HOSPITAL CASE MANAGEMENT

COVERING CASE MANAGEMENT ACROSS THE CARE CONTINUUM

INSIDE



Relias Media
From Relias

SEPTEMBER 2021 Vol. 29, No. 9; p. 101-116

# Hospitals and Case Managers Need More — and Better — Disaster Planning

*Care transitions are crucial in mass crisis*

*By Melinda Young*

The ongoing COVID-19 pandemic has shed light on hospitals' and communities' insufficient disaster preparedness plans. Researchers and healthcare professionals say hospitals need to take more concrete steps to better handle the next crisis, whether it is a hurricane, explosion, wildfire, flood — or another pandemic.

"We know that emergency preparedness is absolutely essential for healthcare organizations," says **Paul D. Biddinger**, MD, FACEP, chief preparedness and continuity officer at Mass General Brigham and vice chair for emergency preparedness at Massachusetts General Hospital. "Obviously, with what we've seen in the pandemic, but also with hurricanes like Sandy or Katrina, or in other events, we have to be able to surge our ability to provide care in the time of crisis. That's really hard in a healthcare system that's always being pushed for maximum efficiency and to eliminate waste."

For instance, there is no waste in a system maximizing all resources. "From my perspective as an emergency medical planner, that means we have no ability to surge," he adds.

Since it is not feasible to employ physicians and nurses on the payroll when they are not providing care, or to oversee empty hospital beds when a disaster has not occurred, hospitals need to assess how to deploy their resources and pivot in times of crisis, Biddinger says. This will help hospitals better handle a disaster without adversely affecting patient care.

Hospitals, as well as individual departments such as case management, should create a disaster playbook, says



**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.

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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: This educational activity is intended for nurses and nurse practitioners who work in case management environments.
This activity is valid 36 months from the date of publication.

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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



**Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, senior director of care management nursing at Cleveland Clinic.

Now that every case management department has experienced a national disaster (the COVID-19 pandemic), they understand what skills they need to prepare for the next event, she notes. *(See story on case management best practices for disaster preparedness in this issue.)*

"Everyone had to learn so much on the fly that no one was prepared for," Davis says. "Ironically, at the height of the pandemic, case managers in the hospitals were not that busy because patients weren't coming, and the patients who came in were sick and taking a long time to be discharged."

The lull in activity did not last long, as some hospitals furloughed staff or case managers and other professionals to COVID-19 units or ICUs. Before long, nearly every hospital in the country experienced a surge in COVID-19 patients.

"It's now a double whammy because people have resigned or are taking time off," Davis says. "Our patient activity is increased, so there is stress there."

Case management leaders need to think about how to best use their available staff and what kinds of skills their case managers need during a disaster. "All of our case managers during the pandemic were retrained to be nurses again, and that in itself was stressful," Davis adds. "Even though they were never asked to do anything out of their comfort level, it was still stressful."

The disaster preparedness lessons that emerged during the pandemic were apparent during an earlier flu epidemic, but health systems did not pay enough attention to that crisis, according to the results of a study about the 2017-2018 influenza season.[1]

"We had actually completed the research prior to the pandemic emerging. But as we were doing the data analysis and writing of the study, which happened during the pandemic, we noted very eerie echoes," says **Gavin H. Harris**, MD, assistant professor in the divisions of pulmonary, allergy, and critical care medicine and professor of medicine in the division of infectious diseases at Emory University School of Medicine.

Harris and colleagues read about the problems their research subjects faced with how hospital systems handled the earlier flu crises. They could see the same problems were

## EXECUTIVE SUMMARY

The COVID-19 pandemic and other recent crises have shown the need for improved disaster planning.

- Disaster plans should be clear, well-defined, and ready to implement before a crisis even strikes. This includes preparation for surge, triage, and crisis standards of care as well as skills training for case managers and other health professionals.
- The pandemic bears many similarities to the 2017-2018 influenza epidemic in terms of preparedness and strain.
- Case managers play a critical role in care transitions during these crises and should create a well-defined plan for patient transitions.

happening in real time with the COVID-19 crisis.

"We were very interested in how hospitals respond to strain in general. We used the lens of pandemic strain as a good way to analyze the capacity of hospital administration and personnel to see how they might respond," Harris says.

For example, staffing was strained in terms of how hospitals worked around employee sick call-ins, overtime, and other issues that affect delivery of care.

"The 2017-2018 flu season was the largest epidemic this country had experienced since the H1N1 flu epidemic of 2009," Harris explains.[1]

Disasters disrupt daily work and leisure routines for hospital staff responding to the crisis. But this disruption usually is limited and everyone expects to return to those routines within weeks or months.

This did not happen with COVID-19. "The world went from its day-to-day grind to derailment," says **Wyona Freysteinson**, PhD, MN, professor of nursing at Nelda C. Stark College of Nursing at Texas Woman's University. "The world in which nurses had been in dissipated with COVID-19. They had gut-wrenching fear after [watching] newscast videos. They found themselves cooped up in front of computers or in a COVID unit, which was opened without a budget."

Nurses and other healthcare professionals learned to ration personal protective equipment, which was both infuriating and terrifying, Freysteinson adds.

Disasters can be slow-moving, like the COVID-19 pandemic, or fast-moving, like a large-scale earthquake. The fast-moving disasters do not give a hospital time to prepare staff for emergency conditions, Biddinger notes. With slow-moving disasters, it sometimes is possible to redeploy staff after providing some training for their new role. In the event of a fast-moving crisis, this is not possible.

In some crises, there is no time to train staff before redeploying them, or to create more units to handle the influx of patients, Biddinger adds.

"THE WORLD WENT FROM ITS DAY-TO-DAY GRIND TO DERAILMENT. THE WORLD IN WHICH NURSES HAD BEEN IN DISSIPATED WITH COVID-19."

One challenge for hospitals is that people are surviving massively destructive events like never before[2], says **Michel D. Landry**, BScPT, PhD, MBA, aid worker with the World Health Organization and professor in the department of orthopaedic surgery at Duke University.

"We have to start thinking about what happens to people after they survive emergencies," Landry says. "This is true in COVID-19. We have a whole lot of people who survived with very traumatic, rehabilitation-sensitive conditions."

Case managers play a crucial role in helping patients transition to rehabilitation and other care after discharge. "We have to have a community-engaged process," Landry says. "Hospitals have to use the transition of care — a very clear, well-defined process — to transition people."

Case managers should develop a plan to execute these transitions during a disaster. The worst time to plan for an emergency is when it is happening, Landry adds.

One striking study, which was conducted before COVID-19, showed most physicians and nurse practitioners surveyed said their facilities were unprepared for a recent crisis or disaster.[3] For instance, some practitioners included in the study experienced the Boston Marathon bombing crisis as well as a storm disaster around that time, says **Karen Donelan**, ScD, EdM, Stuart Altman professor and chair of U.S. health policy at Brandeis University and senior scientist at Massachusetts General Hospital.

"One of the things they said after the bombing was that the team they had established in trauma rooms really helped the city cope with that mass casualty," Donelan says. "We thought that we should ask people around the country if they felt like they were in a team, and if that team was ready for a disaster."

Researchers also assessed whether teamwork led to better outcomes for patients as well as better safety and coordination. "We saw that people who felt they were working well in a team were more prepared for disaster scenarios," Donelan says.

Teamwork also is needed between hospitals, emergency services, local governments, and other community entities.

Coordinated efforts between multidisciplinary agencies can strengthen communities' capacities to respond to mental health and other health needs during a disaster, according to the authors of another recent study.[4]

"Case managers and others

can play an important role in the coordination," says **Aram Dobalian**, PhD, JD, MPH, professor and director in the division of health systems management and policy at the University of Memphis. "A lot of the disaster planning focuses on the acute triage needs, particularly in an inpatient hospital setting. Part of this is how do we handle surge capacity, how do we triage patients, and how do we establish crisis standards of care." ■


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# Ways Case Managers Can Improve Disaster Planning

*Case managers are essential to crisis management plans*

*By Melinda Young*

Disaster planning must encompass a growing number of potential crises, including wildfires, flooding, and hurricanes — all of which have increased in recent years. Healthcare facilities also should prepare for events such as terrorist attacks, mass shootings, earthquakes, and pandemics.

Case managers are essential to any crisis management and disaster preparation, says **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, senior director of care management nursing at Cleveland Clinic.

"Case managers need to be part of an overall emergency plan. They need to be used to the full extent of their ability," Davis says. "Case managers need to step up and say, 'Here is how we can help you if there is an emergency.'"

The following are suggestions for how case managers can improve the disaster planning process.

**• Improve annual disaster preparedness training.** When creating a disaster plan, designate alternative space for high-intensity patients in a pandemic or other mass casualty event.

One lesson learned during the pandemic is employees need a place they can go to calm down and practice stress-reducing techniques.

"There needs to be designated quiet rooms for staff to retreat to," says **Wyona Freysteinson**, PhD, MN, professor of nursing at Nelda C. Stark College of Nursing at Texas Woman's University. Disaster plans should indicate which projects will be suspended during a disaster. Documentation should be streamlined.

Training should include how staff can maintain transparent and frequent communication, and how leadership will stay in touch with employees during a disaster, Freysteinson says. From a leadership perspective, disaster planning should address mental health needs and stress levels of staff. Also include ways to


## EXECUTIVE SUMMARY

Effective disaster planning requires improved annual preparedness training, better focus on patient transition, more emphasis on rehabilitation after discharge, strengthened teams, and transitions of care contingencies.

- Case managers should be part of the emergency planning and offer help.
- Disaster plans should maximize efficiency while planning for patients' needs and resilience.
- Teamwork is important during a crisis and helps prepare case managers and health professionals for their roles and responsibilities.

initiate virtual meetings for clinician engagements as well as with patient families.

**• Focus on patient flow and transitions.** Include techniques for improving patient flow within and across the healthcare system to maximize efficiency, says **Paul D. Biddinger**, MD, FACEP, chief preparedness and continuity officer at Mass General Brigham and vice chair for emergency preparedness in the department of emergency medicine at Massachusetts General Hospital.

"It is extremely important that we continue to build on the lessons learned, recognizing how patients need to flow from inpatient to outpatient, and recognizing the connections between hospitals and acute nursing facilities," Biddinger explains. "We've learned very quickly during the pandemic that acute care hospitals that are unable to discharge their patients quickly cannot take care of new patients because they aren't flowing correctly."

Any obstacle to efficient flow creates problems for everyone. "We need to recognize, from the moment a disaster happens, how to discharge from the hospital environment to a skilled nursing facility," Biddinger says. "We have to plan for patients' needs and resilience just as much as we do in the acute care environment."

Throughout the pandemic, the healthcare enterprise has been developing new models of delivering care outside the hospital. These include mobile response programs, hospital-at-home programs, and community paramedicine, Biddinger says. These new models of care allow patients to be transitioned safely home, shortening their length of stay.

"All of these things are rapidly becoming part of the healthcare landscape because of the necessity of the disaster response," Biddinger explains. "We know how we can restart these things very quickly in a no-notice event if we have to rapidly discharge patients in response to a mass casualty incident."

Case managers can create an appropriate outflow for patients during these crisis periods.

"If they have preplanned for that outflow, then they have a whole array of options for safe discharge," Biddinger says. "They are effectively making the healthcare system bigger, and they're augmenting our capacities and capabilities in time to help the hospital admit patients from the ER and elsewhere."

**• Consider rehabilitation needs at the beginning of a crisis.** Hospitalized victims of most disasters, including the COVID-19 pandemic, likely will need some type of rehabilitation care after their hospital stay.

"Historically, we have placed very little attention on the rehab outcome (i.e., what happens after you save a life)," says **Michel D. Landry**, BScPT, PhD, MBA, aid worker with the World Health Organization and professor in the department of orthopaedic surgery at Duke University.

In many disasters, there is little talk about what happens with the survivors. "If we are prepared to preserve life, we better be ready to provide some quality of life to the people we saved," Landry says. "It is not morally appropriate to only consider the acute, immediate intervention; we need to think about the rehab context for people who've survived."

Landry travels to crisis areas around the world, providing rehabilitation training and services to those regions. Among his recent trips were visits to Armenia, following an ethnic and territorial conflict, and to Lebanon, where people were injured after an ammonium nitrate explosion.

"We've had a whole lot of people who've survived these crises with very traumatic, rehabilitation-sensitive conditions," Landry says. "With intervention at the right amplitude and time, you can significantly invert the curve to improve really challenging mental health and physical mobility issues."

**• Strengthen teams.** Research suggests health organizations should encourage and improve teamwork to help units perform effectively in emergency preparedness.[1]

"In general, we found that when there was more team-building activity and collaborative teamwork, there was more of a perception that people were ready for a crisis because they had a way of working through problems," says **Karen Donelan**, ScD, EdM, Stuart Altman professor and chair of U.S. health policy at Brandeis University and senior scientist at Massachusetts General Hospital.

It also helps when members of the team believe their roles are clear. "They feel more prepared for disasters," Donelan says.

Disaster teams can include members of different departments in a hospital or healthcare system. For example, case managers can be part of an emergency department disaster team, and primary care providers can be part of an acute care emergency response.

"In my hospital, we have internal medicine specialists on our medical crisis [team]," Biddinger says. "They come to the emergency department in a crisis because they know it will be crowded and they can help take over the care of existing patients in the emergency room, helping push the stretchers elsewhere to create room for new trauma victims."

The same teamwork is true for case managers, who are an essential part of making sure there is capacity to treat disaster victims, Biddinger says.

Crisis response teams should be configured to include the needed skill sets within the teams. "Do you have people who understand that in that disaster this is what their role becomes?" Donelan asks.

The team's planning and policies should reflect their healthcare organization's environment, including state laws, local laws, and the local market for healthcare labor.

"Will we need to bring in people from other parts of the country? Do we need to do additional disaster preparedness training?" Donelan asks.

Although many major medical centers provide good disaster preparedness training, they were not ready for a different kind of disaster, like the pandemic.

"There are places that are probably really good at floods, earthquakes, fires, and shootings, and have that kind of trauma team. But this type of pandemic is a different type of crisis," she says.

**• Create care transition contingencies for a crisis.** Case management departments can plan for alternative ways to transition patients during a major crisis or disaster.

In 2016, case managers at Cleveland Clinic thought of several contingencies in the event of riots or violence at the Republican National Committee Convention in Cleveland, Davis says.

"Every contingency that could be thought of was thought of. Thank God nothing happened," she adds. "But the pandemic was different. It was a disaster no one was thinking about."

Case managers are excellent at transferring patients, even under complex and challenging conditions, Davis says. During an emergency, case managers can call families or receiving hospitals.

"Those are skills they can do in their sleep," Davis notes. "If you have the time, you can logistically plan transfers during a crisis. Case managers are very good at that."

Case managers can find resources for patients and notify community healthcare providers to ensure patients are transferred safely.

"If you have social workers in your department, they can provide the moral support and counseling that is necessary in the middle of a crisis," Davis says.

During some emergencies, it may be difficult to discharge patients to the usual community settings, including skilled nursing facilities, says **Aram Dobalian**, PhD, JD, MPH, professor and director in the division of health systems management and policy at the University of Memphis.

"The hospital may be trying to discharge patients to a nursing home, but the facility may not have places to put people. They may not be able to care for these patients during a disaster scenario," Dobalian explains. "There tends to be a lack of planning along those kinds of needs and the needs of the medically vulnerable."

Healthcare organizations should identify vulnerable patients. This is where case managers can play an important role.

"They need to identify people with functional or access limitations," Dobalian says. "Because we really don't know how the disaster is going to unfold, there needs to be thinking about this in the immediate response phase." ■

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# Include Staff Mental Health in Disaster Plan

*By Melinda Young*

Mental health needs increase following a disaster. This is true of healthcare professionals as well as disaster victims.

New York City saw an increase in post-traumatic stress disorder (PTSD) after the 9/11 terrorist attack, says **Aram Dobalian**, PhD, JD, MPH, professor and director in the division of health systems management and policy at the University of Memphis.

Healthcare providers and affected populations can feel these long-term effects following a disaster.

"Not everybody is going to be receptive to mental healthcare, but being able to prepare people for it and normalize it ahead of time might make them more likely to seek out care later," Dobalian says. "That could mitigate some of the impact."

Even disasters that seem less personal, like the BP oil spill in the Gulf of Mexico, can raise long-term mental and behavioral health issues, he notes. For instance, people in

regions near the oil spill were affected financially. Some might have become more reliant on substances that affect their marital and family lives.

"It's not unusual for domestic violence or other things to escalate after an event," Dobalian says. "Even something like smoking tends to be exacerbated by larger-scale events."

These problems also affect the people who deliver care. Disasters can increase burnout and stress in healthcare providers.

"Case managers and others may have been impacted by the disaster and some could have a kind of secondary trauma," Dobalian explains. "Organizations like the employee assistance program are not really well-suited to handle those kinds of things."

Crises also can increase stress on healthcare leaders, says **Wyona Freysteinson**, PhD, MN, professor of nursing at Texas Woman's University.

Freysteinson and co-investigators recently found that disaster policies and procedures are needed to alleviate leadership angst, build trust, and enhance communication.[1] For example, case management departments could provide quarterly education on gentle deep breathing and mindfulness for staff as well as the leaders.

"Those three gentle deep breaths can hopefully pull you back into a calmer state," she explains. "The gentle deep breathing technique can return the body to a parasympathetic state."

Mindfulness techniques also can reduce emotional exhaustion, stress, and increase work engagement, Freysteinson says.

During the COVID-19 pandemic, case management leaders and other healthcare professionals sometimes had to change roles to help patients at the bedside or in the ICU. They had to learn how to turn over and transfer as well as provide other bedside care, she says. It would be better in disaster planning if health systems provided their staff and these leaders with clinical training so they could quickly move into these roles in an emergency.

When leaders and staff are asked to change their work routines overnight, they may experience higher levels of stress and distress. The key to helping leaders cope in these disaster situations is to improve communication and to be as transparent and honest as possible.

"Let people know that you're in this with them," Freysteinson says. "When I say I'm not holding anything back, it's me being really honest about where they're at." ■

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# Learn Best Practices for Conflict Management

*By Melinda Young*

One of the most important tactics case management leaders can learn and teach their staff is how to resolve interpersonal conflicts.

During the COVID-19 pandemic, case managers and other healthcare professionals have seen a rise in stress and tension at work. This can lead to more conflicts between employees and managers.

"I think this past year and a half has been very stressful," says **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, senior director of care management nursing at Cleveland Clinic. "We have seen a lot of distress over things that are seemingly not that important, but they become important because of other underlying reasons."

Davis offers these suggestions for how case managers and case management leaders can successfully resolve and manage conflicts:

**• Stay calm and step back.** "Always staying calm is absolutely essential," Davis says. "Really try to listen to what others are saying."

If a conflict arises between two case managers, they should step back a little and try to listen to what the other person is saying. "They can use those techniques that case managers know, which is repeating back what they thought they heard and always looking for grounds for negotiation," Davis adds.

It is important to literally remove oneself from the situation. "If you mentally need to remove yourself, then you can do that within your own mind following some very simple techniques," Davis says.

One technique is to ask oneself the question, "How important is this really?" she says.

Breathing techniques also can help.

"Sometimes, people are really so agitated — it might be a patient or family member — and you just need to excuse yourself from the situation, saying, 'Let's take a break here, and when everyone has a little breathing room, we'll reconnect,'" Davis says.

**• Use negotiating skills.** One of a case manager's skill sets is the ability to always look for grounds for negotiation.

Sometimes, even simple negotiations can be stressful, Davis notes. For instance, two employees might argue over desk location. In these kinds of situations, the case manager should look at the situation from the other person's perspective. The co-worker who is taking a simple issue seriously might have reported to work after a stressful period in their home life, possibly related to the pandemic.

"What's going on at home or in their life is all part of it," she says. "Not that any of us are equipped to fix other people's circumstances, but we can just be mindful that everyone has gone through an unprecedented, stressful situation."

**• Staff scheduling can be rife with conflict.** Often, there are times when a couple of employees will want the same days off from work. It might not be possible to accommodate them both. A lot of people are leaving their healthcare jobs, creating even more tension.

"It seems there is an incredible shortage of not only case managers, but also nurses," Davis says. "The vacancy rate, at least in our area, is quite high."

Staffing shortages create even more difficulties when the hospital's patient population increases, as has happened in many facilities since the COVID-19 case rates have dropped due to the national vaccination program, she adds.

"People are coming back to the hospital for elective surgeries and other non-COVID-19 circumstances," Davis says. "Staffing is very low, so the workload is extremely high."

This makes it difficult for employees to take time off. When a case management leader is faced with a scheduling conflict, such as an employee who wants a specific weekend off even though the manager has explained that this would be very difficult, they should resort to their negotiating skills, Davis says.

"If it's obviously really important to them, then I'll say that we will switch the time around or wait until that date and see what happens, because maybe the conflicting date they're so concerned about won't be as much of an issue later on," she explains. "I ask them if they can live with a little flexibility and revisit it in six weeks."

Case management leaders also should be aware of how anxiety can be contagious among their staff.

"If one person sees a lot of colleagues leaving or quitting work, there can be a kind of panic effect," Davis says. "We need to try to help people calm down and keep the lines of communication open."

For example, the case management leader could say the organization has hired more people to replace those who have left, and they will onboard sometime soon. "Keep communication free-flowing and open so people know what is going on, what we're doing to try and remedy the situation," Davis says.

**• Encourage staff work it out among themselves.** Every day, cases of minor or moderate interpersonal conflicts arise among employees in a department. The leader's role is to teach people ways to keep these to a minimum. *(See story on handling complicated conflicts in this issue.)*

One tactic is to tell employees to work it out between themselves, Davis says. For example, employees could handle some scheduling conflicts by finding their own replacement for a particular day off.

This could be more challenging in situations where staff has recently been reshuffled.

"Finding case managers whose skill set is very specific and unique is challenging," Davis says.

In those situations, leaders might have to think outside the box and engage staffing agencies to help fill in gaps. "They need to make sure they communicate everything they're doing to their employees, showing staff they're doing everything can to find solutions," Davis says. ■

# Some Case Management Conflicts Can Be Tricky

*By Melinda Young*

There are times when best practices and calming techniques might not work in resolving conflicts involving case managers. These situations are trickier and more complex because of behavioral issues or the people involved.

When this occurs, case management leaders need to be more proactive and take charge of the situation.

These are examples of complex conflicts:

• **Bad behavior.** "Sometimes, individuals just don't get along," says **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, senior director of care management nursing at Cleveland Clinic. "They can resort to hurtful behavior to one another. It's important to immediately put an end to that."

A manager must immediately intervene in those situations. For example, a manager could ask the employees to talk through their differences to learn what caused the conflict. They can help the employees understand how their words or actions might have been hurtful.

"We can get so much more accomplished if we're working as a team," Davis notes. "We can solve a lot of problems as a team vs. trying to singularly work on an issue."

Managers can teach staff that part of developing a good team is to have respect for one another. "There's a line one of my old case management bosses said to us, which was, 'We don't all have to go to cocktail parties together, but we do have to respect each other,'" Davis says. "That stuck with me. You don't have to be the best of buddies, but the respect has to be there."

There might be certain staff behaviors and situations where the manager has to call in human resources. "You can't let bad behavior continue," she says. "If my staff can't work it out themselves or they're afraid to, then it's our responsibility to step in. If we can't resolve it, then we do call in human resources."

• **Festering conflicts.** Sometimes, conflicts involve managers and employees. They might not be resolved by simply listening to each person's point of view, Davis notes. When this happens, the manager will have to find a different tactic for resolving the conflict so it does not fester.

"I think managers on the frontlines really have difficulty with that," Davis says. "Conflict management or resolution is not a favorite activity because it can be unpleasant and stressful for the manager."

Leaders need to address these conflicts head-on, knowing they have the tools they need. For instance, they could even role-play on how to work out a conflict between case managers and patients, or an employee and the manager, Davis says. Staff should take advantage of any conflict resolution opportunities.

"Don't feel like they're an exercise in silliness, because they're not," Davis adds. "They're designed to be helpful."

• **Conflicts with physicians.** "Sometimes, you get mixed messages as a case manager," Davis says. "You'll be told to move this patient to a more appropriate level of care, then everyone says you can't send them there because you don't have the right supports in place."

This is why case management is difficult: It requires constant negotiation. "You'll take 10 steps one way, then you have to go down a few steps, and then sideways," she notes.

Case management leaders should teach other case managers about how to practice speaking with physicians and not taking things personally.

"If a physician says, 'Are you kidding? You're not sending the patient there,' you have to just take a step back and think about what they're really saying," Davis explains. "Do they not understand this level of care? Or, did they have an experience with this facility and not like it? You have to find out what the barrier is and why they would not want to move their patient to this level of care."

The more complex a patient's case, the more layers of individuals the case manager will have to go through. This can be frustrating, Davis notes.

"The case manager just needs to take a deep breath and say, 'OK, let's find another angle for this,'" she explains. "Or, they can just listen and say, 'I didn't realize that; we don't have all the answers, either.'"

The best tactic is to listen to everyone's concerns. There probably are legitimate reasons behind them.

"Case managers need to take care of themselves and not take disagreements personally," Davis says. "Nine times out of 10, if you're trying to negotiate arrangements for a patient, it's not personal."

Case management leaders need to remember there is a give and take in their relationships with staff.

"Trust has to be there," Davis adds. "The old saying of 'principles above personality' applies here. They should keep that front and center." ■

# Half of Hospitals and Skilled Nursing Facilities Use Care Integration Activities, Study Shows

*By Melinda Young*

A major point of vulnerability at skilled nursing facilities (SNFs) is the high rate of readmission caused by errors and gaps in care — usually involving medication issues, according to the results of a recent study.[1]

"When medications aren't continuously maintained across the transition of care, or when things get missed, that really ties back to the quality of the handoff between the hospital and [SNF] staff," says **Dori Cross**, PhD, BSPH, study co-author and assistant professor in division of health policy and management at the University of Minnesota School of Public Health.

Inadequate communication and information-sharing contribute to poor care transitions, Cross notes.

"In a lot of cases, there's a real lack of understanding of what that high-quality communication and information-sharing would even look like," she says. "Our research has shown that as the hospital providers and discharge planners are getting patients prepared to go to the skilled nursing facilities, there's not a real clear understanding of exactly what information is needed."

Integration efforts can improve care transitions. "Integration efforts are really about wanting to improve the outcomes, reduce readmission, and have the patient stay comfortably while at the skilled nursing facility," Cross says. "A lot of these integration efforts are about improving tactics, such as care pathways and information-sharing, but it's also about relationships."

Hospital case managers need to build relationships with SNFs to better understand and fulfill the SNF needs, she adds.

Cross and colleagues studied 487 SNF-hospital pairs and found informal integration was most common in 53.3% of pairs. They also noted 43% of the integrated pairs shared clinicians, and 36.5% shared care coordinators. Quality/safety activities were shared in 35.1% of pairs.

Cross and colleagues were careful not to describe optimal integration because there is not one optimal form. "There's everything from leadership teams meeting together quarterly, to building shared pathways, to formal integration," she explains. "Some pairs even have co-location or shared ownership with the SNF."

A crucial aspect of the integration is the hospital sending timely information to the SNF to help provide smooth, continuous care at the point of handoff.

"Our research is showing that hospitals and SNFs are trying a lot of different things, but in some ways, the fact that they are trying multiple different things means they are not quite there yet," Cross explains. "They're still trying to find out what really builds that strength of relationship for integration."

From a hospital discharge planner's perspective, they need to clearly understand what their SNF counterparts need. They need to communicate patients' behavioral health needs, medication and equipment needs, and other important items that would help eliminate gaps of care when the patient is discharged to the SNF.

"Discharge planners have a lot on their plates," Cross adds. "For a successful handoff, there has to be nuanced understanding of the interdependence between the hospital and skilled nursing facility."

Cross and colleagues found sites that shared clinicians communicated information faster and more completely.

"We think that shows a real investment, a real strength of relationship, if the hospital is placing clinicians on site, at that SNF, to bridge the handoff," Cross says. "So much of integration is about a warm handoff and having people to bridge the gaps."

Care coordinators shared by hospitals and SNFs are key to bridging communication between the sites, Cross says. They are part of the needed layers of integration. Hospital leadership, including case management, should be in lockstep with the SNF in what the shared care pathways look like and how the teams will support care on the ground.

"Any single strategy in isolation is unlikely to yield huge gains," Cross explains. "There needs to be a layered, or bundled, [approach] to have the necessary investment to help build that relationship."

The study was conducted to find out how hospitals and SNFs are improving transitions of care. Using shared care coordinators is one of the solutions they asked about, she notes.

"I think that there's a need for both administrative and true operational alignment within those practices to get us where we want to be in terms of investing and integration," Cross says. "Responsibility for the

patient doesn't end as soon as they leave the hospital's doorstep. It is a continuum. Having an understanding of what happens to patients when they are discharged, knowing how to support them, and working with the skilled nursing facility is, to me, true operational alignment." ■

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# New Tool Helps Administrators Evaluate Patients' Need for Care Coordination

*By Melinda Young*

Researchers developed a new tool, the Special Intensity Score, that healthcare administrators can use to determine a patient's need for care coordination across multiple specialist doctors. It also helps with evaluation of care coordination practices.[1]

"We developed it, and then tested it using patient safety indicators," says **Ashley Hodgson**, PhD, co-creator of the Special Intensity Score, Frank Gery associate professor economics, and department chair of economics at St. Olaf College in Northfield, MN. "Some patients need a lot more care coordination than other patients. The basic idea with this score is to identify which patients are going to need the most coordination."

"We ask about specialists and then also about secondary conditions," Hodgson continues. "Conceptually, this is about how many specialists you would expect to see on average based on your diagnoses." Researchers measured ICD-10 codes to determine which specialists were needed.

The tool was developed with internal grants. The investigators have no plans to patent it — they are making the tool available for anyone to use the formula, Hodgson says.

The study included two parts. The main part involved developing the Special Intensity Score and measuring how many specialists a patient would see.

"The one way we tested it was using patient safety indicators, the Charlson Comorbidity Index, which was developed essentially as a measure of frailty — assessing the probability of death," Hodgson explains.[2] "Death isn't what we were interested in; we were interested in care coordination and the patient's complex needs in the health system. Basically, we wanted to see when we compare the two measures — ours and Charlson — which one is more correlated with patient safety incidents."

Hodgson and colleagues predicted the Special Intensity Score would show a more complicated interaction with the healthcare system. They found what they expected. "Our measure is much more predictive of health safety events," she says.

The Special Intensity Score is more statistically significant as a patient safety indicator, but it does not mean a clinician could look at the score and say that a particular patient will experience a safety incident. "It predicts that they are more likely to have an incident," Hodgson explains.

For healthcare leaders, the bigger finding is the score could help them predict the cost of treating patients, the number of visits, and which doctors they will see.

"Basically, if a healthcare administrator is trying to predict which patient you should invest coordination efforts in, and it's expensive to do that for everybody, our score will say which patient should receive more of the focus," she explains. "I think the deal is, most people know that care coordination is a problem. There's been a lot of care coordination measures, but we just don't have good ways of measuring who's doing it well in terms of patient outcomes and triage."

Patients with multiple chronic conditions spend significantly more dollars in the healthcare system, but they are excluded from studies because their conditions are complicated and would make it more difficult to achieve research outcomes.

"They are so much of what our healthcare system does, and yet they're excluded from official research trials because they're too complicated," Hodgson says. "We need more ways to look at and research these patients and how they are involved in the healthcare system because [most] Medicare [funding] goes to these patients with chronic conditions." ■

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# Improving Case Manager Workforce Development

*By Jeni Miller*

Case management is not an ancient profession. Most professionals date it back to the mid-1970s or early 1980s when insurance changes necessitated expert navigation.

As the role of case manager developed, so did the expectations and dreams of how these professionals would be trained to excel in their role.

"We perhaps had a bit of a Pollyanna attitude that this would all fall into place," says **Mindy Owen**, RN, CRRN, CCM, principal of Phoenix Healthcare Associates. "We thought there would be courses in the universities that would be strictly case management-focused and that we would get a place in employer orientation specifically on how to provide case management initiatives and practice. Instead, it often happens that in many places, either you shift into a case management role or you're asked to shift into one, but once you get in and figure out what it's all about, it's a lot of heavy lifting from what your knowledge base is as a nurse or social worker."

Owen explains that, largely speaking, it is the case manager's responsibility to proactively build up their body of knowledge, but they sometimes are grasping for educational tools to get up to speed quickly. While some schools offer a case management curriculum in their academic program, and some hospital systems allow their leadership to build a strong case management orientation, it is not true everywhere. With other specialties, it is more typical to undergo advanced training before the professional enters the specialty role, and as they continue.

"There were a lot more steps, and maybe we were naïve, but we truly had to have more published and built up before case management was looked at as a specialty in the academic world," Owen recalls. "And it is a specialty. I can't work in a NICU, for instance, because I don't have a knowledge base for that."

Organizations like the Case Management Society of America and Commission for Case Manager Certification have come along to provide tools and self-study, but case managers first have to know about those resources to get the education they need.

In particular, case managers need to be solidly acquainted with the financial aspects and sustainability of health systems, Owen says. This comes with a steep learning curve due to state and federal rules and regulations that encompass healthcare. In addition, Owen notes new case managers would be better served if they had a clearer picture of what would be expected of them before stepping into the role.

With many aspects of the case management role not apparent until after the position is filled, it is no wonder employee retention issues run rampant in the industry.

"People come into this with a naïve thought process that they can just plug in and do it," Owen says. "Many people come in not really understanding what the job is really about. Sometimes, they'll come in and their eyes are opened, they're shell-shocked, and then say, 'I don't want to sign up for this.' Now you've hired someone who is going to leave you."

With more focus on the tools to develop the practice of case management, new case managers would have a better idea as to whether they want to work in this specialty, and for a significant amount of time. This is critical because of recent "difficulty in retaining good people in case management for a long time, and especially with the pandemic," Owen notes.

**Toni Cesta**, PhD, RN, FAAN, also sees how a mere quick training in case management can lead to low satisfaction and high turnover in the department.

"Many case managers move into their role with very little foundational knowledge in case management and its related topics," explains Cesta, partner and consultant with Case Management Concepts. "Some may receive a basic 'how-to' orientation from another case manager, but do not understand the 'why' behind what they do. When this happens, their work becomes a series of tasks. This can lead to burnout and turnover."

To avoid this burnout and turnover cycle, Cesta recommends education for case managers include:

• A foundational series of classes in case management geared toward RN or social work case managers, covering reimbursement systems, utilization management, discharge and transitional planning, compliance, coordination of care, avoidable delay management, outcomes, and other topics;

• A preceptorship with another case manager with weekly goals;

• A small assignment to start that is expanded over time.

Other topics that might be covered include federal, state, and healthcare plan regulations; overall financial responsibility; advocacy; social determinants of health; ethics; and communication skills, Owen says.

Education for the case manager, regardless of whether they are new to the role or have decades of experience, is an even more pressing need as the healthcare industry becomes increasingly complex and overwhelming.

"Often, the patients themselves don't know what their health plan covers. If that is overlaid with a factor like depression or a lower socioeconomic status, it becomes even more difficult," Owen says. "Meanwhile, through the pandemic, we have some case managers who work from home, others who are only on site, and as we come out of that we need to ensure better workforce development or we may not end up as strong as we should be."

## Next Steps

One way case managers could approach this better workforce development is through seeking certification.

"Case managers should seek certification in the field of case management," Cesta notes. "Not only does this certification identify them as an expert, but it also requires yearly continuing education. In today's healthcare environment, things are changing rapidly and often. Without continuing education, a case manager will lose that 'why' that drives the work that they do. The theoretical framework of our work is essential in the movement of a case manager from novice to expert."

Case management is an "advanced practice," Owen notes. "Those who are case managers are healthcare professionals who have a responsibility to enhance their individual knowledge base. I believe it is important for both an organization and a healthcare professional to partner in enhancing their training/education."

Much work is needed in building a clear understanding and collaborative support with senior leadership, human resources, and those making hiring and training decisions for case management professionals, Owen adds.

As opportunities continue to present themselves, case managers should participate as often as possible for personal career growth, encouraging others in their profession to do the same. Case management leaders should advocate for those in their department, ensuring these opportunities are available and reimbursed.

"Several universities have implemented online or in-person case management master's programs as well as post-master certificate programs," Cesta says. "Many of the live conferences have moved to a virtual format, and these are always available to case management professionals and should be taken advantage of. Additionally, case management leaders may choose to budget for a program for their staff that is individualized to the hospital and department, and taught by a consultant who is knowledgeable in these topics." ■

# Social Work and Social Determinants of Health Interventions

*By Jeni Miller*

Social determinants of health (SDOH) are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks," according to health.gov.[1] These fall under five domains, including economic stability, education access and quality, healthcare access and quality, neighborhood, and relationships/social context.

Case managers assess and consider SDOH from the moment a patient enters the hospital. That consideration continues throughout the stay and discharge process. When SDOH go unnoticed or unaddressed, the quality of care declines.

"Not addressing SDOH leads to health issues," explains **Bonnie Geld**, president and CEO of The Center for Case Management (CFCM). "People need to make tough choices. For instance, people with chronic conditions often require special diets. For those with food insecurities, they are forced to make poor choices, resulting in poor health or potential hospitalization."

**Thomas Higgins**, MD, MBA, FACP, MCCM, chief medical officer for CFCM and ICU attending physician at Baystate Medical Center in Springfield, MA, has seen how SDOH plays out.

"If you're caring for a diverse group of patients, you will notice that the same diagnosis can affect patients differently depending on their socioeconomic status, where they work and play, and their support networks," Higgins explains.

Historically speaking, this is not a new development. "John Snow, a pioneer of epidemiology, stopped a cholera outbreak in 19th century London by recognizing a neighborhood well was contaminated," Higgins says. "At a basic level, then, medical diagnoses can be related to the neighborhood where you live. Environmental exposure to toxins can be subtle but significant."

Higgins also cites an example of how understanding neighborhood or built environment SDOH can make a difference in how a case manager approaches a patient's care.

"Early in my career, I worked near the Tobin Bridge in Boston. It was well-known that lead levels were highest in children living closest to the bridge, which was periodically scraped and repainted, releasing lead into the environment," he recalls. "Left untreated, lead poisoning causes long-term neurologic damage. If you're aware of these geographic sorts of dangers, you can more efficiently protect the population at risk. You might screen for lead levels more aggressively in an inner-city environment where there is still lead paint in older housing."

Of course, it is not only the patient who is affected by SDOH. The hospital or organization as a whole feels the effects of unaddressed SDOH. Geld notes this can lead to "organizational capacity and financial challenges."

For example, "35-45% of discharge delays and 25% of readmissions are due to SDOH issues," she explains.

Since both the patient's and hospital's well-being are important to the healthcare team, a team approach to SDOH is critical to the health of the organization and those who are served by it. For Higgins, quality communication with a vigilant case manager recently played a key role in helping properly treat a patient — and, perhaps, prevented a recurrence and readmission.

"Every member of the healthcare team has a piece of the puzzle, but value is created only when we share those impressions, including the social determinants of health," Higgins explains. "Last week, I had several patients present with drug overdoses. The case manager shared that one patient swallowed a handful of pills in a dramatic gesture when confronting her husband with suspected infidelity. That's going to require a whole different post-discharge approach than an accidental overdose where fentanyl was contaminating what the patient thought was cocaine. Each of these patients came to me intubated and unconscious, but their long-term success is going to depend on properly addressing their underlying issues."

## COVID-19 as a SDOH

SDOH became a renewed topic for discussion when COVID-19 showed the world just how important risk factors can be, whether medical or social.

"Prior to vaccines being available, one of the biggest risk factors for getting COVID-19 was living in a conjugate setting such as a nursing home, group home, or long-term care facility," Higgins says. "COVID

had a devastating impact on people with intellectual disabilities, even those not living in group settings. The risk of getting COVID has been dramatically mitigated with vaccination, but we need to remember these lessons for the next pandemic, and in communities where people are still vaccine-hesitant. There's no doubt that living in close quarters, pre-existing respiratory illness, diabetes, obesity, and kidney disease are risk factors for COVID. Many of those factors correlate with SDOH."

For Higgins, the lessons do not stop there. The COVID-19 pandemic itself has become a SDOH in part because of the isolation and substance abuse that has quickly escalated over the past year.

"I've been an ICU attending [physician] for almost 35 years, and I've never seen the volume of alcoholism, cirrhosis, endocarditis, and drug overdoses we're seeing now as COVID begins to wind down," he laments. "I've seen some estimates that overdoses are up 30% in the past year, and that might be undercounting based on my experience. COVID has decreased access to medical care for the past year, and there will be adverse effects from delayed screening for cancer diagnosis, an increase in substance abuse, poor diet, and mental health issues for months, if not years, to come."

## Interventions

It is not a hopeless situation. Social workers and case managers can use several tools to uncover SDOH and address them appropriately. Geld points to several interventions that can help case managers better understand the patient's story and circumstances:

- Use a family-centered SDOH screening tool;
- Ensure good psychosocial interventions;
- Identify needs as early as possible in the patient's stay;
- Develop and sustain interventions through team-based care and community collaborations;
- Use grassroots advocacy efforts.

In practice, case managers should be attuned to how their interventions can affect the patient's success following a hospital discharge.

"It might be as apparent as the need to find a place for a homeless patient following hospital discharge, or less obvious, such as when a patient lives in a 'food desert' and can't access nutritious food choices," Higgins says. "There have been a few peer-reviewed studies that show if you invest in social services and integrated models of healthcare, you'll improve outcomes and save money overall, although admittedly you can find negative studies as well. But the more important issue is that patient care suffers if SDOH aren't addressed. Case managers have the knowledge and experience to anticipate care problems and address them."

These interventions can affect acute care or long-term care. For the former, a hospital case manager might register a patient for Medicaid or help her manage "other issues that will prevent them from getting proper care after discharge, [including obtaining] durable medical equipment like oxygen tanks and concentrators, wheelchairs, rides to appointments, and so forth," Higgins adds.

For long-term care, case managers can advocate for widespread change, like improved housing or transportation, psychiatric services, education, and the availability of healthier food options in the community.

Social workers and case managers should not underestimate their effect on patient outcomes. Employing their knowledge of SDOH can contribute to a positive effect that reverberates through a community.

"Of the entire healthcare team, case managers and social workers often have the best up-to-date knowledge about social conditions in the community because they are constantly arranging interventions with local providers," Higgins notes.

Some of those local providers might include:

- alcohol and drug treatment centers;
- home health agencies;
- skilled nursing facilities;
- Veterans' Affairs;
- Meals On Wheels.

"I'm at an academic medical center where there's a constant stream of new residents and fellows from all over the world, and who may not yet have cultural knowledge about our patient community," Higgins says. "We absolutely look to our case managers and social workers to be the subject matter experts on SDOH when we are doing multidisciplinary rounds."

Geld sees the social worker and case manager as key to helping the rest of the team understand the whole patient. They also work to communicate the patient's narrative in ways that may affect the treatment and discharge plan, which could make a difference for years to come.

"The role of social work is to learn and communicate the family story," she says. "Through this, the patient's true self can be integrated into developing a realistic and sustainable plan for the patient." ■

## REFERENCE

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HOSPITAL
CASE MANAGEMENT



# CE QUESTIONS

1. **In a survey on healthcare responses to crises, which professionals said their facilities were not prepared for a crisis or disaster?**

   a. Risk managers
   b. Hospital CEOs and directors
   c. Infectious disease clinicians
   d. Physicians and nurse practitioners

2. **To improve conflict resolution skills, case managers should:**

   a. placate the injured party.
   b. negotiate.
   c. refer issues to employee assistance.
   d. listen.

3. **Integration efforts between case management in hospitals and community providers is about improving outcomes, reducing readmissions, and:**

   a. best practices in provider referrals.
   b. nursing satisfaction.
   c. the patient's comfort in post-acute facility or setting.
   d. the lowest suitable intensity of care.

4. **From the moment a disaster happens, hospitals and case managers need to recognize:**

   a. how to discharge patients from the hospital to a skilled nursing facility.
   b. when to open specialized disaster units.
   c. which supplies to order from alternative vendors.
   d. staff in need of ongoing mental health support.

5. **Lack of education or continuing education for case managers can lead to:**

   a. burnout and turnover.
   b. higher rate of job satisfaction.
   c. decreased pay.
   d. better patient outcomes.

6. **What percentage of discharge delays are due to social determinants of health issues?**

   a. 10-20%
   b. 20-20%
   c. 35-45%
   d. 75-85%

7. **A recent study on nursing leadership during crises revealed disaster policies and procedures are needed to alleviate:**

   a. leadership angst.
   b. staff burnout.
   c. patients' mental health.
   d. physicians' stress.

8. **The Special Intensity Score was shown in a recent study to predict:**

   a. Medicaid costs and length of stay.
   b. the cost of treating patients, number of visits, and which doctors patients see.
   c. emergency department (ED) visits, rehospitalizations, and out-of-pocket patient costs.
   d. comorbidities and ED visits.