finding common ground with the patient, or at least learning about what he or she likes, can help calm the patient and create a better atmosphere for discussion.

"Find out what gives them joy," Cornelius says. "Do they like music? Bring in a radio. Be proactive. They may love music, but won't necessarily make the connection or ask for it. But if you make that happen for them, it could instantly reduce their anxiety."

Creating a Safe Space

Since high levels of anxiety and visible agitation are common for people living with dementia, it is important for the case manager or other hospital staff to create a safe, calm environment for the patient. Before looking to medicate the patient, it is wise to spend time finding out what is going on and if the patient is anxious because he or she is legitimately concerned for their safety and well-being.

"Medication is not always the right choice," Cornelius explains. "If the patient seems upset about something, the case manager has an opportunity to be a detective, to figure out what exactly is going on. Because of the way the brain operates for a person with dementia, their repeating of 'I want to go home' may actually indicate that they feel unsafe, feel lost, or don't know who is around. In this case, anti-anxiety medication may not necessarily be needed; rather, they need someone to make them feel safe."

Whoever is in the room at a given time is the right person to help the patient feel safe and secure. Due to the nature of the disease, the patient might experience a fleeting sense of safety and security. While he or she may have become calm during a previous interaction, the next person who enters the room may need to reassure the patient he or she is safe. The case manager can help the staff by charting how the patient appears, how he or she responds, and the appropriate words to calm the patient.

While many patients can benefit from their family or loved ones

communicating with their hospital case manager, it is important in the case of a patient living with diagnosed or undiagnosed dementia.

"For those without a formal diagnosis, the case manager may want to reach out to the family to say, 'I don't know if your loved one has a memory impairment or not, but here are some resources you may find helpful.' We need to be willing to hand things out without the diagnosis, especially because out of the 50% who are formally diagnosed, only 50% even acknowledge it."

For a patient with a formal diagnosis, the case manager still might face unique challenges when broaching the topic with family members.

"Families can have a tough time opening up and telling you what's going on if they don't think you understand dementia," Cornelius explains. "It's hard at home. It's a grief process as they slowly lose this person they love, and often the patient's family member wants to seem capable of caring for their loved one while at the same time not wanting their loved one to look like they are unable to do what they need to do."

The patient's family needs a case manager who understands the caregiver's situation and will not judge them. Caregivers might be hesitant to tell the case manager "how they have to secure all the doors to keep the person home, or hide all the shoes to keep them from walking away," she says. "They don't want you to know that their person is less than capable."

One way to approach the patient's caregiver in a disarming and effective way is to ask pointed questions to show you understand what is going on. "Rather than asking if they are showering their loved one at home, it's better to ask, 'How are you showering this person at home?'" Cornelius suggests. "This type of question can elicit answers that indicate what struggles they are having at home, allowing the case manager to focus the intervention or recommendations for care. Usually, case managers are comfortable with asking those questions, but sometimes they may not ask because they don't want to offend the caregiver, especially if they seem more guarded."

Once a connection is established with the family, the case manager can provide them with resources to help at home — especially considering most doctor's offices are not likely to offer much information, even with a formal diagnosis. The family connection is important for patients living with dementia or Alzheimer's — the case manager cannot rely on the assumption that any information or instructions they give the patient will be remembered or followed.

Extending to the Community

Gathering resources on dementia and Alzheimer's can start with connecting to the Alzheimer's Association, which provides information on several forms of dementia. Cornelius also recommends "starting within whichever location [case managers are] in and connecting with the big hitters in that area."

Local organizations often provide staff training, lunch-and-learn sessions, and other continuing education. "It's a win-win," Cornelius adds. "Case managers connecting with the community helps both parties. You get to know the community partners, and they're helping you understand dementia better. What all of these organizations want is to be partners with hospitals so when case managers reach out to the memory care agencies, a real connection takes place."

If case managers need to discharge a patient to a memory care facility, Cornelius suggests considering both the care needs of the patient and the family's budget. She also notes case managers should look for facilities whose entire staff is well-versed in memory care.

"If only the dementia care nurses in the facility are good at it, that may not help the patient or family," she says. "But if everyone is — including the dining staff, the housekeeping, everyone — that is a great thing."

Finally, she recommends case managers check in regularly with patients, families, and their hospital's emergency department (ED) to better understand the quality of local memory care facilities.

"You do have to continue to get feedback from patients, and especially from the ED, because they'll know which facilities are constantly sending patients in or even dropping them off at the door without sending a staff member to escort them in and stay with them," Cornelius explains.

Most importantly, caring for patients living with dementia requires an excess of patience.

"Take a deep breath and be patient with yourself and patient with them," Cornelius says. "They'll pick up on your energy, so if you are a calming presence, they will likely be calmer. Being OK with having the same conversation over and over, and knowing every case is different, can help keep expectations realistic." ■

REFERENCE

1. Eichler T, Thyrian JR, Hertel J, et al. Rates of formal diagnosis in people screened positive for dementia in primary care: Results of the DelpHi-Trial. *J Alzheimers Dis* 2014;42: 451-458.

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log onto ReliasMedia.com and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

CE QUESTIONS

1. **According to an American Nurses Foundation survey, what percentage of nurses said they wanted to quit their jobs?**

   a. 15%
   b. 28%
   c. 42%
   d. 50%

2. **According to researcher Eileen Kim, MD, which conditions were common among patients transitioned from the ICU to hospital beds?**

   a. Fatigue, low mobility, cardiac issues
   b. Low appetite, high blood glucose
   c. Delirium, functional decline, dysphagia
   d. Incontinence, poor breathing function

3. **Approximately what percentage of people living with dementia have been formally diagnosed with the disease?**

   a. 20%-30%
   b. 5%-10%
   c. 50%-80%
   d. 90%-100%

4. **If patients with dementia seem anxious or agitated, one likely reason is:**

   a. they feel unsafe.
   b. they are difficult patients.
   c. they need medication.
   d. they are receiving poor medical care.

CE OBJECTIVES

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

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

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

The Role of the Social Work Case Manager Across the Continuum of Care

By Toni Cesta, PhD, RN, FAAN

The continuum of care is defined as "an integrated system or package of healthcare support services that assures comprehensive, coordinated care for patients based on individualized service needs." For patients with a disease, this covers all phases of illness, from diagnosis to the end of life.

Social workers play a vital role on the interdisciplinary care team across the continuum of care. Working in concert with RN case managers and other members of the healthcare team, they assist in guiding and tracking patients over time through physical health, mental health, and social services, spanning all levels of intensity. We will review the evolving role of social work professionals across the healthcare continuum, both within the acute care setting and beyond the walls of the hospital.

CASE MANAGEMENT IS THE GLUE THAT HOLDS THE CONTINUUM OF CARE TOGETHER. INTEGRATED CARE CANNOT HAPPEN WITHOUT IT.

Case Management Across the Continuum

The continuum of care includes a wide range of services. Social workers are needed for high-risk patients at all points along that continuum. Examples of these services include:

- hospital;
- emergency care;
- urgent care;
- home health;
- skilled nursing facilities;
- hospice;
- adult day care;
- primary care;
- ambulatory care;
- sub-acute care;
- rehabilitative care;
- wellness centers.

The challenge for healthcare providers today is to understand the best methods of integrating these services. This is where case management comes in. Case management is the glue that holds the continuum of care together. Integrated care cannot happen without it. Case managers provide these important linkages across all healthcare settings and providers.

The Role of the Social Worker in Acute Care

The social worker role in acute care can vary depending on the type of model the hospital uses. The various combinations include:

- psychosocial support and interventions;
- discharge planning;
- psychosocial support, interventions, and discharge planning.

In some instances, a physician or RN case manager refer patients to social workers. In other examples, the social worker may self-refer. Patients also can request these services. In the integrated case management model, RN case managers assess patients to determine whether they meet high-risk criteria for referral. This is performed during the initial admission assessment.

As one reviews the data sets, note the social work referral triggers. These triggers must be individualized by

each hospital implementing the tool. These triggers cover social workers who are performing some elements of discharge planning as well as psychosocial support and interventions. The case manager completes this assessment and refers to the social worker as needed. Additionally, the home care referral criteria are embedded in the assessment so referrals can be made to home care early in the stay.

The process of including these criteria in the admission assessment provides for an early and comprehensive referral based on predetermined criteria. This is critical in several ways:

- reduces the risk of overlooking high-risk patients;
- front-loads the referral process by making referrals early in the hospital stay;
- provides a structure for the RN and social work case manager to work together on high-risk patients;
- provides the social worker with information to help him or her determine if they will follow the case (they can refuse if no needs are identified);
- informs the social worker as to what psychosocial interventions might be needed during the hospital stay.
- provides information that might inform the discharge plan.

Acute Care Social Worker Case Loads

Social workers identify and carry psychosocially complex patients. Roughly 30% of all hospitalized patients will require the services of a social worker while in the hospital. Because only high-risk patients are followed, caseloads are consistent regardless of the patient's clinical area.

Unit Type, Social Worker/ Patient Ratio:

- Medical: 1:17;
- Neurology: 1:17;
- Surgical: 1:17;
- Intensive care: 1:17;
- Step-down (intermediate): 1:17;
- Pediatric: 1:17;
- Obstetrics/Gynecology: 1:17;
- Acute Rehabilitation: 1:17;
- Observation: 1:17.

The Social Worker in the Outpatient Setting

Community-based providers work with social work case managers to identify and treat patients with high-risk psychosocial needs that may affect their ability to manage their care in their home or other setting, including areas such as subacute. Patients who are struggling with managing their care are at greater risk for returns to the emergency department or admission to the hospital. While the clinical team manages the medical needs of the patient, the social work team manages those psychosocial triggers that, if not addressed, can cause negative outcomes for the patient. The identification of high-risk, high-cost, high-volume groups can provide a good starting point for identifying these patients.

Social workers, through high-risk screening, identify those patients at highest risk and intervene as needed. Examples of high-risk groups include:

- geriatric;
- chronically ill;
- underinsured;
- uninsured;
- behavioral health issues;
- substance abuse;
- homeless;
- catastrophic illnesses;
- frequent readmissions.

In addition, it is important to consider the category of "rising risk" patients. These are patients who may fall into low- or moderate-risk categories but are at risk for poor outcomes without case management intervention. The intervention needed may be less than other patients, but will be important in maintaining these patients in the community.

Each provider setting must choose the criteria most relevant to them and their patient population. Note that some criteria are high-risk, some are financial, and some are social. Each criterion may bring issues that cannot be managed well by patients and/or their support systems. The table on page 3 is a high-risk screening tool that helps the social worker identify the specific areas that may require social work intervention or support.

Social workers function as the primary case manager for patients with psychosocial or financial issues. They also might provide support to patients with clinical issues. In the second case, the social worker collaborates with the RN case manager. Some patients only might require some brief counseling. As in the acute care setting, the social worker may carry some patients for a short period. Others may require long-term support.

Patients receiving community-based case management services are stratified into low-, moderate-, or high-risk groupings that further help identify the duration and level of support they may need.

While staffing varies and always should be individualized, there are some general parameters when staffing for a community-based setting. Many times, these caseloads

Social Work High-Risk Screening Tool		
Date of Assessment:	**Consulted By:**	**Reason for Consult:**
Family/Social Support: • Marital Status: - single; - married; - divorced; - widowed. • Relationship(s): - stable and supportive; - conflicted; - minimal interaction; - unsupportive; - abusive; - highly stressed. **Support System:** - available/helpful; - available occasionally; - available with incentive; - effective; - limited; - none. **Household Composition/ Caregivers:** • name; • location; • availability. **Housing:** • single-story home; • two-story home; • apartment/level; • condo/townhome; • shelter; • hotel; • housing authority; • other. **Mental Health:** • Counseling/Psychiatric Treatment: - none; - past; - current. • Mental health counselor/ caseworker. • Use of medications for psychiatric illness.	**Substance Use:** • Nicotine - yes; - no; - past; - frequency; - last use. • Drug Use: - yes; - no; - past; - frequency; - last use. • Alcohol Use: - yes; - no; - past; - frequency; - last use. **Legal Issues:** • incarceration; • probation/length; • parole; • driving while intoxicated/public intoxication. **Religious Affiliation:** • active; • inactive; • unaffiliated. **Employment Status:** • full-time; • part-time; • unemployed; • retired; • disabled. **Occupation:** **Employer:** • last date of employment. • Employer aware/supportive? - Yes - No **Income Status:** • patient's primary income source/ amount; • additional income source/ amount.	**Disability Status:** • short-term disability; • long-term disability; • FMLA/date; • Social Security Disability; • SSI; • Social Security. **Positive Characteristics (Strengths):** • well-informed; • processes information well; • appropriate affect; • motivated; • realistic; • insightful. **Negative Characteristics (Concerns):** • stressed; • inappropriate affect; • evasive; • cautious/suspicious; • anxious; • angry; • hostile; • exhibiting symptoms of depression; • difficult to engage. **Factors to Consider:** • history of family dysfunction; • limited support system; • current substance abuse; • problems with transportation; • unable to read; • limited ability of the primary caregiver; • limited finances; • language/cultural barriers; • emotional problems; • poor coping capacity; • history of noncompliance; • limited understanding; • other.

are based on insurance coverage. Generally, Medicare patients present with clinical issues but also might experience financial or social issues. They represent the highest-risk group.

The second highest-risk group is the Medicaid patients who often present with social and behavioral health and/or chemical dependency issues. The lowest-risk groups are the commercially insured patients as they are employed and tend to be younger and more stable.

Social Workers' Responsibilities

• Identify, screen, and assess in a timely manner those patients and families/significant others who require social work service consults.

• Integrate the social work plan into overall patient care through interdisciplinary collaboration.

• Provide professional social work services in the areas of comprehensive case management, discharge planning, continuing care services, advocacy, clinical social work services (including crisis intervention), and appropriate education to patients and families/significant others using appropriate modalities.

• Understand and use hospital and community-based resources and government funding. Refer patients, families/significant others, and hospital staff to appropriate services to ensure continuity and quality of care.

• Develop and use specialized knowledge of resources related to the needs of specific patient populations. Facilitate the business department's efforts to obtain insurance coverage for hospital- and community-based services.

• Document patient care plans, staff interventions, and outcomes promptly and completely in the patient's medical record. Complete statistical reports as required by the department and other programs.

• Identify service gaps and participate in other hospital and departmental programs to address and improve quality of care.

• Collaborate with case managers to identify, track, and resolve avoidable delay days and saved days throughout the hospital stay.

• Participate in and assume leadership of hospital and departmental committees.

• Collaborate with case managers to ensure complex patients receive appropriate and timely discharge planning.

Summary

Whether in the hospital or in the community, social workers are an integral part of the interdisciplinary care team. Optimizing the skill sets of each discipline is the best way to ensure patients receive the case management services they need and that the professional staff are working at the top of their license.

Social workers are educated in social, family, and stress management, among other skill sets. Below are examples of social work's areas of expertise:

• biopsychosocial assessments and treatment planning;

• counseling regarding effect of illness and compliance with medical and transitional plans of care;

• crisis intervention regarding abuse and neglect, domestic violence, substance abuse, or trauma;

• identification of barriers to creating a safe and timely discharge plan.

By focusing on these important skill sets, social workers play a vital role in addressing the patient's social or financial issues that may impede his or her achievement of positive clinical outcomes. Resources are limited in any practice setting, so identification and use of the educational preparation of social workers will result in better patient outcomes and improved job satisfaction for social workers across the continuum of care. ■