



HOSPITAL CASE MANAGEMENT

COVERING CASE MANAGEMENT ACROSS THE CARE CONTINUUM

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 **Relias Media**

From **Relias**

Limited English Proficiency Can Impede the Transition Process

By *Melinda Young*

The 2020 U.S. Census data show the nation is becoming more diverse. Anecdotal reports from some health systems suggest hospitals are seeing the same trend — particularly an increase in patients with limited English proficiency.¹

Care coordination and transitions could improve if health systems provide more consistent and adequate interpretation help to patients with limited English proficiency, research shows.²⁻⁵

Patients with language barriers can struggle to transition from the hospital. Investigators found more than half of patients with limited English proficiency did not have access to medical interpreters and translated materials at discharge.²

“It’s a huge problem, and it is a problem not only in Los Angeles — where there is a high number of people with limited English proficiency — but throughout the country,” says **Breana R. Taira**, MD, MPH, associate professor

of clinical emergency medicine with the David Geffen School of Medicine at UCLA. Taira also is the director of social medicine at Olive View-UCLA Medical Center. “There are more than 25 million people in the U.S. who have low English proficiency. It is definitely a potential communication barrier, and health systems do a variable job in terms of providing the frontline staff with the resources they need to surmount that barrier.”

Title VI of the 1964 Civil Rights Act requires healthcare facilities that receive federal money, such as Medicare and Medicaid, to provide language assistance as part of its ban on discrimination based on race, color, or national origin. Federal funds can be withheld if there is evidence of discrimination.⁶

Healthcare organizations are required to provide interpretation and translation assistance to patients, but health providers often rely on patients’ family members or other non-certified interpreters, the results of a recent study show.²

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“More than half of patients with limited English proficiency said they did not have an interpreter present at the time of discharge, and they did not receive translated materials in their respective languages,” says **Esteban A. Barreto**, PhD, director of evaluation of equity and community health at Massachusetts General Hospital and research fellow at Harvard Medical School. “There are a lot of reasons why a medical interpreter may not be present. Some patients may bring a family member — although it’s not recommended — or there may be other caregivers who can provide help and communication.”

When providers ask patients if they need an interpreter, they often decline because they are accompanied by a family member who can speak English, or there is a provider or staff member who can speak their language.

“Our question was whether there was a certified medical interpreter present, and we couldn’t really tell if these patients were able to have their communication needs addressed,” Barreto says. “What we know is that more than half of these patients did not have a certified medical interpreter present, which is essential because these medical interpreters are trained in a way to

provide not only communication, but also anything related to culture competency.”

Emergency department (ED) providers often resort to automated translation software like Google Translate for patient instructions. Researchers found using Google Translate for discharge instructions in the ED is inconsistent between languages, and providers should not rely on it for patient instructions.⁷

“If you think about it from an emergency medicine standpoint, time is often of the essence — either in the ED or inpatient setting,” Taira says. “A lot of providers feel like it’s a tradeoff with their own efficiency because some of the language assistance provided can be clunky to interface with. Providers try to avoid them in some circumstances.”

A better practice is for health systems to establish an interpreter services department, says **Chris Kirwan**, PhD, director of medical interpreter services at Massachusetts General Hospital.

It is challenging for health systems to recruit qualified and certified medical interpreters. “At a major academic medical center, the types of patient encounters are so wide-ranging that it becomes a challenge. You need someone who is certified and has that experience and

EXECUTIVE SUMMARY

As the United States becomes more diverse, healthcare facilities treat more patients with limited English proficiency. This highlights the need for more effective interpreter services, especially at discharge.

- Patients with language barriers can struggle to transition from the hospital to community-based settings, research suggests.
- The 1964 Civil Rights Act, Title VI, requires healthcare facilities that receive federal money to provide language assistance.
- The optimal goal is to have a certified medical interpreter present, but this happens too infrequently.

competence in medical interpreting,” Kirwan explains. “Quite frankly, there is a shortage of qualified medical interpreters across the country.”

It even is challenging to find medical interpreters for Spanish. “As a result, every hospital has a back-up service because the law requires us to provide interpreter services 24 hours a day, seven days a week, free of charge to the patient,” Kirwan explains. “It’s an unfunded mandate, although some states have a very small Medicaid reimbursement.”

There is no guarantee that providers will use a certified medical interpreter, even when one is available. “If you’re working with an interpreter, the conversation will take twice as long,” Taira says. “That’s a good thing in terms of clarity, but for someone who is hurried and who doesn’t have time for 20 minutes, they may think they can do it in five minutes [without an interpreter] — even if [the conversation] is muddled.”

Remote interpretation networks also can be difficult to access. They might require a certain device that has to be charged, and staff need to know how to use it. All these barriers to ease of use slow down patient encounters and create disincentives to using interpretation services.

“From the health system side, you have to think about how they can make this easy for their frontline staff,” Taira says. “That’s where health systems can fail — if they’re providing something that is not easily accessible, then staff won’t use it.”

Academic medical centers and public hospitals in urban areas often treat many patients with limited English proficiency. For example, at Olive View-UCLA Medical Center, which is a public safety net hospital, more than 55% of patients requested an interpreter, Taira says.

“Up until six months ago, we had one interpreter on staff, and everything else was done by a remote interpreter network,” she notes.

Taira’s research and advocacy has helped convince leadership to improve its interpretation process. “We are currently approved to hire an interpretive staff of 10 people,” she says. “It really shows that this is an issue that’s coming to the forefront. Health systems are starting to realize it’s a safety issue, a quality issue, and a social justice issue.”

The COVID-19 pandemic also has affected some hospitals’ need for interpreters. “We average between 100 and 120 patients per day who have language access needs,” Kirwan says of Mass General operations. During the height of the pandemic, Kirwan reports the number of patients who needed language assistance exploded, from 10% during normal operations to 55% during the height of the first wave.

While many of these patients could ask for and receive interpretation service, few do, Kirwan adds.

Hospitals’ interpretation challenges were augmented because of COVID-19, but they also were given more attention by health system providers, Barreto notes. “Maybe a physician would see one to three patients a day with limited English proficiency, but when they start seeing dozens of patients a day, that could really change how they go about their work,” he says.

The interpretation gap is further complicated at discharge when clinicians might rely on the patient’s English-speaking family member to interpret instructions, Kirwan says. “Just the chaotic pace at which inpatient units work kind of

mitigates against using interpretation at the time of discharge,” he says.

During the pandemic, when family members were not allowed to be with patients at discharge, the hospital’s interpretation demand skyrocketed.

“We were being used for these discharge situations more through the pandemic than previously,” Kirwan explains. “Now that visitors are allowed, our volume still is increasing overall.” ■

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How to Help Patients with Limited English Proficiency

By Melinda Young

As with many other unfunded federal mandates, interpretation services in hospitals face a variety of resource challenges, including insufficient staff training, too few interpreters, and cumbersome technological solutions.

“It’s easier for people to grab whoever is around than it is to call an interpreter,” says **Breana R. Taira**, MD, MPH, associate professor of clinical emergency medicine with the David Geffen School of Medicine at UCLA. Taira also is the director of social medicine at Olive View-UCLA Medical Center. “We have to make it easier for people to call the certified healthcare interpreter, who is the professional meant to fill that role. I have been trying to figure out how we can make the right thing to do the easy thing to do as well.”

To surmount communication barriers, case managers and other healthcare professionals should pay attention to language access, such as interpreters and translations, usable health information (which is eliminating medical jargon), and cultural humility, Taira says. Cultural humility is knowing patients might not understand health the same way as a provider. Their goals might not be the same.

“Being open as a provider is to ask patients what health means to them and what are their goals for a treatment,” Taira explains.

Research shows interpretation is important to quality care transitions.¹ “Based on our findings, health systems need to address the lack of integration and integrate the different workflows when bringing in

interpretation — whether by phone, video, or in-person,” says **Esteban A. Barreto**, PhD, director of evaluation of equity and community health at Massachusetts General Hospital and research fellow at Harvard Medical School.

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Discharging patients in a fast-paced environment can be a challenge, particularly when case managers and providers need extra time to locate an interpreter or find translated material, he adds.

Because free interpretation for patients is an unfunded mandate, some hospitals will tell staff it is available, but might not make it user-friendly.

“Most hospitals do not have standardized training,” Taira says. “You’d think it would be part of orientation, but it’s almost an afterthought.”

Title VI of the 1964 Civil Rights Act requires healthcare facilities that

receive federal funds to provide interpretation services.² “But it doesn’t require them to train people on using the services or to help them understand why it’s necessary,” Taira says.

Healthcare staff need to understand why interpretation services are important, she adds.

These are suggested tactics for improving language access for patients with limited English proficiency:

- **Find resources on the issue.**

One book that captures cultural and language differences that affect patient care is *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, by Anne Fadiman. The book is part of the curriculum at some universities and medical schools.³

One website explains the differences between interpretation and translation, noting interpretation is a service that happens in the moment and is delivered simultaneously or consecutively with the original speech. Interpreters do not receive help from scripts or reference materials. Translators can use computer-aided tools in their work and can work on information in any written form.⁴

- **Provide accurate and up-to-date translated educational materials.** “This is a massive challenge,” says **Chris Kirwan**, PhD, director of medical interpreter services at Massachusetts General Hospital. “Translated materials are a great thing to be able to put into the hands of a patient. The problem is when you look at the size of the discharge instructions, translating a document is very costly. The electronic medical

record may do a very poor job of translating sections of the discharge instructions.”

Sometimes, the discharge instructions for Spanish-speaking patients include English words in as much as half of it.

“We have a translation specialist who does work with the unit staff to get sections of the discharge instructions translated for patients,” Kirwan says. “We have them identify key things the patient needs to know, and focus our efforts on those.” It also is helpful to include an interpreter during discharge.

Case managers also can provide discharge materials with pictures and/or colors patients can understand. For instance, a hospital can use a wallet-sized medication pamphlet that is color-coded with the medication bottle, Kirwan suggests.

Some translated material can be created in advance and used for many patients with the same needs. These could include physical therapy and occupational therapy instructions translated into many different languages.

“The challenge comes with individualized discharge instructions

and medication instructions,” Kirwan says.

• **Look at interpretation needs through equity lens.** “This goes back to the importance of increasing diversity in the health profession because people with diverse backgrounds will have that equity lens,” Barreto says. “I’ve gone through the health system with family members with limited English proficiency, and I do have that experience. That is the lens I look through for all the different issues that come to us. I always ask myself if these options are available in different languages.”

Racial and cultural equity rose to the forefront of the national conscience with the glaring healthcare inequities laid bare in the pandemic, and with the social justice movement given new energy by the 2020 summer protests over the police killing of George Floyd.⁵

“The sociopolitical climate has health systems thinking about structural racism and equity issues,” Taira says. “The climate is ripe now to act on improving language access.”

There is growing understanding that patients with limited English

proficiency are treated inequitably if they cannot access interpreters and translated materials.

“Not providing language access is a contributor to health disparity within groups,” Taira says. ■

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Case Managers Can Use 6 Interventions to Help Patients with Dementia

By Melinda Young

Researchers recently began studying transitional care that focuses on people with dementia in rural communities, an understudied research area.

“We really don’t know if the current transitional care model is applicable to older people with dementia in rural communities,” says **Mary T. Fox**, RN, PhD, associate

professor in the School of Nursing at York University Centre for Aging, Research, and Education in Toronto. “Most of the studies [on transitional care] have all been done in urban communities with people without dementia. People with dementia have much higher rates of hospitalization with potential cumulative function decline.”

Patients with dementia can lose their ability to function well when they enter a hospital because they are lying on a stretcher in the emergency department, or in a hospital bed all day.

“They’re not walking around doing their daily chores [as they would be at home],” Fox explains. “When they leave the hospital, they tend to lose

some of their functioning. They lose more each time they go back to the hospital.”

Fox and colleagues identified six evidence-based interventions that can help patients with dementia.¹

- **Orthostatic tolerance.** This refers to a person’s tolerance for staying upright.

“The strategy is to promote upright physical activity tolerance after a period of physical inactivity, like lying on a bed in a hospital,” Fox says.

This technique helps the patient progressively stand, walk three times a day, and try to be upright through either sitting up or standing for 3.5 hours a day.

This intervention is based on studies from NASA.² “NASA couldn’t send everyone to space to see what happens to the body, so they put them on bed rest,” Fox says. “We’ve taken that literature and designed this intervention, showing that you have to be up for at least 3.5 hours a day.”

Case managers can teach patients and their caregivers this intervention to use at home.

- **Ambulation.** A second step is to promote ambulation after the hospital stay, including supervising the patient walking and ensuring they wear non-skid footwear.

“We know that people, after they have been sick, will fall more, but you can’t keep them non-ambulatory because their health will start to deteriorate,” Fox explains. “We are giving these strategies to family caregivers to keep patients safe while promoting physical activity.”

Case managers teach caregivers how to remove tripping hazards and how to walk with the patient, particularly if the patient is afraid of falling. They also help caregivers incorporate walking into the patient’s daily activity, and ensure the patient is wearing shoes, glasses, or hearing aids.

“We’re teaching families that our senses have a lot to do with how safe we are when we’re walking,” she says. “If your eyesight or hearing is clouded, you could easily trip.”

- **Activities of daily living.** These techniques promote the patient’s independence in their daily activities.

“This intervention is a bit more focused on families,” Fox says. “We’re telling both the patient and family member what the intervention is about.”

For example, a hospitalized patient could experience some functional declines while admitted, including decreased sleep due to bright lights or impaired cognitive functioning.

“They may not remember how to brush their teeth,” she adds. “We are teaching them how to break down the activity — to put toothpaste on the toothbrush, wet the toothbrush, move it over your teeth.”

Case managers need to teach patients and caregivers how to break down activities for the person with dementia because they might not remember how to perform certain tasks.

“If an activity is too difficult, a family member may take over, and a patient will lose more skills,” Fox says. “[The intervention] sounds easy, but it works.”

- **Sensory intervention.** While the above three interventions focused on physical functioning, three other interventions involve mental functioning, including this cognitive intervention. Sensory intervention is designed to improve orientation.

For example, caregivers can place a clock and calendar within view of the patient, ensure adequate lighting, and minimize distracting environmental factors (such as noise) that can cause overstimulation, Fox says.

- **Sleep.** Patients often do not sleep well in the hospital. “People with dementia tend to stay in the hospital almost twice as long, so they can sometimes come home with a new sleep problem, if they didn’t already have one,” Fox explains.

Case managers can teach patients and their caregivers how to promote healthy sleep habits. For example, if the person with dementia is worried, their sleep could be affected.

“We tell them to make a plan to deal with [the thing they are worried about] by writing it down on a piece of paper so they’re not worried about remembering it,” Fox says. “Then, they can deal with it the next day.”

Other tactics include avoiding mental stimulation before bed, as

EXECUTIVE SUMMARY

Recent research suggests new transitional care interventions are needed to improve physical and mental functioning after discharge for patients with dementia.

- People with dementia are more likely to experience cumulative functional decline after an inpatient stay.
- Physical interventions target orthostatic tolerance, ambulation, and activities of daily living while cognitive interventions target sensory intervention, sleep, and communication.
- Future research involves directly interviewing people with dementia — and their caregivers — to assess need.

that can increase anxiety or decrease relaxation.

“We teach them to try to not watch a very stimulating movie or scary movie before bed,” she says. “Or, [their caregiver] should not have a conversation about things that might upset the person with dementia.”

For instance, people with dementia should not be told about activities that are going to occur the next day — even something as ordinary as grocery shopping.

“You want to have them put the day to rest and not talk about tomorrow until it arrives,” Fox adds.

• **Communication.** This technique can help family caregivers promote the patient’s comprehension and memory.

Case managers can teach caregivers how to ask patients simple yes-or-no questions. They teach caregivers to speak in short sentences and to use pictures if the person is struggling with their words.

“If the patient is anxious about forgetting certain information, the caregivers can write down a reminder on a piece of paper and leave it within the patient’s view,” Fox adds.

Fox and colleagues plan to interview people with dementia as they continue their research.

“We will show them user-friendly pictures and have the patient look at the pictures with us, asking them what they think about this strategy, and whether it is something they think would help them,” she says. “Then, we are doing the same

kind of interview with the family members, but with a little more depth.” ■

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Early Engagement Is Crucial to Workers’ Comp Case Management

By Melinda Young

Engaging early with clients who were injured on the job can create a collaborative relationship between patient and case manager that helps the person’s recovery journey.

Injured workers often do not know what their next steps will be in returning to health and work. Sometimes, family members and friends give them opinions about what they should do. These opinions are not always accurate, says **Michelle Despres**, PT, CEAS II, REAS, CETS, vice president of physical therapy with One Call in Jacksonville, FL.

“If physical therapy is needed, it should be started as soon as possible after injury,” she says. “If you start within three days, the costs are lower and the [rehabilitation] time is less.”

Also, patients who start physical therapy early require fewer opioids and diagnostic tests. “If care starts within seven days vs. 30 days, it lowers costs and the outcomes are substantially better,” Despres says.

There are exceptions for patients who need to be immobilized, or if the physician does not want the care to start. But beginning within seven days will work for most musculoskeletal injuries with no breaks or fractures, Despres explains.

A client’s social factors and the case manager’s communication skills can affect early engagement. Despres offers these best practices for connecting with patients and engaging earlier:

• **Improve education and communication.** One of the best ways to optimize collaboration is to

provide patients with educational resources. Case managers need collaborative-friendly educational techniques and materials, Despres adds.

For instance, case managers can give clients information about preparing for physical therapy. One Call provides educational resources on how to prepare for physical therapy, MRIs, aquatic care, and other appointments.

“[A large part] of getting people well is empowering them to not only understand what is happening, but to take charge and be prepared,” Despres says. “Your life is a little out of control if you’re injured, and you can’t necessarily take good care of yourself. Having a [case manager] as a reassuring presence is important.”

Case managers can build trust with patients by acknowledging their pain and difficulty with therapy. They can say, “A lot of the things we will ask you to do will hurt, but they won’t harm,” Despres says.

Patients fare better when their therapist or case manager communicates why certain interventions or actions are needed. For example, if the physical therapist tells the patient to squat five times, the patient is more likely to do so if told why.

“There is a rationale behind educating people on the process, on what’s happening and what the recovery looks like,” Despres says.

Case managers can be the voice that tells patients it is OK if they are sore or hurting a little after therapy, but it is a building process that will help them return to normal activities and work. “The better you get, the more you do, and the more you do, the better you get,” she says.

Physicians’ time with patients is limited. If patients have many questions about their diagnosis and symptoms, the case manager might be the best person to ask.

Although doctors and case managers might not always give the answer the patient wants, it is important for the patient to hear accurate information from a

healthcare professional instead of relying on internet searches, Despres says.

• **Reach out to patients before problems arise.** If a case manager is too busy to contact the patient early, he or she is left to figure things out on their own.

“Some patients may do a fine job [of following healthcare instructions]; others may not,” Despres says.

Left on their own early in the process, patients might not understand what their providers have asked them to do, so they get off on the wrong foot. They also could be influenced by the opinions of their friends and family members who do not know their whole situation.

“They could start to bring in legal people, which changes how the person interacts with their medical providers,” Despres says. “If patient care is not appropriate or is not delivered early enough, we lose their trust.”

Sometimes, patients can become contentious with their case managers, creating an unfortunate situation. One way to prevent this is for the case manager to contact the patient within the first few days, which is when the patient is the most nervous and asks the most questions about returning to work.

“A lot of people are worried they may not be able to do their work,” she explains. “If you are 20 to 30 years into being a truck driver and suddenly can’t be a truck driver anymore, how are you going to provide for your family?”

If case managers engage with patients early, they can answer those questions and prevent long-term engagement problems.

• **Resolve attitude conflicts.** Sometimes, healthcare providers become jaded with workers’ comp patients. This can be a problem, Despres adds.

For instance, a physical therapist might believe workers’ comp patients are less motivated and not as willing to perform their physical therapy exercises as other patients.

In another example, a case manager might have to call a patient who is behaving poorly. The case manager could be tempted to respond in kind.

“You get that one phone call where the person is horrible on the other side, but if you respond in kind, you can lose that person,” Despres says. “Remember — this is a human being and they are likely angry and bitter because they are afraid and in pain.”

Case managers should learn methods to turn these situations around and not react negatively to an angry patient, she says.

Despres has made it a personal challenge to actively take on patients who are angry and dissatisfied to see if she can turn them around on their care.

“I found that if I treated them with respect, kindness, and listened to their concerns, nine-and-a-half times out of 10, I could turn that person around and say, ‘Together, we will get through this, and I will give you the best I have,’” Despres says.

EXECUTIVE SUMMARY

Early engagement with injured workers is necessary to improve education and communication, prevent problems, and to facilitate collaboration between patient and case manager.

- One important tactic in dealing with workers’ compensation cases and building trust is to empower the patient by providing educational resources and explaining why certain interventions are needed.
- If left alone early in the process, the way the patient interacts with medical providers can change. This could lead to contention with their case manager.
- It is important to not react negatively to an angry patient and to treat him or her with respect and kindness.

“If the best isn’t good enough for them, we will come up with a plan B.”

One technique is for the case manager to not take the patient’s anger as a personal attack. It likely means the patient is upset at the world and afraid because of his or her injury or illness.

“Even though it feels personal, you should take that larger view and say, ‘I hear you. Get it all out. Now, let’s talk about how to get through this and do it together,’” she says.

• **Salvage fractured relationships.**

“The key is to listen with an open ear and listen to understand,” Despres

says. “Ensure that compassion is there.”

Case managers must be clear with the sound of their voices over the phone about what they want the patient to do. They can ask open-ended questions, such as, “Can you tell me about your family? Tell me about your job. What do you like to do outside of work?” she explains.

It is important to get to know patients as individuals and not just as workers or someone on Medicare. “Come up with something to talk about that links you outside of the official relationship,” Despres suggests. “If you’re friendly,

respectful, compassionate, and the spirit of what you’re asking of the patient is out of kindness and concern, that person will begin to hear it and react.”

Case managers should know any psychosocial factors that affect a patient’s ability to self-manage their care.

“If there’s something that is impacting the recovery journey, be thoughtful about whether [a new provider] needs to be brought in to help,” she says. “We don’t want to add any unnecessary services, but sometimes you have to make the call.” ■

Nurses Note Needed Improvements in Care When They Are Patients or Caregivers

By Melinda Young

Nurses who were patients or caregivers overwhelmingly said they felt the need to intervene in care, a new study revealed.¹

More than 82% of nurses surveyed said they had been either a patient or a caregiver to a patient with a serious medical condition. Ninety-six percent said they felt the need to intervene based on their medical knowledge.

“It would be fair to say that, overall, they were satisfied with the care, but were able to identify specific things that gave them pause,” says **Marian A. O. Cohen**, PhD, director of the Center for Social Research at Framingham (MA) State University.

Most patient satisfaction data related to hospital and healthcare services come from patients who are not clinicians and who do not possess the background to fully evaluate their care.

“For the most part, patients evaluate their care based on whether

the provider was nice to them, but that is not the same thing as technical competence,” she says.

The researchers asked nurses questions about the care they or their family member received. They completed a questionnaire that measured their assessment of the health system and described their experiences.

“Some of the questions were close-ended, such as ‘Have you had this experience, yes or no?’” Cohen says. “Others were ‘If you’ve had this experience, tell us about it,’ or ‘If you have identified the need for better care coordination, what specifically should be coordinated?’”

Care coordination issues included teamwork and whether teams would be established on paper but not necessarily practiced in reality.

“The nurses felt that better communication was needed, including greater access to medical records,” Cohen explains. “Some of them

recognized that this might require changing the culture of the healthcare system, but the coordination had to do with the fact that providing healthcare doesn’t rest on the shoulders of a single person; it requires teamwork and coordination so that everyone is on board and everyone has the same information.”

The goal is to prevent situations where one clinician is providing treatment for a patient and the next person does not know what that was, she adds.

More than 63% of the time, the nurses believed their intervention improved safety and prevented significant complications. These issues included errors related to provider carelessness, inappropriate treatment regimens, problems with therapeutic management, and inadequate postoperative care.

Communication issues often were cited as a problem. “They didn’t think

there was adequate communication among the providers of services and, frankly, between the patients and clinicians,” Cohen says. “Sometimes, you might get a situation where the teams would be working together and wouldn’t necessarily be telling the patients what was going on, or they would be getting different information from different providers.”

For instance, patients with nonmedical backgrounds might not know what to do with an offhand comment by their provider. “While the nurses understood what was being communicated to them, the patient/non-caregiver did not understand,” Cohen explains. “The healthcare team was not being clear and not providing adequate information. They were answering questions without a thorough explanation and just ignoring some things.”

The nurses who responded to the survey said they intervened when they believed there was carelessness, inadequate postoperative care, or failure to consider underlying conditions.

“It wasn’t just that the provider didn’t communicate to the patient — it was that the provider failed to ask the right questions of the patient,” Cohen says. “Sometimes, the respondents were able to say there

was a treatment plan put together, but it failed to acknowledge another condition or home-life situation that could affect the care or efficacy of post-hospital care.”

It turned out it was important for the care team to know that additional information. The nurse, as the patient’s caregiver, intervened and provided the context.

Solutions could include following a checklist, or simply acknowledging it is important to ask questions about patients’ lives and home situations.

“It comes back to that notion of coordinated care, of people working together,” she says. “That is certainly more true now than it has been historically in healthcare delivery, but I guess what these nurses were saying is ‘we can still do better.’”

When asked if their interventions were well-received by other medical personnel, 48.5% of respondents said they received negative reactions, such as the personnel becoming annoyed and the interventions perceived as interfering. About 40% said they received positive reactions, and personnel were appreciative and respectful of the respondent’s contribution.

When nurses intervened on behalf of family members, they sometimes requested specific types of care or additional information. “They felt they had to advocate for themselves

and their family,” Cohen adds.

“Some nurses said their intervention helped to reduce the pain and anxiety for the person they were providing care for, some said it allowed the patient to be transferred to a more appropriate facility, and a few even said it managed to save lives.”

For example, nurses would intervene if a patient was given a new medication regimen and providers were unaware of the patient’s current medications, or that the patient experienced an adverse reaction to a specific medication on the new regimen. In these situations, intervention could prevent adverse reactions or a worsening medical condition.

Researchers also wanted to identify ways to improve care coordination. “When we asked nurses what they thought would make situations better and [facilitate] high-quality care, respondents said there needed to be high-quality communication, and also suggested more staffing,” Cohen says. “They said to improve interactions with patients, there would need to be more time spent with each patient.”

To improve coordination, care teams need better communication, more effective teamwork, and access to medical records.

“For accessibility of care, they talked about more care options in remote areas so people who don’t live around a lot of hospitals can still receive care,” Cohen says. “People also need [more] transportation options so they can get to the care that is available and access more primary care providers.”

Cohen became interested in this area of research after a dinner with her physician husband and his physician friends. They talked about their experiences with their elderly parents.

EXECUTIVE SUMMARY

A recent study of nurses’ thoughts after being a patient or a caregiver revealed better care coordination is needed.

- Overall, nurses were satisfied with their care. But 96% of respondents believed they needed to intervene in their care.
- Better communication and greater access to medical records is necessary, especially when creating a treatment plan.
- Potential solutions include facilitating more staffing, spending more time with the patient, and improving communication on most levels.

“All the physicians in the group felt that being a physician made a difference in the kind of care that was being provided for the elderly parent,” Cohen explains.

Cohen and colleagues found it is not uncommon for healthcare professionals to help improve their loved ones’ care.

Physicians and nurses know what should or should not be happening, and they can step in to provide relevant information or ask the right questions.

“The bottom line is we’re doing a good job overall, but as is with all things, we could do better,” Cohen says. ■

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A Hospital at Home Program and the Role of the Care Management Team

By Jeni Miller

For many healthcare systems, a hospital at home program was a necessity born out of COVID-19.

At Indiana University (IU) Health, a program that allowed patients to continue treatment and recovery at home after discharge had been discussed before the pandemic, but never put into action. That changed when the pandemic started. They went forward with the program, knowing it was the right time to try it.

“There are other programs that have been doing this longer than we have, mostly because we weren’t yet ready to do it,” says **Michele Saysana**, MD, vice president, chief quality officer, and chief medical officer for virtual health at IU Health. “There was a bit of resistance to doing it at first because so many wondered, ‘How could we possibly deliver care like this in the home?’”

To qualify for a hospital at home program, patients need a caregiver in the home 24/7. The caregiver must be physically able to assist the patient. Sometimes, this person meets with a physical therapist to determine any mobile barriers that would prevent them from serving as a caregiver. While the patient must

be sick enough to qualify for the program, there also are limits on how much oxygen they can use at home. If a patient’s oxygen requirement is too high, they might not be accepted into the program.

As of August 2021, more than 940 patients participated in IU Health’s hospital at home program, which mainly focused on patients with COVID-19 who were discharged early. These patients were sick enough for hospitalization, but were set up with “wraparound support with monitoring, a nursing team, advanced practice providers, and hospitalists” at home to receive a similar level of care, Saysana says.

The hope was to return the patients “to the place where they’re most comfortable recovering, back to family and caregivers, to heal and get better sooner,” she adds.

Launching a program like this during a pandemic was no small feat. “Since it was something new that really started as a response to COVID — and felt rushed to begin with — there was hesitancy all around,” recalls **Liz Fulford**, MBA, MSN, RN, director of integrated care management for IU Health. “The patients said, ‘Yes, sign me up,

get me out of this hospital.’ They wanted to go home, to be back with their families. It required a lot more involvement from families.”

Benefits All Around

Considering the initial 941 patients in the hospital at home program, the IU Health team noted overall greater patient satisfaction than that of inpatients.

Adria Grillo-Peck, MSN, RN, CNS, CMC, vice president of integrated care management for IU Health, explains that for older patients, “getting them home safely with wraparound services” made a huge difference in their experience and contributed to fewer readmissions.

The readmission data confirmed a seven-day readmission rate of 2% for hospital at home COVID-19 patients, while patients not in the program recorded a readmission rate of nearly 7%. They saw the same trend with their 14- and 30-day readmissions.

“We saw that our emergency department visits, too, are lower, at less than 2%,” Saysana adds.

With more available beds, the hospital served more people. “[Hospital at home] allowed us to open up beds for patients who we knew were waiting to get into the hospital,” Fulford explains. “We were also finding that there were not a whole lot of places for patients to go. Acute care couldn’t take some because of their oxygen needs and COVID status, and it didn’t feel safe to just send them home with traditional home care. The hospital at home option offered a safer discharge plan while also opening beds to those who needed them most.”

Keeping patients out of the hospital setting while still providing similar care at home also helped reduce the incidence of other hazards in the hospital experience.

“The longer patients stay in the hospital, the more sad things can happen, like falls,” Grillo-Peck says. “The benefits in having them at home were about attaining great outcomes for patients while also looking at value-based care and care in the most cost-effective manner.”

The patients were not the only ones experiencing positive outcomes from the program.

“It also provided a benefit to the workforce,” said Saysana. “We have nurses with tons of experience from previous years at the bedside who do not necessarily want to continue to work at the bedside. Their experience is invaluable in a program like this — it’s a way for them to provide direct patient care, but it works better for them and their lifestyle.”

Even the communities benefitted from this program, considering how it enabled the hospital to take in more patients who needed a hospital bed.

“As many hospitals were challenged with staffing issues, this was another place where patients

could receive safe care at home while we took care of others who are post-surgical or need to be in the hospital,” Saysana notes. “So many people put off surgeries during the pandemic — this way, we were able to bring them back.”

Lessons From Challenges

Success like this does not come without great effort. “It took the involvement of 14 or 15 different departments for this initiative,” Grillo-Peck says. “Everyone had to be on board to make it successful.”

Of course, considering the situation, those departments had to meet virtually regarding the hospital at home program, and only recently met in person.

“We were never in a room together, and many of us had never even met,” Saysana notes. “Still, the team was not to be underestimated. Once we were able to get our heads above water and look up, we started making continuous improvement every day. We met at 3 every afternoon for 30 minutes. It all moved very fast and was very challenging. It wasn’t easy, but we were committed to the patients.”

The program shed light on what happens when patients are discharged. “Seeing what happens when a patient leaves the four walls of the hospital gave us some insight into what the reality is when a patient gets back home,” Saysana says. “They’re tripping over animals, maybe they have no internet, [and more]. There are things we never really knew about before. This experience has exposed challenges we have even in the discharge process.”

Some of those challenges include clearly and meticulously outlining the steps of the discharge plan. The

discharge planner needs to think through nearly everything the patient might need since their healthcare experience and outcome depends on it. The caregiver at home also is critical.

“It’s a heavy lift at home,” Grillo-Peck notes. “There are so many things to remember, so making sure that you have an engaged caregiver is really important. They need to know the expectations up front.”

Caregivers might be shocked when they realize how much work goes into caring for a sick loved one at home. Not only that, Saysana adds, but with visitor restrictions during COVID-19, most family members “didn’t always have an appreciation for how sick they were.”

“They dropped their family member off at the ED and didn’t see them for a few days or a couple of weeks,” she says. “Because of that, they didn’t realize what the burden of care was for when they got home. We have to make sure we’re explaining what the [hospital at home] program is and what it isn’t.”

Another drawback is the accessibility of resources in the home. Fulford explains some physicians got creative with home care since they do not always have every necessary item at their fingertips.

The team also noted a final challenge: ensuring patients in the hospital at home setting take their medications, and take them on time.

“When the patient is in the hospital and they don’t take their medications, it’s a safety issue, so we make sure they take them,” Saysana says. “But when patients are in the home, they decide if they’re going to take their medications. COVID-19 patients often have comorbidities, so to not take their insulin is a big deal. We don’t have the same level of control that we have in the hospital. We have to be creative and motivating

and know what to do as they make their own choices at home.”

Monitor at Home

According to CMS, hospitals should meet these requirements to participate in a hospital at home program:

- Use appropriate screening protocols to assess both medical and nonmedical factors;
- Schedule daily evaluations, either in person or remotely, with a physician or advanced practice provider;
- Assign a registered nurse to evaluate each patient once daily, either in person or remotely;
- Schedule two in-person visits daily by either registered nurses or mobile integrated health paramedics based on the patient’s nursing plan and hospital policies;
- Ensure the patient has reliable remote audio connection with an Acute Hospital Care at Home team member who can immediately connect the patient with a nurse or physician;
- Respond to a decompensating patient within 30 minutes;
- Track patient safety metrics with weekly or monthly reporting;
- Establish a local safety committee to review patient safety data;
- Using an accepted patient leveling process to determine level of care;
- Provide or contract for other services required during an inpatient hospitalization.¹

Adapting the Role of Case Management

Treating patients in the home rather than the hospital requires

some slight adaptations to the way the acute care case manager’s role is handled, but the role largely stays the same.

“Once you have a patient who is accepted into the hospital at home program, you really have to make sure all of the discharge needs are met: oxygen, therapy, all of those wraparound services they’ll need to stay safe at home,” Grillo-Peck explains. “But in either case, you’re still working with the interprofessional team to discuss patient needs.”

Fulford agrees, adding that “with the COVID [hospital at home] program, you also need to provide the caregiver with isolation supplies like masks, gloves, and gowns, some of which was hard to find in the beginning of pandemic.”

In addition, “case managers may need to include items in their assessment or in their discussions with family members that they wouldn’t typically have to address, like educating the caregiver on isolation and keeping themselves safe,” she says.

A caregiver assessment for a hospital at home patient typically is more robust than usual since that caregiver must meet certain qualifications to ensure they are physically able to provide care.

Another consideration is the role of social determinants of health. It is not just about the medical diagnosis, Saysana explains. Social workers might be needed to determine any social issues that could affect the quality of care.

A New Perspective

When working with a hospital at home program, case managers can gain new insights into what happens when the patient goes home.

With typical discharges, the case manager and patient do not stay in touch. With hospital at home, that connection continues as the acute care case manager remains available to assist in ensuring all the patient’s needs are met.

“It’s a much closer communication loop,” Grillo-Peck says. “When a patient goes to another facility or other home care, we didn’t used to stay much in touch. Now, we’re more aware of what’s happening when they leave the four walls of the hospital. It’s different from a traditional discharge, and it’s definitely opened our eyes to how things could potentially fall apart when people leave the hospital. It’s strengthened our perspective on how our partners are so important.”

Saysana notes it harkens back to the days of house calls. “What I can see in your environment is so much more important than what I see in my office,” she notes. “I see the rug that you might trip over when you lose your balance, or what’s in your refrigerator. I now have a window into the patient’s life.”

“When we can see the home environment, it’s obvious when social workers may need to be more involved,” Fulford adds. “They can identify if a patient doesn’t have the finances to eat the way they’re supposed to be eating in order to recover. We need to learn how to ask more questions to help overcome barriers. Case managers may struggle at first to find the words. But asking questions like, ‘How can we help you be successful at home?’ can help us determine which wraparound services are needed.”

Case managers also can see firsthand how patients attempt to return to regular life after discharge.

“People go home and think they can go back to work,” Saysana says. “We’ll call and can’t reach them

because they went to work. This gives you an interesting picture of what patients think they can do when they go home. Some people feel that they have to go back to work, and this can result in ED visits. I never dreamed I'd have a nurse tell me in the morning, 'Mr. Jones was at work today, on his oxygen.' It's something we need to address."

Making It Work

Creating a hospital at home program is not easy. Flexibility is key to making it work. A successful program relies on honesty, holding tough conversations with patients and caregivers, and clear communication with the healthcare team.

"Don't be afraid to ask the hard questions," Fulford advises. "It's

setting the stage for what needs to happen at home. You have to ask, 'Are you truly going to be the caregiver or are you just saying that? If you're not able to care for them, then we will need to keep them here for their safety.' These deep-dive questions can be difficult, and some patients and caregivers don't always want to let us know about barriers. In either case, you need to educate them on what to expect, and sometimes you have to say the same thing four, five, six times in order for it to be heard."

Watching the data closely also helps the team change course and adjust the program where needed. "We review all readmissions with the team of clinicians to learn what worked and where to course-correct," Grillo-Peck explains.

There is no shame in humbly adapting a hospital at home program, even if it means admitting the initial plan was not the best way.

"The way you design it is not how it will end up," Saysana says. "Expect to learn from patients along the way and know that just because you change things doesn't mean you failed. We are learning and growing. Making changes doesn't mean that the program doesn't work. When you're committed to making it work, you'll always see continuous improvement." ■

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The NICU/PICU Case Management Experience

By Jeni Miller

While many departments and practices within the medical field might entertain a shift toward a more family-centered care model, no place exhibits this more than neonatal intensive care units (NICUs) and pediatric intensive care units (PICUs). Care for these patients must include family, and so differs somewhat from case management in adult populations.

Social Work Is Half the Battle

Families of children in the NICU/PICU might require more social work resources. Care also might be more time-consuming than is seen in other units.

"In the NICU, you're dealing with families when they're in crisis mode and overwhelmed," says **Kathy Brancely**, RN, CCM, RN care manager in the NICU/Continuing Care Nursery at Maine Medical Center. "Social work is critical at that time, especially when they are unsure if their child will survive."

Brancely also notes it is vital for the social work case manager "to be in tune with insurances," as parents with a child in the NICU/PICU often cannot go back to work — and sometimes lose their jobs.

While most case managers conduct assessments for their patients early in their admission, **Jennifer Boone**, LCSW, social work care manager in the NICU/Continuing Care Nursery at Maine

Medical Center, explained that early assessment is a must in the NICU.

"We see every new admission, every family, within 24 hours," Boone shares. "After the trauma that they may have had after having the baby, we need to find out what needs the family may have and follow through with mental health support, social determinants of health, and sometimes also with the Department of Health and Human Services regarding substance-exposed infants."

For NICUs and PICUs that are part of a major hospital system, the social work case manager and the case management care team also help families find temporary housing near the medical center.

"We often have families who come from six to eight hours away,

so social work helps them with the stressors around finding housing,” Boone says. “Some families are able to stay at the Ronald McDonald House, but not all.”

Differences in Discharge Planning

Often, babies in the NICU are born prematurely and with low birth weight, leading to other medical issues that need attention by physicians and case management staff.

“Low birth weight babies often qualify for low birth weight SSI [Supplemental Security Income], so the case manager has to stay on top of each infant’s possible eligibility” Brancely explains. “Unlike the adult inpatient units, our discharges are a bit different because we need to focus on the growth and development of infants.”

Brancely notes most of the babies in the NICU require services to be arranged by the case manager.

“Most get some types of home care referrals, whether its developmental services at home, sending infants home with oxygen or ventilators, and even private-duty nursing is often approved for babies who require extensive care,” she says. “In rural areas, these services can be more challenging to set up as many resources are less available in the community. It can be especially hard in those places to find a visiting nurse or private-duty nurses.”

In addition to the challenges of making appropriate referrals during discharge planning, Boone also points to the need for finding services for the patient’s family.

“There are considerations with going back to work, with food, lodging, gas prices,” she explains.

“Financial barriers are what we come across most often. We work with families with untreated mental illness/substance use and homelessness with their support networks being far from home while in the hospital setting. We always do what is in the best interest of the baby, but there is a lot of work to be done with families. We spend hours and hours with families, just trying to help.”

Critical Communication for Critical Care

Case management teams rely on regular meetings, rounds, and other forms of communication to keep the process running smoothly. In the NICU and PICU, this communication is be even more critical.

On one hand, there is less turnover in the NICU/PICU due to increased lengths of stay, but the census often is higher than in other units.

At Maine Medical Center’s NICU/Continuing Care Nursery, “interdisciplinary meetings [are] set up for once a day, but [there are] other avenues throughout the day also for follow-up.” This frequent communication is essential, as many babies and children often are discharged and transferred out of a major hospital system and into a

local hospital closer to home as soon as they are stable.

Thankfully, it is more likely on a NICU or PICU to have quick, easy access to the physicians, Brancely says.

“I know that some adult case managers may find it hard to track down providers when needed. But as an intensive care unit, we have to have access to a physician at all times, so that gives us great opportunities for access,” she adds.

‘An Adventure’

Case managers should exhibit compassion and patience with the families under their care, Brancely advises.

“You truly have to meet the family where they’re at,” she says. “When you first meet them, they’re not the same as what you’ll see down the road because of how stressed out they are at first meeting.”

Working with babies, children, and their families in the NICU/PICU has its challenges, Boone and Brancely explain. But they both reiterate it is an incredibly rewarding place to practice case management.

“You’re making such an impact early on in the child’s life, making such a difference,” Boone says. “You never know what to expect next because every day is an adventure. We’re never bored at work.” ■

COMING IN FUTURE MONTHS

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- Care transitions clinic can reduce ED visits
- Tactics to improve geriatric care transitions
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CE QUESTIONS

- 1. What can help improve care coordination and transitions of patients with limited English proficiency?**
 - a. Showing patients discharge videos in their language
 - b. Case managers who use Google Translate services
 - c. A bilingual family member
 - d. Consistent and adequate interpretation services
- 2. Which is an intervention that can help patients with dementia, according to Mary T. Fox, RN, PhD?**
 - a. Promote daily hugs with family members
 - b. Engage in weightlifting
 - c. Improve orthostatic tolerance
 - d. Improve dietary nutrition
- 3. Case managers should engage early with worker's compensation patients because:**
 - a. starting physical therapy within three days results in lower costs and less rehabilitation time.
 - b. patients might not adhere to physical therapy protocols if they do not start early.
 - c. early engagement results in fewer lawsuits.
 - d. case managers who procrastinate are less likely to engage patients within the first 21 days than those who start engagement within 72 hours.
- 4. What percentage of nurses surveyed said they felt the need to intervene with their own or their family member's medical care when they had been a patient or caregiver?**
 - a. 79%
 - b. 84%
 - c. 96%
 - d. 100%
- 5. Why is it challenging for case managers to give patients with limited English proficiency translated discharge instructions?**
 - a. There are too few translators that hospitals can access.
 - b. Electronic medical records already do a good job of translating instructions that can be emailed to patients.
 - c. Most patients do not ask for this or need it.
 - d. Translating a document is costly.
- 6. In IU Health's hospital at home program for COVID-19 patients, what percentage of readmissions did they see compared to their inpatients?**
 - a. 2% vs. 7%
 - b. 10% vs. 20%
 - c. 1% vs. 15%
 - d. 20% vs. 12%
- 7. It is not uncommon for babies in the NICU to be discharged with:**
 - a. developmental services.
 - b. a care package from the NICU staff.
 - c. an assigned social worker.
 - d. 24-hour nursing care.