CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

## INSIDE

Case management under the Affordable Care Act necessitates patient advocacy and educational skills, experts say . . . . . cover

When communicating with patients, try using an active engagement approach. . . . . 16

Examples of EBHC and MI in practice . . . . . 17

Tips to actively engage patients . . . . . 18

New model reduces boarding of psychiatric patients . . . . . 19

Progress lags on needlestick prevention in hospitals . . . . . 22

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# Case management and advocacy in the era of the Affordable Care Act

*Patients need lots of education*

Case management has made a cultural change in recent years to greater patient advocacy, a trend encouraged by the Affordable Care Act (ACA) and its provisions that are shifting focus to reducing readmissions and keeping patients out of hospitals.

"You need to see yourself as a patient advocate," says **Laura Ostrowsky**, RN, CCM, director of case management at Memorial Sloan Kettering Cancer Center (MSKCC) in New York City.

"Many insurance case managers see themselves as insurance advocates, and you need to bond over what's best for the patient," she adds. "You have to identify that what you're doing is working within limitations to provide what's best for the patient."

Because of ACA changes to the healthcare industry, patients need more education, says **Joanne Simone**, RN, MBA, director of advocacy services

## EXECUTIVE SUMMARY

With the surge in the number of newly insured under the Affordable Care Act, case managers increasingly need to serve as patient advocates, educating people about their health plan benefits.

- One role for case managers is to teach patients how to choose and use health plans wisely.
- Case managers also could help the newly enrolled understand how to access wellness care and select a primary care physician.
- Since plans begun under the ACA sometimes have different copays and deductibles, case managers can help patients understand what their costs might be when confronted with a health crisis.



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melindagyoung@att.net

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**EDITOR:** Melinda Young
**ASSOCIATE MANAGING EDITOR:** Jill Drachenberg (404) 262-5508
**EXECUTIVE EDITOR:** Russ Underwood (404) 262-5521, (russ.underwood@ahcmedia.com)
**EDITORIAL & CONTINUING EDUCATION DIRECTOR:** Lee Landenberger



at Guardian Nurses Healthcare Advocates in Flourtown, PA.

"Patients need to learn how to negotiate, and we need to learn how to work together as a team — the private patient advocates as well as case managers," Simone says.

Part of a case manager's advocacy role includes educating patients and helping them adjust expectations. For example, the thousands of people who have never had health insurance but are now insured under the ACA will need some education about what to expect with their new coverage.

"Many people think that once they have insurance everything is covered, and that is rarely, if ever, the case," Ostrowsky says. "They need to understand the difference between premiums and copays and deductibles."

Simone learned firsthand how complicated ACA coverage can be when her husband lost his job and she had to select a health insurance plan through the ACA.

"I'm very knowledgeable about insurance, and I chose a plan that fit my budget," Simone says. "We were in good health, so it wasn't a concern."

Her husband returned to work, and she kept the ACA plan for herself. All was well until it wasn't: "Unexpectedly, I ended up with a back problem and had to have surgery," Simone says.

"Suddenly, I was facing a $250 copay for an MRI, a $100 copay for a specialist, and then — depending on which facility I went to — no deductible or a $3,000 deductible, just to start, plus $1,500 a day," she explains. "It all became clear to me how difficult this would be for the average person."

Simone became her own health advocate, seeking additional medical opinions and obtaining information on the two different hospitals where the surgery might be performed. She found that both facilities were rated high, although the more expensive one had a slightly higher rating. She selected the one where there was no deductible and a $400 daily copay.

The surgery went well, and Simone was left with a deeper understanding of how difficult it is for people to manage health crises under ACA plans.

Another issue? Simone found that once her husband was employed and she was eligible for coverage under his health insurance plan, she no longer qualified for subsidized insurance under the ACA. Her premium climbed from $230 a month for three people to $1,000 a month just for herself.

"I feel fortunate to have walked through this process myself because it's definitely enlightened me," Simone says. "When I called up the insurance company, they didn't say they had someone who could help me with it."

Simone knew enough to advocate for herself, to discuss the health bills and copays and make certain she paid no more than required under her plan. But she found that these are all skills that patients need to be taught.

"There are a lot of moving parts where advocacy and case management come into play," Simone says.

The newly insured also need help in picking a plan that's best for them. Once they have a plan, they need to understand how to use it and make the most of their benefits, she adds.

Case managers can educate patients about what is covered, provider and network limitations, and optimizing someone's wellness

benefit, she says.

"With ACA, there are a lot of changes in what is and isn't covered and network limitations," Ostrowsky says.

Deductibles and copays have changed, as have healthcare savings accounts, she adds.

"People need help in selecting a plan," Ostrowsky says.

"They may opt for the cheapest plan without realizing it might not cover certain drugs or hospitals," she adds. "It's very complicated, and that's where case managers and insurance advocates come in."

For instance, case managers need to make certain people know about the wellness benefits of ACA plans. Newly insured people might have had the habit of using emergency departments for primary care. Under ACA, they have access to preventive medicine and need to learn how to maintain their health with immunizations and screenings and even how to select and see a primary care physician (PCP), Ostrowsky explains.

"People with chronic illnesses need to learn how to make the most of having a general practitioner or PCP, how to use them, identify them," she says.

"Under the ACA, we have more people with insurance coverage and less knowledge than we've had before," Ostrowsky says. "There is a need for a lot of health teaching."

One of the issues arising from the ACA is how it's changed existing insurance for patients with major health problems, says **Sylvia Corbin**, MS, associate director of patient financial services at MSKCC.

ACA insurance requires coverage of pre-existing conditions and preventive care, and it has no lifetime limits, Ostrowsky says. "But the network might be tighter, there are different drug benefits, and certain things are eliminated," she says.

For example, MSKCC has a small Medicaid population. Most of the patients with new coverage under ACA have private insurance they found through ACA, Corbin says.

The problem is that prior to ACA, New York had an affordable health insurance option called Healthy New York that ended Dec. 13, 2013, when the ACA changes took place, she explains.

All patients covered by the New York plan had to switch to an ACA insurer.

**PART OF A CASE MANAGER'S ADVOCACY ROLE INCLUDES EDUCATING PATIENTS AND HELPING THEM ADJUST EXPECTATIONS.**

"Under the ACA, existing patients with cancer have to choose an ACA primary care physician, see the doctor to be assessed for cancer treatment — even though they've already been on chemotherapy," Corbin says. "That's an undue hardship, and it's something we hope will change because it's a lot to handle for cancer patients to choose a new doctor they don't need while they're on treatment here."

Other logistic and financial issues arise, as well.

For instance, once a primary care physician refers a cancer patient to MSKCC, then the hospital's case manager has to continually fax clinical updates for the patient to the doctor and receive prior authorization from the payer, Corbin says.

"If the patient can't afford their premium under ACA, then they will lose their coverage after 90 days," she adds.

Case managers will talk with patients about financial hardship when they have no insurance, and they'll discuss covered patients' ability to pay copays. But sometimes patients will fall behind on paying their insurance premiums, and case managers will not know this is happening until the coverage is about to be dropped, Corbin says.

"If the patient misses three months of paying their premium, then we'll get a denial, saying the patient's claim is terminated," she says.

A hospital's charity care cannot pay patients' premiums, even if that would work better financially than covering the unpaid cancer treatment bills. "We could get in trouble if we did that," Corbin says.

"The ACA doesn't look at what a person is paying in rent," she says. "Some patients have incomes above 400% of the federal poverty level, but they still cannot afford ACA coverage because they have other bills."

Hospital case managers need to verify benefits and find out what is covered and not covered under the patient's ACA health plan, Ostrowsky says.

"Negotiations may require the case manager to convince the insurer of the value of certain benefits to maintain health, prevent readmission, and maximize value," she adds. "Advocate for the patient and get the patient what is needed, but everything is limited, so you may need to conserve your resources." ■

# Active patient engagement is goal for case managers dealing with patients

*Best practice: Evidence-based health coaching*

Case managers who are looking for better ways to engage patients in their healthcare decisions might consider using a method that is based on evidence of what works and what doesn't in communication and engagement, experts say.

"Case managers want another approach to engage their patients and families actively," says **Melinda Huffman**, BSN, MSN, CCNS, CHC, co-founder of the National Society of Health Coaches, and principal, Miller & Huffman Outcome Architects in Winchester, TN. Huffman has presented workshops on patient engagement at the Case Management Society of America conference and other conferences.

Huffman teaches two models for better patient engagement and listening: the evidence-based health coaching (EBHC) model and the motivational interviewing (MI) model, which was created by psychologists William Miller, PhD, and Stephen Rollnick, PhD. *(See sample of how to use EBHC and MI, page 17.)*

"They can use these skills with managed care to help motivate patients," Huffman says. "It's a way of communicating and guiding those individuals to have more empathy with people they're working with and to be a better listener."

Listening might not come easily to healthcare providers whose training focuses more on providing care and giving instructions. Their default practice is to tell patients what to do because that's how they were taught, she says.

"If I were a case manager who is working with another healthcare provider, I would encourage the case manager to use these new listening skills," Huffman says. "There's no question about the outcomes to be achieved with this method."

The key is to connect with patients in a way that allows patients to feel engaged in the process, Huffman says. *(See tips for actively engaging patients, page 18.)*

Teaching does not create this connection because it involves the one-way act of giving information, she says. "Teaching doesn't motivate patients to act and be fully engaged or to take action on their own behalf," she says.

"That has to come from the provider helping patients discover for themselves what their motivators are and what they are willing to do on their own behalf," Huffman says.

Learning how to motivate patients can produce an exhilarating feeling: "We've had clinicians say, 'I have never felt as much as a clinician as I do now,'" she adds.

Teaching patients and providing them with information about their condition and treatment is necessary, but it's not necessarily the best way to encourage behavior change, she says.

"The reasons people change behavior are personal — not because they don't have the knowledge to change," Huffman says. "If someone hasn't acted on an instruction and there's ambivalence there, it's because they feel two ways about the issue and so they're stuck."

It's the same ambivalence a person might feel about adding a daily exercise regimen to their routine: "'I would exercise every day, but I get home late from work and I just don't have time,'" Huffman says.

"It's the 'but' in the middle," she adds. "When it comes to resistance, there's an internal argument because we feel two ways about something; if I push you to do it, then because of the internal argument you naturally

## EXECUTIVE SUMMARY

Case managers can help patients with health behavior changes by using a method combining evidence-based health coaching (EBHC) and motivational interviewing (MI).

- EBHC/MI combine open-ended statements and questions with empathy to improve listening skills.
- While directives and teaching are traditional methods for obtaining a patient's behavior change, this approach fails to consider the patient's ambivalence and concerns about the suggested change.
- The EBHC/MI model assumes that arguing with someone about the benefits of change and sternly warning them of the consequences of not changing can create resistance.

will take up the other side of the argument."

The EBHC/MI model is based on the premise that arguing with someone about the benefits of change and sternly warning them of the consequences of not changing can create resistance. "It's a naturally occurring phenomenon — ambivalence," Huffman says. "So what we try to do is avoid resistance and avoid trying to argue."

Here's a healthcare example: A patient has high blood pressure that could result in a stroke. The case manager might be very emphatic in suggesting the patient make changes to reduce the blood pressure, Huffman says.

Years ago, if a hypertension patient told Huffman that he was uncomfortable with the diet and couldn't stick with it, Huffman's response would have been, "Oh yes you can! We're here to help you. You'll do just great." That traditional type of response totally dismisses the patient's concerns.

The EBHC/MI response would be: "What is your concern about that? What is causing it?"

This isn't an easy way to get someone to change their behavior, but a small step in that direction, she says.

"It's one tiny piece of skills to help someone to lower their resistance and to think about what is creating an issue for them," Huffman says. "Then the case manager can be there to help in terms of guiding, listening, and providing information that can empower patients to be more accountable."

The key is for providers and case managers to make a paradigm shift in their thinking. Instead of giving patients suggestions for fixing whatever their problem is, case managers can guide them to discover their own motivators and suggestions, she says.

"While the concepts are simple to learn, they're not easy to implement," Huffman says. "It takes practice to implement them correctly in how you approach patients." ■

# Examples of EBHC And MI in practice

*Conversational skills shown*

The traditional provider-patient exchange can result in misunderstanding and a patient's incomplete knowledge of what he or she needs to do to maintain better health, one expert says.

With the evidence-based health coaching (EBHC) approach, combined with motivational interviewing (MI), a patient will gain a more complete understanding of what he or she is expected to do, according to **Melinda Huffman**, BSN, MSN, CCNS, CHC, co-founder of the National Society of Health Coaches, and principal, Miller & Huffman Outcome Architects in Winchester, TN.

The National Society of Health Coaches website at www.nshcoa.com contains additional information about how EBHC and MI work.

Huffman provides the following sample of how an EBHC with motivational interviewing works:

## Traditional approach

**Patient:** I think I might be able to give myself the insulin shot we talked about.

**Case Manager:** Good for you! I knew you could do it!

Then the provider goes on about his/her business of the day.

## EBHC w/ MI approach

**Patient:** I think I might be able to give myself the insulin shot we talked about.

**Case Manager:** "Might be able to." *(As a reflective statement, not a question; so the patient hears what he has said.)*

**Patient:** Yes.

**Case Manager:** Explain "might be able to." *(Open-ended response that encourages patient to expound.)*

**Patient:** If I had more practice.

**Case Manager:** Tell me about the concerns you have so we can address these in practice? *(Open-ended questions allow patient to explore and think about it.)*

**Patient:** Drawing up the right amount.

**Case Manager:** What troubles you most about it? *(Open-ended questions allow patient to explore further.)*

**Patient:** Being able to see the little marks on the syringe.

**Case Manager:** Would you like to look at the syringe together now and talk about it? *(Asking permission that empowers the patient in the relationship.)*

**Patient:** Yes, I would. ■

# Actively engage patients following these simple tips

*Can be used instead of teaching and directives*

Evidence-based health coaching (EBHC), a novel approach to engaging patients, combined with motivational interviewing can produce lasting change because it delves into the reasons behind patients' resistance, one expert says.

It produces health behavior changes that resonate with patients more effectively than the traditional approaches employed to convincing patients to change their health behavior, says **Melinda Huffman**, BSN, MSN, CCNS, CHC, co-founder of the National Society of Health Coaches, and principal, Miller & Huffman Outcome Architects in Winchester, TN.

"From my own experience and expertise in the field, if you do these you'll have improved health," Huffman says. "We know the better way of encouraging patients to change is to tap into their own motivation to act."

For several years, Huffman has used motivational interviewing to help healthcare providers encourage patients' behavior change.

"In the past, we told our patients what to do and didn't treat them as true partners in health," Huffman says. "What they bring to the table are their own personal values, beliefs, concerns, faith, and any health conditions they might have."

When patients make healthcare decisions, they do it through the social context of their lives including all of those factors, she explains.

"How often have you ever not filled a prescription after taking the trouble of going to the doctor?" Huffman asks. "Sixty percent of us will have gone to the doctor's office and yet not filled a prescription or followed their doctor's plan."

EBHC is a model for encouraging behavior change. "It's all about guiding, partnering, tapping into your patient's motivation or the patient's family's motivation to act," she says. "It's a 50-50 partnership, and to engage someone actively as a partner, that patient has to be involved to the point where the provider sees the patient as an active partner."

> "WE KNOW THE BETTER WAY OF ENCOURAGING PATIENTS TO CHANGE IS TO TAP INTO THEIR OWN MOTIVATION TO ACT."

## Patient engagement tips

Here are some of Huffman's tips on how to actively engage patients:

• **Do not think of patient engagement as compliance.** Patient engagement is not a directive the patient follows. It's the patient's involvement in the process of improving the patient's clinical care and health. Through collaboration, the patient becomes the expert in his or her own healthcare, and the foundation is built for behavior change, Huffman says.

• **Engage in skilled listening.** Providers are accustomed to doing most of the talking. But EBHC/MI encourages case managers and other providers to learn listening skills, including asking open-ended questions and waiting for a response. A listening skills self-assessment is available at http://www.nshcoa.com/pdf/listen.pdf.

• **Guide the agenda.** Case managers can ask the patient and the patient's family about what most concerns them regarding the health behavior change that's prescribed. First, all of their concerns should be considered, and then the case manager can guide the patient to identifying the concerns that have the most personal importance to him or her, Huffman says.

• **Address ambivalence.** Ambivalence results from conflict that maintains the patient's status quo. A case manager can have the patient list the reasons why he or she hasn't changed the behavior in one column and list the reasons why the behavior needs to change in another column, Huffman says. The patient can decide which of those behaviors has priority.

• **Brief encounter motivational interviewing.** Case managers can use motivational interviewing tactics to help the patient identify

the real issue or dilemma, Huffman says. This tactic includes open-ended questions, statements, and responses, as well as empathy.

For example, one open-ended statement could be, "Tell me what concerns you about ____ (taking insulin, quitting tobacco, changing eating habits, losing 35 lbs)." The key is to avoid interrogating, and to adopt a tone that suggests exploring the root concerns, she says.

• **Give information the patient desires.** Providers traditionally give information based on what they think the patient and family need to hear. They do not take time to find out what they already know or what their own immediate concerns are, she says. According to Huffman, the MI approach suggests asking permission from the patient to provide information, such as in this example: "What do you understand about high blood pressure? Would you like some more information about it?" ■

# New model significantly reduces boarding of psychiatric patients

*Program developers urge use in other communities*

No problem has proven more vexing to ED leaders in recent years than the issue of boarding related to patients with mental health concerns. It is not unusual for these patients to be held in the ED for hours, if not days, before a psychiatric bed is found. This has the effect of running up the healthcare tab while bogging down throughput, and it leaves virtually no one satisfied.

The good news is that new models of care are emerging that show promise in not only alleviating chronic instances of boarding, but also connecting mental health patients with appropriate care in a much more cost-efficient way. Further, it's clear that leaders in both the psychiatric and emergency medicine communities think the time is right to get both policymakers and regulators fully engaged on the issue.

## Look for new solutions

**Michael Gerardi**, MD, FAAP, FACEP, the incoming president of the American College of Emergency Physicians (ACEP) and an attending physician in the Department of Emergency Medicine at Morristown Medical Center in Morristown, NJ, has made it clear that tackling the issue of psychiatric patient boarding in the ED is a top priority in the coming year. He signaled his intentions on this issue in October 2014 during ACEP's scientific assembly meeting in Chicago, referring to the fact that there were already communities showing the way forward on this issue. In particular, Gerardi points to "the Alameda model," an approach developed over several years by **Scott Zeller**, MD, chief of psychiatric emergency services for the Alameda Health System in Oakland, CA.

"It was something that kept evolving over time. I kept adding parts that I thought made the most sense to help our population and also to improve things for EDs in the area," says Zeller. "I didn't realize how unique [the model] was until I became president of the American Association for Emergency Psychiatry from 2010 to 2012 and visited many different systems during that time."

That's when Zeller came to appreciate how significant the problem of boarding had become in EDs across the country, but he found it curious that the only solution anyone was talking about was building more psychiatric beds. "Psychiatry is the only medical emergency that seems to have a default treatment of hospitalization," he says.

It made much more sense to Zeller to focus more attention on treating psychiatric patients at the front end because what he had found through his own model was that when these patients are quickly connected with the appropriate psychiatric care, the vast majority of them don't require hospitalization. "That is when I [realized] that our system could really be a solution for a lot of people around the country," says Zeller.

## Streamline transfers

There are a number of critical pieces to the system now in place in Alameda County, but one of the first steps in putting the model together involved ending the common practice of having police officers transport patients on an involuntary psychiatric

hold, stipulated as "a 5150 hold" in California, to the hospital. "We created a system where police initiate the hold and then contact an EMS ambulance service. The police then transfer custody of the patient to the ambulance crew, and then the ambulance crew will do a field screening, looking only for medical stability issues," explains Zeller. "Then, based on some criteria that we wrote together with the EMS leadership, the ambulance crew will decide if someone is medically stable, and if they are, they will bring the patient directly to our dedicated psychiatric ED at John George Psychiatric Hospital [in San Leandro, CA]."

With this process, roughly two-thirds of all the patients placed on psychiatric holds go directly to the dedicated psychiatric facility for evaluation and treatment. The other one-third of patients — whom the ambulance crews have determined need more medical clearance — will go to one of the county's 11 EDs. For these patients, Zeller has established a streamlined process to facilitate transfer of the patients to the psychiatric facility as soon as they are medically cleared.

"The ED is just charged with making sure a patient is medically stable. As soon as [providers] feel comfortable that a person is medically stable enough to go to a psychiatric ED, they call us up and we immediately take the patient in transfer," says Zeller. "We don't request any specific labs, there is no specific alcohol level [required], and it doesn't make any difference what the patient's insurance is. We are just glad that someone has taken a look at these patients and made sure there isn't any medical compromise prior to sending them over to us."

The receiving psychiatric physicians at John George have a triage form that they use when accepting patients from area EDs. "All the patients are transported, physician to physician, using EMTALA [Emergency Medical Treatment and Labor Act] guidelines," says Zeller. "We are considered a higher level of care for psychiatric cases than other EDs, so [emergency physicians] can make a transport from ED to ED, similar to going from a general ED to a trauma center."

The way this typically works is the emergency physician will first call the receiving physician at John George to discuss the patient. "If they both agree that [a transfer to John George] is appropriate, which they do in the vast majority of cases, we will then take the patient immediately and will just have a short record of the discussion," says Zeller.

Not all patients with mental health concerns are appropriate for transfer to John George Hospital, says Zeller. "We are a very high acuity site that is only set up for people who have what EMTALA would define as psychiatric emergencies — being imminently dangerous to themselves or others, or being so incapacitated by a psychiatric illness that they can't care for themselves," he explains.

Nonetheless, by eliminating all the hoops that emergency providers often have to jump through before they can transfer a patient to a psychiatric facility, the boarding of psychiatric patients has been all but eliminated in the county, says Zeller. "The only boarding in our county is the length of time it takes for emergency providers to arrange transport from their facility to our facility, and two-thirds of the patients aren't even stopping at an ED anyway," he says. "We are pretty much trying to avoid any unnecessary use of medical EDs by psychiatric patients, but when they are in an ED, we try to get them out to an appropriate treatment site as quickly as possible."

## Consider alternative dispositions

Another key component of the model is the way John George Hospital manages psychiatric patients upon arrival. A triage nurse will first confirm that a patient is medically stable and conduct an initial evaluation. "Then the patient goes to a triage psychiatrist who is stationed right by the ambulance bay who will again assess medical stability and make a quick determination if some immediate medicines are needed prior to full evaluation," says Zeller.

At this point the patient will go to a large waiting room-type area where people can sit in chairs or lie down with a pillow or a blanket; people don't have individual rooms because it is an outpatient service, says Zeller. "People are worked with by psychiatrists, nurses, and social workers," he says. "We've got 23 hours and 59 minutes maximum to get them better, and by that point we have to have made a decision that we need to hospitalize them, send them home, or somewhere else that is less restrictive than an ED."

Currently, only 22% of the patients ultimately need to be hospitalized; the other 78% are able to go home or to an alternative situation such as a detox program, substance abuse program, crisis residential housing, or perhaps back to a board and care arrangement, says Zeller. "There are many dispositions that are a lot more comfortable and not nearly as coercive a situation as being in a hospital," he says.

## Eliminate unnecessary workups

**Mark Notash**, MD, who became medical director of the ED at San Leandro Hospital in San Leandro, CA, in April 2013, says the difference between the way psychiatric patients are managed in Alameda County and the other regions where he has worked is profound. "My experiences at other hospitals were so negative, with patients boarding for days or even up to a week," he says. "I have not experienced psychiatric boarding [here] except with pediatric patients who still need to have a bed at the psychiatric facility that we are allowed to send them to."

Notash adds that his throughput data have shown that psychiatric patients are getting out of the ED faster, on average, than medical patients who require big medical workups. "That is not because of reduced lab requirements, but because of the ease with which these patients are accepted [by the ED emergency program at John George Hospital]," he explains.

However, Notash notes that the program could work even more effectively. For instance, he observes that many emergency physicians routinely order labs and bloodwork on psychiatric patients even though these steps are not required under the model in patients who are deemed medically stable. This happens in the ED at San Leandro Hospital as well as several of the other EDs in Alameda County, according to Notash. "Both the issue of [establishing a particular] alcohol level and the issue of getting all the labs and drug screens on these patients can add hours to the process," he says. "So once everyone is educated about [the model], it can become even better than it already is."

Notash explains that he is also experiencing some problems with patients from outside the city of San Leandro presenting to his ED with a clear need for psychiatric hospitalization, but the police from the other jurisdiction have refused to place these patients on "a 5150 hold" because they also have a medical issue such as nausea, headache, or abdominal pain, he explains.

"What ends up happening in these cases is we need to call [the police in] those other places, and then sometimes they respond quickly, but other times it takes three hours for them to come [to San Leandro] and write a 5150 that, frankly, they should have written when they saw the patient and called the ambulance," says Notash.

If physicians could issue 5150s on their own in Alameda County, that would resolve the problem, says Notash, explaining that each county in California determines how it will handle 5150 holds. "I will be working with the county health officer, and if we can get that issue resolved by actually enabling physicians to issue the 5150, then it will be a non-issue, and I think the police will be happy," he says. "If I can get that [issue resolved] then basically we will be having the shortest length of stay of any hospital in the country for adult psychiatric patients."

## Push for change in philosophy

To persuade other regions to consider developing Alameda model-style solutions of their own, Zeller recognized that he would need data, so he designed a 30-day study during which researchers tracked all ED patients placed on involuntary mental health holds at five community hospitals in Alameda County. In particular, researchers noted the length of time between when patients were deemed stable enough for psychiatric disposition and when they were discharged to the regional psychiatric emergency service at John George Psychiatric Hospital.

The results, which were published in February 2014, showed that that in a sample of 144 patients, the average boarding time was one hour and 48 minutes, and only a quarter of these patients ultimately required inpatient psychiatric hospitalization. Researchers note that the boarding times were as much as 80% lower than comparable ED averages, and that the data showed that an appropriate psychiatric emergency service can stabilize more than 75% of psychiatric patients, significantly reducing the need for inpatient psychiatric beds.[1]

ACEP's Gerardi certainly took notice of the data, and so did a number of states and communities around the country. "We have had visitors from all over the United States, and we have helped other parts of the country develop their own versions of the model," says Zeller. "We know of 12 different programs that are getting started that we have had some bit of participation in, and we seem to get new inquiries about it every day."

However, a major stumbling block for many communities is coming up with a way to fund such a program. California's Medicaid program has established a unique billing code for crisis stabilization which has been sufficient to cover the program costs of the Alameda model and several similar approaches that have cropped up around the state.

To get around this hurdle, advocates interested in establishing a similar approach in their own regions need to push for the same type of

regulatory provisions or identify another source of funding, explains Zeller. Meanwhile, he and others in the psychiatric emergency field are advocating for coding changes on a national level.

"The key thing we have found is that not only can this billing code make it so these programs can be self-sufficient, but it also costs less than the cost of boarding, so actually creating this code saves money rather than creating a new demand for billing," says Zeller. "Then, if you are able to avoid three out of four people being hospitalized, then you are actually saving thousands and thousands of dollars per patient there also."

Making such a billing change is a "no brainer," according to Zeller, but he notes that it requires a general shift in philosophy with the understanding that most psychiatric emergencies can be resolved in less than 24 hours. "Once you get away from the idea that any psychiatric emergency requires hospitalization, then everything else can follow from that."

**Kimberly Nordstrom**, MD, JD, president of the American Association for Emergency Psychiatry and medical director of psychiatric emergency services at Denver Health in Denver, is wholeheartedly in favor of a national revenue code similar to what California has established for crisis stabilization. "We are reimbursed at a very low level, and because of that, most systems can't afford to have psych emergency services because we are providing a high level of care and getting reimbursed at a lower level," she says.

At Denver Health, there is a separate psychiatric emergency area that is adjacent to the medical ED, so psychiatrists are always available to see both patients from the ED as well as patients who present directly to psychiatric emergency services. Otherwise, Nordstrom explains that the service operates very similarly to the way the Alameda model does, with similar statistics. "We are able to discharge 76% of our patients, and we only see patients who are suicidal, homicidal, or what we call gravely disabled, meaning they can't take care of themselves," she says.

However, without adequate reimbursement, the psychiatric emergency service barely squeaks by financially, says Nordstrom. "Even though we are doing as high as an inpatient level of care, we are getting reimbursed on an outpatient level," she says. "So without re-looking at this whole revenue code issue, I don't think there will be more of these kinds of services popping up, and we will continue to see a lot of patients boarding in EDs [around the country]."

Nordstrom says she is heartened by the fact that this issue is finally getting added recognition, and she is hopeful that improvements are on the way. "Boarding now is considered a national crisis … so it is no longer just psychiatrists arguing for [change], it is emergency physicians," she says. Nordstrom adds that other medical specialties and associations are also engaged on the issue, and the national government is paying attention as well. "We are going to start working on this together rather than the way we have been doing it up until now, which has been individually."

Nordstrom's advice to ED leaders who are struggling with a boarding problem is to start forming partnerships. "You are not going to know about options until you start talking as a community," she says.

Notash agrees, suggesting that ED leaders open a dialogue with the medical directors at the psychiatric facilities in their communities. "Show them the research that Dr. Zeller has published with emergency physicians. If other counties could get this thing going, it would be very helpful because nobody has funding, and nobody has beds."

### REFERENCE

1. Zeller S, Calma N, Stone A. Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *West J Emerg Med* 2014;15:1-6. ■

# Progress lags on needlestick prevention

*Massachusetts hospitals rate same for three years*

Needlestick injuries remain stubbornly common, despite a long-standing federal law and worker safety regulations requiring an annual review of safety devices. Forging a path to improvement requires collaboration with hospital purchasing and quality improvement, says the coordinator of the nation's most comprehensive needlestick surveillance system.

"It's clear that devices that lack sharps injury prevention features are still available for purchase and hospitals are buying

them," says **Angela Laramie**, MPH, epidemiologist with the Massachusetts Department of Public Health Occupational Health Surveillance Program.

Massachusetts hospitals reported 3,019 sharps injuries in 2012, for a rate of 19.1 per 100 beds in acute care hospitals.[1] That reflects a decline of about 18% from 2002, when surveillance began. But the rate of sharps injuries remained essentially the same for the past three years.

Why has progress on sharps injury prevention stalled? An increase in reporting could make it seem that prevention efforts aren't providing new improvements, Laramie cautions. Conversely, as other occupational injuries such as patient handling get more attention, sharps injury awareness may have lagged, she says.

Massachusetts plans to conduct some analysis into the types of devices used and the units where injuries continue to occur, she says.

Some concerning trends are apparent from the surveillance reports. Little progress has been made in the operating room, where 44% of sharps injuries occurred in 2012. Almost one in four injuries (23%) was from a suture needle.

About 200 sharps injuries occurred with hypodermic needles that lacked safety features — although the Bloodborne Pathogen Standard of the Occupational Safety and Health Administration requires employers to use safety-engineered devices, when feasible. About 21% of sharps injuries involved devices from pre-packaged kits used in the OR.

That illustrates why it is important for employee health and infection preventionists to work together with hospital purchasing to ensure that the proper devices are included in kits, says Laramie.

Meanwhile, 54% of sharps injuries occurred with safety devices (excluding suture needles).

"[That] tells us we need to take a look at the devices that do have sharps injury prevention features and we need to do more research on the efficacy of the various mechanisms for these devices," she says.

"We've said consistently that devices with engineered sharps injury protection are not fail-safe and they are not the only answer. They are one component of a comprehensive sharps injury program," she says.

**MASSACHUSETTS HOSPITALS REPORTED 3,019 SHARPS INJURIES IN 2012, FOR A RATE OF 19.1 PER 100 BEDS IN ACUTE CARE HOSPITALS.**

## Look beyond numbers

OSHA requires employers to provide annual training on bloodborne pathogens and sharps injury prevention, and employers must review their safety devices at least annually.

While you should look at your data, go beyond the numbers and ask frontline employees which devices they like or don't like, Laramie says. If your injuries indicate that the safety feature was not activated, probe deeper, she says.

"Why aren't people using the mechanism? It might be that they're unfamiliar with the device. It could be a training issue," she says. "It could be that it's a poorly designed device. It should be intuitive. It should be easy and simple. If it's not, people might not be using it."

Laramie suggests partnering with quality improvement at the hospital to look more deeply at the causes of sharps injuries. A root cause analysis can reveal factors, such as a device that requires two hands to activate or a nurse feeling uncomfortable with the device.

The best strategy is to eliminate the sharp, such as using surgical glue rather than sutures. Passive devices, such as needles that retract without any additional action, are preferable to devices that require the users to activate the safety feature, Laramie says.

"I think there will always be a human component, but more and more we need to look at the design of devices [to reduce needlesticks]," she says.

### REFERENCE

1. Occupational Health Surveillance Program. Massachusetts Department of Public Health. August 2014. Available at mass.gov/eohhs/docs/dph/occupational-health/injuries/injuries-hospital-2012.pdf ■

## COMING IN FUTURE MONTHS

- Palliative care offers successful strategy for CM of end-of-life patients
- ART framework teaches better CM communication skills
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# CNE QUESTIONS

**1. According to Joanne Simone, RN, MBA, what do newly insured patients under the Affordable Care Act need most from case managers?**

A. Assistance making doctor appointments
B. Strategies for controlling their chronic illnesses
C. Education about the benefits and limitations of their new health insurance coverage
D. None of the above

**2. According to Melinda Huffman, why is teaching patients about the changes they need to make to improve their health not the most effective way to connect with patients and motivate them to change their behavior?**

A. Teaching is difficult and case managers are not well-trained to be the best teachers.
B. Patients tend to associate teaching with negative experiences and therefore do not pay full attention when a case manager is offering instructions.
C. Teaching does not create a connection between case manager and patient because it involves the one-way act of giving information and lacks the ability to motivate patients to act and be fully engaged in taking action.
D. None of the above

**3. Which of the following statements is not a method employed under motivational interviewing, says Melinda Huffman, BSN, MSN, CCNS, CHC?**

A. "Good for you! I knew you could do it."
B. "What troubles you most about it?"
C. "Tell me about the concerns you have so we can address these in practice."
D. "Would you like to practice this technique and talk about it?"

**4. Patient engagement is the same as compliance, according to Melinda Huffman.**

A. True
B. False