



HOSPITAL CASE MANAGEMENT

COVERING CASE MANAGEMENT ACROSS THE CARE CONTINUUM

MARCH 2022

Vol. 30, No. 3; p. 33-48

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Omicron Created Problems of Too Few Staff, Too Many Patients, Too Much Distress

By Melinda Young

After two years of the COVID-19 pandemic, healthcare leaders know how to react and prepare. But with omicron, the earlier lessons learned were not enough to prevent patient surges and staffing shortages.

“Across our organization, it’s worse than we expected. It’s the worst we’ve experienced,” says **Mary Beth Pace**, RN, BSN, MBA, CCM, vice president of care management of Trinity Health in Livonia, MI.

New data show a steep decline in nursing employment. Compared to October 2018 to December 2019, nursing employment was lower during the period of April 2020 to June 2021, including a 10% decline in nursing assistants and a 20% drop for licensed practical nurses.¹

Staffing problems appear to be even worse now. In January, newspapers from Massachusetts to Mississippi reported their hospitals were strapped

with too few healthcare workers and too many patients. Many locations requested help from the National Guard.²⁻⁴ Hospitals also reported large numbers of staff out sick with COVID-19, or waiting for test results.⁵ A record 155,900 people were hospitalized with COVID-19 by mid-January, according to the U.S. Department of Health and Human Services.⁴

“The biggest challenge with omicron is keeping the hospitals staffed. So many healthcare workers have omicron themselves,” says **Stephen Colodny**, MD, FIDSA, FACP, chief of infection control and prevention at St. Clair Health in Pittsburgh. “We’re trying as hard as we can to keep staffing safe and effective.”

Omicron has been less deadly than the delta variant because it mainly affects the upper pharynx instead of the lungs, Colodny says.

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

HOSPITAL CASE MANAGEMENT

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

GST Registration Number: R128870672.

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

TARGET AUDIENCE: This educational activity is intended for nurses and nurse practitioners who work in case management environments.

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

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AUTHOR: Melinda Young

AUTHOR: Jeni Miller

EDITOR: Jill Drachenberg

EDITOR: Jonathan Springston

EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS DIRECTOR: Amy M. Johnson, MSN, RN, CPN

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The main problem in managing omicron is its extreme transmissibility. “It’s way more transmissible than the original one, and more than delta,” Colodny adds.

Even people who are vaccinated and have received booster shots are getting sick, although their survival rate is significantly higher than those who are unvaccinated.

“If omicron can infect enough people before a new variant emerges, then there’s a significant possibility we will achieve herd immunity,” Colodny says.

But not without pain, particularly among the nation’s vast healthcare structure. Even if a smaller proportion of people are dying from COVID-19 now, too many are filling beds. Worse, too many healthcare workers — even when fully vaccinated — are contracting the virus and taking sick time. Plus, many nurses and other professionals have left hospital work, or left the field entirely.

Staffing, Patient Surges Are Pain Points

The dual challenges of staffing and the surge of patients make the current COVID-19 wave the worst

— despite the availability of highly effective vaccines.

“A few of our hospitals actually report higher volumes of COVID patients than they did during the other two surges that we have experienced,” Pace says. “You can anticipate to the best of your ability, but the fact of the matter is we don’t have enough beds and we don’t have enough staff to care [ideally] for the amount of patients who are hitting our emergency department.”

Michigan reported record-high COVID-19 cases in January, says **Colleen Parks**, MSN, CCM, ACM-RN, CMAC, director of system care management for Trinity Health.

“Our staff seem to be holding it together, doing a great job for their teams, but they’re drained,” Parks says. (*See story in this issue on how case managers endure and cope during the omicron wave.*)

With the first phase of the pandemic, and with the delta wave from mid-2021, fewer healthcare workers were getting ill. Facilities still had adequate staff to handle severely sick patients, says **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, senior director of care management nursing for Cleveland (OH) Clinic main campus.

EXECUTIVE SUMMARY

If the first COVID-19 surge was about safety, and the second surge about vaccination, then the third surge is about staffing. Health systems nationwide have seen too many employees leave their jobs and too many workers out sick because of exposure to omicron.

- Some states called in the National Guard to help overwhelmed hospitals.
- Omicron’s spread included mostly mild infections in fully vaccinated people, contributing to worker shortages.
- Although omicron sent a smaller proportion of infected individuals to the hospital, its larger and faster spread still caused hospitals to quickly fill with COVID-19 patients.

“This strain is washing through everything, everybody,” Davis says. “This round of COVID is more of a staffing issue, along with the surge of patients.”

In 2020, health systems learned a lot about staffing models, what worked, and what did not. But those early lessons have not been as useful as the pandemic evolved and changed, says **Meeta Prasad Kerlin**, MD, MS, associate professor of medicine, pulmonary, allergy, and critical care division at the University of Pennsylvania Perelman School of Medicine. Kerlin also is with the university’s Palliative and Advanced Illness Research Center. *(See story on study about hospitals’ COVID-19 response in this issue.)*

“There has been a lot of attrition — people leaving the healthcare workforce in droves and across professions, including nurses, respiratory therapists, physicians, and others,” Kerlin explains. “It’s probably because the last few years have been so taxing.”

Hospitals cope with shortages of beds and staff, including case managers. “Our hospitals are generally pretty full,” Davis says. “We used to be able to triage some patients and move them to another hospital that could care for them just as well, but now every hospital is full.”

Omicron has made the pandemic’s challenges even worse. “This has been terrible and really difficult. Every healthcare worker is exhausted,” says **Monica Gandhi**, MD, MPH, director of the University of California, San Francisco (UCSF) Center for AIDS Research (CFAR) and professor of medicine and associate chief of the division of HIV, infectious diseases, and global medicine at UCSF. “I don’t think anyone is going to escape exposure to

omicron because it’s so transmissible and everywhere. I think this idea that everyone is going to get it is, unfortunately, true.”

Is an End in Sight?

The good news is omicron is so efficient that it is helping build immunity among Americans, including those who are not vaccinated. This might help end the pandemic.

“We’re getting an astronomical number of cases, and we’re building a wall of immunity. A population of those who have been unvaccinated, and even those who have been vaccinated, are also getting a lot of exposure,” Gandhi says. “I think omicron will bring down quells of the pandemic.”

Once the pandemic ends, COVID-19 likely will remain, but in a more limited way, like the annual flu. “What happened in the 1918 pandemic is not that influenza went away. We deal with influenza every year,” Gandhi explains.

The pandemic phase of the 1918 influenza virus ended when populations reached higher levels of immunity. The next phase is endemic, meaning people deal with the virus every year, such as seasonal flu.

“It’s exhausting, and we have so much to go through, but life will get better for healthcare workers in the future,” Gandhi says.

The results of a recent study show nurses need effective communication from their organizations and leadership to support them through crises, such as the COVID-19 pandemic.⁶

“We spoke with nurses about what was healthy and what helped them with contemporary challenges that were pushing them physically

and mentally to the limit,” says **Shannon Simonovich**, PhD, RN, the study’s lead author and assistant professor of nursing in the College of Science and Health at DePaul University in Chicago.

Survey respondents said they wanted to see their leaders on the floor with them. They also benefited from knowing other nurses were present — that they were not in this crisis alone.

Respondents told researchers they believed their work during the pandemic was a call to duty, says **Roxanne S. Spurlark**, DNP, APRN, FNP-C, study co-author and assistant professor of nursing in the College of Science and Health at DePaul University. *(See story on the study of nurses during COVID-19 crisis in this issue.)*

“They felt they were on a battlefield,” Spurlark says. “They’re going to work because it’s a call to duty to serve others, to care for others, but they also felt like while they’re feeding others, they need to be fed, too.”

What healthcare professionals want boils down to these three things, Spurlark says:

- The presence of leadership and co-workers in their department, working on the floor;
- More and timely education about the pandemic and infection prevention;
- Emotional support from leadership and an understanding of their daily challenges.

The strain and distress nurses have experienced during the pandemic is what case managers also have experienced. Everyone’s jobs in hospitals and in the community have been altered because of the pandemic.

“They’re all exhausted, and case managers and social workers are no

different,” Pace says. “How they keep morale is based on what they do for their own teams.”

The teams at Trinity Health deserve credit for keeping their heads above water and trying different tactics to maintain team balance, Pace says.

“They try to encourage people to take time off when they can,” she adds. “I applaud each and every case manager because we support them as best we can, but they’re exhausted, and ‘exhausted’ is not a strong enough word.” ■

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Study Results Reveal How Hospitals Handled COVID-19’s First Wave

By Melinda Young

Healthcare systems’ responses to the first wave of the COVID-19 pandemic varied, but most canceled elective procedures to preserve intensive care unit (ICU) capacity and adapted staffing and physical space to prepare for patient surges, according to the results of a recent study.¹

“Hospitals in the first phase learned a little about what worked and what didn’t work, and what was needed and what was not needed,” says **Meeta Prasad Kerlin**, MD, MS, lead study author and associate professor of medicine, pulmonary, allergy, and critical care division at the University of Pennsylvania’s Perelman School of Medicine. “One example was elective surgery. Almost all hospitals canceled surgeries and procedures in the spring of 2020 in preparation for having more beds, more staff for COVID.”

But fewer surgeries were canceled during the surge in the winter of 2020-2021.² “I think that’s because we learned that it didn’t improve

our efficiencies, and we didn’t need to impede the care of non-COVID patients to improve the care of COVID patients,” Kerlin says.

Another difference is how hospitals dedicated space for patients with COVID-19. In the first phase of the pandemic, many hospitals created dedicated space for these patients, largely due to uncertainty about virus transmission, and the need to use personal protective equipment (PPE) efficiently.

“In the second phase, that was much less the case because we had learned how to take better care of COVID patients and to keep healthcare workers safe, even if patients were not all dedicated in one unit,” Kerlin adds.

With the omicron wave, health systems found one of their biggest challenges was unprecedented numbers of staff out sick with COVID-19. “This was despite having good PPE and people being vaccinated,” Kerlin says.

As health systems enter the third year of the pandemic, the challenges related to staff turnover and burnout are increasing — and should be a leadership priority.

“We need system-level attention and intervention that is focused on understanding and appreciating the needs and addressing the burnout that comes with it,” Kerlin says. “At a minimum, we need to acknowledge and appreciate the hard work healthcare workers are doing.”

Healthcare leaders also should implement changes to help alleviate staff stress, including public gestures of appreciation, such as billboards that thank healthcare workers.

“I was reading an [op-ed/article]³ somewhere about how at the start of the pandemic, there was appreciation for healthcare workers, and two years later, all of that is gone,” Kerlin says. “We need to renew the sense of appreciation, such as billboards of healthcare workers — but maybe that’s not enough.”

Hospital workers are experiencing disdain and threats of violence from family members of patients and others. In a September 2021 survey, more than 30% of hospital nurses reported an increase in workplace violence.^{3,4}

“One way to start recognizing and appreciating staff is to listen to them about what they feel they need,” Kerlin says. “A big challenge might be that what is needed most is more staffing. That’s hard to come by right now because the workforce is diminished.”

Kerlin and colleagues asked about triage policies and whether health systems were undertaking any policies related to crisis standards of care, such as who can or cannot receive a ventilator, or who can or cannot be admitted to the hospital.

“Largely, in 2020, hospitals

said they were prepared for triage, but didn’t have to implement it,” Kerlin says. “The hospitals were not completely overwhelmed in the winter of 2020-21. But there’s a lot of concern that omicron is going to push hospitals into thinking about all of those things again.”

For example, some hospitals in small networks or regions might have to make triage plans because of the speed and ferocity of the omicron surge.

“We do see omicron is less severe and has a lower rate of critical illness,” Kerlin explains. “But the point is that even a small percentage of hospitalization of millions of people sick at the same time can tip things over.” ■

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Infection Prevention Tips for Omicron Variant

By Melinda Young

As omicron swept through the nation, creating chaos at hospitals, the Infectious Diseases Society of America (IDSA) made four major suggestions for how organizations and individuals can prevent infection and serious illness.

“These four pillars are our best way out of this phase of the pandemic,” said **Jeanne Marrazzo**, MD, MPH, FIDSA, treasurer of the IDSA board of directors and director in the division of infectious diseases at the University of Alabama at Birmingham. Marrazzo spoke at an IDSA virtual media conference on Jan. 11.¹

• **Vaccination.** “All you need to do is look at the statistics for each hospital,” Marrazzo said. “We have a graphic out every day with people

icons, including some with COVID vaccination. Clearly, it’s impacting people without vaccination.”

There are few options to prevent people from illness, but vaccines and boosters remain the most effective approach, she added.

• **Masking.** “There are lots of data from the community level that masks really work,” Marrazzo noted. “Should you be wearing KN95, N95 masks? Sure — if you can get them and wear them in settings where you need them.”

The most important part of masking is a proper fit. If someone’s KN95 mask makes them uncomfortable, they might wear it around their chin. That is less protective than if they wore a more comfortable cloth mask.

“Wear what feels good, what feels protective, and, most importantly, mask when you need to,” Marrazzo advised.

• **Stay home when sick.** “When you’re sick, you’re more infectious,” she said. “The sicker you are, the more likely you are going to transmit it to other people.”

The latest advice is to stay in place and isolate when sick, and to not go out to a testing site. “Don’t go get tested and wait for a test. As soon as you feel sick, stay home. Ideally, tests will be available for free at home,” Marrazzo said, referring to the Biden administration’s plan to send 500 million COVID-19 test kits to people’s homes.

Should someone’s home test come back positive, they would be safest by

isolating for 10 days. But few people who feel well will want to quarantine for 10 days.

“Our workforce is decimated,” Marrazzo added. “We’ve been faced with getting people out of isolation faster; just make sure you have no symptoms in five days — especially a fever or anything that prompts testing.”

• **Testing.** “Testing is the gateway to management and to prevention,” Marrazzo said. “If you are sick, it’s helpful to know that you need to more strongly isolate and ensure yourself that you are no longer infectious.”

Healthcare workers and the public should keep in mind infectious disease physicians, scientists, and public health officials are doing their best to impart new COVID-19 information and

recommendations as quickly as possible.

“We’re still building the plane as we are flying,” said **Joshua Barocas**, MD, vice chair of the IDSA public health committee and an associate professor of medicine at the University of Colorado School of Medicine Anschutz Medical Campus. Barocas also spoke at the IDSA conference.

“New evidence is coming on a daily basis, so it’s important to put this in context,” he said. “We have individual goals and public health goals, and part of the discourse is making sure people understand why we’re recommending one thing instead of another.”

Barocas’ overall goal as an infectious disease physician and epidemiologist is to protect older people, those who are vaccine-ineligible because they are younger

than age 5 years, and to protect people who are vulnerable to severe disease, including people who are immunocompromised and those who are unvaccinated.

“My goal is to not get sick myself so I can help my workforce,” Barocas said. “I agree with the World Health Organization that vaccine equity is one of the most important things worldwide that we need to have done. I have had the booster because of the two goals of wanting to protect my community and to protect myself so I can remain in my workforce. Boosters have been shown to do that.” ■

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Care Transitions Are Trickier Than Ever as Pandemic Wreaks Havoc

By Melinda Young

The bottleneck of patients many health systems experienced in early winter was created by a perfect storm of these problems: too few employees, too many patients sick with the omicron variant, and too many ambulatory settings also experiencing staffing problems.

Hospitals continue redeploying staff. The National Guard was called in to help. But when beds are full because patients are too sick to go home without some assistance from a skilled nursing facility (SNF) or home care — and those organizations are not taking new patients due to capacity problems — the bottleneck continues.

“Case managers are showing how valuable they are,” says **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, senior director of care management nursing for Cleveland Clinic. “What case managers are really good at is pivoting. If a plan is not working, they’ll try another plan, and that’s always been their skill. Now, I think other disciplines are recognizing that talent.”

Sometimes, physicians or nurses will ask case managers, “Have you tried this?” “The case manager says, ‘Yeah, that was five steps back,’” Davis adds. “Most of them do not know what we do; they just know it gets done.”

But they can only find so much flexibility in an overburdened system of healthcare entities that rely heavily on everything flowing in one direction.

One of the biggest challenges is patients waiting in the emergency department (ED) for beds on the inpatient unit, says **Mary Beth Pace**, RN, BSN, MBA, CCM, vice president of care management at Trinity Health in Livonia, MI.

“Not as many patients require ICU beds at this phase of the pandemic,” Pace explains.

However, it is difficult to transition patients from hospital beds to ambulatory care or to home with

care services. “We’re missing so much staffing — not just frontline nurses, but also dietary aides, housekeeping, and it’s starting to affect case management as well,” Pace notes. “A lot of that is those who are close to retirement are choosing to retire. The other thing is quarantining the team because they were exposed or COVID-19-positive.”

The staffing problems extend to ambulatory settings, home health, and even companies necessary for care transitions to function well.

“If we want to transport a patient back to their home in Tennessee, and our ambulance company’s drivers are sick, this can have a kind of domino effect,” Davis says.

Case Managers Get Creative

Organizations can be more creative in funding services to help reduce the bottleneck. For example, case managers could suggest the health system pay for a different ambulance service. “That’s more cost-effective than keeping a patient in an acute care bed,” Davis says. “If there’s not an ambulance available from the resource you normally use, or if there isn’t anyone willing to pay for it, then

it makes sense for the hospital to pay for it rather than keeping a patient in the bed.”

Redeploying case management services to help overburdened groups also can help.

“For a little bit of time, we had our utilization management team report to case management,” Davis says. “When they realized how short-staffed the hospital was, they also stepped in and did case management assessments by phone for our patients, stopping what they were doing with utilization management and insurance reviews.”

Another tactic is to flip the case management priorities around compared to what they were pre-pandemic. During a crisis, when it is imperative to transition patients because of overcrowded EDs, case managers can move the very ill and long-term patients to a lower priority to transition than those who could be sent home with only a little extra support.

“Rather than focus on long-term patients with a lot of problems, focus on the low-hanging fruit, those who have the ability to move,” Davis explains. “Some hospitals would say they have always done that, but for big facilities that hasn’t always been the focus.”

This way, more patients could be discharged home after receiving additional support and education. “We try to send everyone home who we can vs. sending them to another facility,” Davis explains. “But some patients have to go to another facility, and the skilled nursing facilities are saying that if a patient has COVID, it’s 10 days before they can take them.”

SNFs at Crisis Point

The staffing levels at SNFs also are at a crisis point, contributing to the bottleneck in care transition. “SNFs are struggling more than acute care hospitals in being able to handle their residents,” Pace says. “That has been a huge barrier to us across all 24 of our states, and it varies from state to state when challenges hit. We’ve even had some SNFs that wouldn’t take their own residents they sent us, and it was because of unsafe staffing levels.”

Some payers are helping by not requiring authorization for the next site of care. But if no SNFs or ambulatory facilities are available, this does not solve the problem, says **Colleen Parks**, MSN, CCM, ACM-RN, CMAC, director of system care management for Trinity Health. Case managers can adapt to these care transition roadblocks by coming up with a different, but still safe, plan.

For instance, if a case manager cannot find a SNF for a patient, it might be safe to keep the patient in the hospital for several more days and for the hospital’s therapy team to work with the patient before he or she can be discharged, Davis suggests.

“Everyone can change their way of thinking from being a consultant to being a treating provider or therapist right now so we can get the patient moved,” she explains.

EXECUTIVE SUMMARY

Omicron caused a perfect storm of too few employees, too many patients, and case managers becoming even more creative and flexible in transitions of care.

- Fewer patients needed intensive care unit beds, but more were bottlenecked in emergency departments, waiting for beds on the inpatient unit.
- Due to employees out sick with omicron, transitions to ambulatory care were blocked by staffing shortages in skilled nursing facilities, ambulance services, and other home health organizations.
- Some payers tried to ease the bottleneck by not requiring authorization for the next site of care, but this was limited by capacity at other community organizations.

This is similar to how case managers have always created backup plans for transitioning their patients. In non-pandemic times, if a patient would benefit from care in a SNF, but the patient's payer does not agree, then case managers help the patient find a different plan.

Home care agencies also have experienced staffing issues. If it is not possible to make those referrals, one tactic is to work with patients' families and caregivers to teach them how to care for the patient.

"We've had terrible trouble finding home care agencies because of staffing," Davis says. "We have had to ask families to do more. They can learn how to do some things while they're in the hospital."

While this is not ideal — shifting care to family members can be frightening for patients — it's the best option when the patient needs to go home and home healthcare is not an option.

"If you can't find anyone else, you teach them in the hospital and send them home, then check with them by phone to see how they are doing," Davis explains. "We're trying to be as flexible as we can and keep the patient safe, doing follow-up phone calls from our ambulatory case management team."

Case management leaders and care coordinators are learning a great deal about how to manage patient care and transitions during a major and long-lasting crisis. But the key is to

remain flexible. What worked at the beginning of the pandemic might not have worked well in the second or third phases.

"People were thinking two years ago, 'We'll write a playbook,' but it's a different chapter of that playbook now," Davis says. "We're thinking about what has worked, what didn't work."

They learned it is possible to conduct case management assessments by phone, although it is not ideal.

"Most of us would prefer to meet a patient in person, but we learned that we can definitely [call them], and it works," Davis adds. "We became innovative with what's the best way to reach a patient." ■

Want to Retain and Support Staff? Better Communication from Leadership Helps

By Melinda Young

Hospital nurses need effective communication from leadership to help them cope with the long COVID-19 pandemic, according to the results of a recent study.¹

Nurses also need to be part of leadership gatherings, local meetings, and decision-making to share their daily experiences and help find solutions to the unprecedented emergencies created during the past two years.

"In many ways, our research study is a time capsule, and you can put yourself in the frame of mind of these nurses when we spoke with them [in 2020]," says **Shannon Simonovich**, PhD, RN, lead study author and assistant professor of nursing in the College of Science and Health at DePaul University in Chicago. "The workforce was faced with a quickly

evolving landscape and disease process. What we intuitively think of as a direct path for patient care was ineffective. We needed new solutions and brainstorming."

Investigators asked nurses 13 questions about their experience during the early part of the pandemic, including:

- "How did the nursing leadership in your department prepare you to work with COVID-19 patients?"
- "Tell us about PPE [personal protective equipment] use during COVID-19. Has this changed over time?"
- "How do you feel taking care of COVID-19 patients?"
- "What implications does the COVID-19 pandemic have for nursing education?"

Nurses shared three main concerns early in the pandemic:

- Access to adequate PPE;
- Caring for COVID-19 patients;
- Ineffective communication from management.

"We heard a lot about communication, and that was what led to a lot of nurses leaving the field," Simonovich says.

Hospital nurses reported their relationships with colleagues helped them survive the first wave of the pandemic, says **Roxanne S. Spurlark**, DNP, APRN, FNP-C, study co-author and assistant professor of nursing in the College of Science and Health at DePaul University. Mental health interventions and additional pay also help, although broader support is needed for a long-term crisis like the pandemic.

“In the first wave of COVID, no one knew how to manage the patients,” Spurlark says. “If you don’t know how to care for patients, how can you care for yourself as well?”

Plus, the infection prevention rules and guidance changed often. “Here come another group of rules you have to abide by that are very different than 15 minutes ago,” she says. “It became, ‘How do we have avenues of communication that are up to date?’”

In their study, Spurlark and Simonovich focused on what worked well in the first phase of COVID-19. “The focus in this paper on COVID was to create information that would be helpful,” Simonovich says. “The positive themes were wanting your leadership to be physically present, timely with up-to-date information, and provide emotional support.”

Study participants did mention some negatives, including a lack of leadership presence on the floor, nurses not receiving timely or enough education, and a lack of emotional support.

“Those three things have contributed to a lot of burnout, especially now that we’re [about two years] into the pandemic,” Simonovich says. “It’s one thing to be in a pressure cooker for a short period of time. But for nurses, especially those providing bedside care in the United States, there hasn’t been any relief.”

The nursing workforce is generous

with their time and talents. They believe only their co-workers and others in healthcare can understand what they are going through.

“An overworked nursing workforce doesn’t have confidence in leaders or emotional support,” Simonovich says.

Researchers found many examples of good leadership from survey respondents. Here are a few:

- “I remember driving in at 3:00 in the morning once and my regional [nurse leader] giving me a call and saying, ‘Are you OK? I’m headed in with you. I know you’re coming in.’”

- “In the beginning, the guidelines changed almost daily because we were learning as we went. We have a daily huddle board. That whole huddle board became a COVID board. As things came from nurse education and the command center and infectious disease, I would make sure I educated all my staff, but also posted all of that on the COVID board.”

- “[We] have what’s called a ‘Zen den,’ and it’s supposed to be a room [where] you can sit and reflect. On your lunch hour, a nurse can sit down and just think or process [their] feelings.”

- “I work with a bunch of awesome nurses. We [have] good camaraderie, good teamwork, things like that. We all kind of just leaned on each other [saying], ‘Hey, we’ll see you tomorrow.’”

- “We created a wellness team [of nursing liaisons] that [go] around 24 hours a day, giving away food, snacks, but also just talking. Our nursing liaisons have a good relationship with our nurses, [and we] added our psychiatrist or psychologist on the rounds also.”

Another way nurse and case management leaders can provide support is to include staff in management planning and brainstorming.

“Have nurses in those meetings,” Simonovich says.

Case managers and nurses know their work challenges best, and it shows them leaders are taking their concerns seriously when they are included in management meetings and planning sessions.

Good leaders create a sense of “We — we’re in this together.”

“When leadership says, ‘We,’ it changes the whole perspective,” Simonovich says. “There should be more transparency. We know what good communication looks like, and it’s within our grasp to do this together — not only as professionals, but also as human beings.” ■

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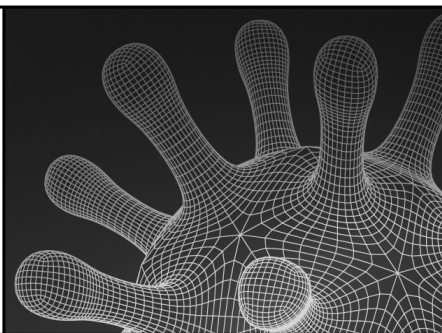
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Undiagnosed Dementia a Risk for Older Patients

By Melinda Young

Patients with dementia may be at greater risk of hospitalization and ED visits, yet many are undiagnosed or unaware of their dementia diagnosis.¹

“A lot of times, clinicians are reluctant to use the word ‘Alzheimer’s’ or ‘dementia,’ so they may say to a patient, ‘You have memory loss,’” says **Halima Amjad**, MD, MPH, lead study author and assistant professor of medicine in the division of geriatric medicine and gerontology at Johns Hopkins University School of Medicine and Johns Hopkins Bayview Medical Center.

Avoid Euphemisms

When Amjad sees that a patient with Alzheimer’s disease or dementia is unaware of the diagnosis, she will talk with the family about what the diagnosis means, and avoid using euphemisms like “memory loss” or “cognitive impairment,” which patients might not understand means dementia.

“There is a lot of stigma about dementia,” Amjad says. “Even though there are studies showing that a diagnosis does not increase anxiety or depression, there’s a fear it will cause depression.”

But the dementia diagnosis is important for patients to receive quality care when they are seen by clinicians and in hospitals.

When patients are undiagnosed, or are unaware of a dementia diagnosis, they might lack needed caregiver support or struggle to manage their diseases because no one recognizes their cognitive impairment, Amjad explains.

Amjad and colleagues used national health and aging trend data that included measures to identify patients with dementia, even if it is not officially diagnosed.

“We focused on those with probable dementia, but we didn’t see anything in their medical claims showing they had been diagnosed clinically,” Amjad explains. “We know from research that people with dementia are more likely to be hospitalized than are those without dementia.”

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People who were unaware of their dementia diagnosis were at higher risk of hospitalization, after adjusting for medical factors. Their risk was comparable to those who were aware of their dementia diagnosis. “They’re landing in the hospital and emergency department more,” Amjad adds.

The patients with undiagnosed dementia were not at greater risk of hospitalization when compared with people without dementia. “They were at lower risk compared to people who were diagnosed and aware,”

Amjad says. “This went against what we thought we might find, but in some ways it validates that these individuals are less cognitively impaired, maybe flying under the radar.”

People with undiagnosed dementia might be carrying on well enough in their daily lives that their impairment went unnoticed by family members, who usually are the first ones to notice dementia and mention it to medical providers, Amjad says.

Case managers sometimes observe cognitive problems among patients who have not received a dementia diagnosis. Or, they may see patients with a diagnosis of which the patients and family members are unaware. When this happens, they could help patients and families understand what happens with dementia and cognitive issues.

“If it seems the patient or family is completely unaware, then if the case manager feels comfortable, they should talk about what they see in the chart or ask the primary care doctor to share the diagnosis more clearly,” Amjad adds.

Case managers also could educate families about the cognitive symptoms or issues related to dementia. They could show family members how to understand patients’ needs, such as helping patients remember to take their medication. Case managers can ask family members to accompany the patient to medical appointments and to start a family support system to help as the patient’s memory loss worsens.

“The patient will need support for complex tasks, like medication management, understanding

medical information, and going to appointments,” Amjad says. “The family may not realize the older person needs help in those areas.” ■

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unaware of dementia. *J Am Geriatr Soc* 2021;Nov 13. doi: 10.1111/jgs.17550. [Online ahead of print].

Loneliness and Social Disconnection Common During COVID-19 Pandemic

By Melinda Young

More than one-third of Medicare beneficiaries said they were more socially disconnected, and nearly one in four reported they were lonelier during the COVID-19 pandemic, according to the results of a recent survey.¹

“There was some overlap, but not total overlap,” says **Louisa Holaday**, MD, MHS, lead study author and instructor in the division of general internal medicine at Icahn School of Medicine at Mount Sinai in New York City. “One thing that comes up in the literature is that asking people directly about loneliness [can be a problem] because it’s stigmatized. But asking them questions like, ‘Are you feeling less socially connected?’ is a way to get the same answer without it seeming stigmatized.”

Internet Access Is No Help

From a case management perspective, any questions designed to screen patients for loneliness also should avoid the word “lonely,” Holaday notes.

“It’s important when people ask, they ask in these indirect ways, saying, ‘Do you see friends, neighbors, and family? Do you feel like you have someone you can talk to? Do you have someone you can connect with?’” she suggests.

Researchers also explored how access to the internet affected the older population’s feelings of loneliness. Their findings were surprising, Holaday says.

“We found that people who had access to the internet were more likely to say they felt lonely,” she says. “The people who lived alone and who had internet access were the most lonely, and we don’t know why.”

This is a topic that researchers should investigate. “It would be interesting to know what is going on with older adults who are on the internet,” Holaday says. “What are the things that are negative for their mental health, and how do we mitigate that?”

It suggests case managers could recommend patients stay connected with family and friends through regular phone calls, rather than through social media posts.

“There are some studies suggesting that the internet can’t replace the phone call connection, and it can’t replace contact in-person,” Holaday says. “People do better with phone calls.”

Access to the internet and online healthcare information has benefits, but it is not the answer to social isolation. “Asking, ‘Is there someone who can call you regularly?’ might be more meaningful,” Holaday says.

Holaday offers these additional suggestions for how case managers

can help patients reduce loneliness and social isolation:

- **Ensure patients have a primary care provider.** “People who had access to a regular doctor for check-ups were also less likely to report feeling lonely,” Holaday says. “It might be their doctor was asking these questions and encouraging them to stay connected with others.”

- **Ask patients if they have any friends, counselors, or other trusted individuals they can talk to when they need support.** “We know this is important because for older adults, feelings of isolation and loneliness can lead to bad health outcomes later on,” Holaday says.

- **Ask patients if they feel lonely, but do this indirectly.** “Do not ask them the direct question of, ‘Do you feel lonely?’” Holaday suggests. “But, say, ‘Do you have someone you can talk with? Do you feel like you have companionship?’”

Those questions will help a case manager discover the patient’s underlying concerns and issues, without having them answer a potentially stigmatizing question.

- **Look for organizations that can provide connections and social support to older patients.** For example, some communities offer doula programs that link older adults with community volunteers, who will call them regularly. Meals on Wheels visits, phone calls from church

members, and other outreach also helps alleviate loneliness.

The COVID-19 pandemic has contributed to more people feeling lonely and disconnected.

“Health systems should ask people when they’re being discharged or coming in for primary care, ‘Do you have someone you can connect with?’

Are you feeling socially isolated?’”

Holaday suggests. “It’s important for your health that you talk with someone regularly. Right now, we’re all going through this pandemic, where we feel fewer connections than we did before. We’re all a little more isolated and are doing our best to stay safe and keep others safe.” ■

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Effect of COVID-19 on Patient Severity of Illness, Evaluating Hospital Performance

By Jeni Miller

It has become well-established over the past two years that the COVID-19 pandemic has affected healthcare from almost every angle, including the healthcare of those not suffering from COVID-19.

Thomas Higgins, MD, MBA, FACP, MCCM, chief medical officer for The Center for Case Management and ICU attending physician at Baystate Medical Center in Springfield, MA, recently studied the effects of COVID-19 on patient severity of illness and how it can affect hospital performance.

Expected Mortality Rates Differ

In a 2021 study, Higgins and colleagues found COVID-19 is different than regular viral pneumonia in terms of expected mortality.¹

“COVID patients are sicker,” Higgins says. “Even using a risk-adjustment tool, such as APACHE [Acute Physiology and Chronic Health Evaluation], a hospital’s outcomes are going to look worse than expected, thanks to COVID.”

Higgins notes patients with COVID-19 not only experience

a higher mortality rate, but also a longer length of stay than other viral illness patients, even when adjusted for other patient factors such as age and comorbidities.

Because of this, it is a challenge to evaluate hospital performance during the pandemic.

“When it comes to hospital mortality rates, you have to consider patient mix,” Higgins explains. “What kinds of patients is the hospital seeing? If you’re at a hospital doing a lot of ‘bread-and-butter’ cases, your unadjusted mortality rate will likely be average. But at a referral hospital, such as Baystate or the Cleveland Clinic or Mass General, unadjusted mortality will be higher than at a community hospital because academic centers accept difficult cases in transfer from the community. Normally, a benchmarking tool such as APACHE or the Mortality Probability Model helps adjust for these systematic differences in presenting severity of illness. These tools help a hospital calculate standardized mortality ratio [SMR], which is the observed divided by the expected mortality rate. An SMR of 1.0 suggests a hospital is performing as expected. Standardized ratios can

also be calculated for length of stay, ventilator days or other outcomes. But COVID presents a challenge, since accurate coefficients for a novel diagnosis have not yet been determined. What we know is that using the corrections for usual viral pneumonia, with or without acute respiratory distress syndrome, are insufficient.”

Effects on Benchmarking Efforts

For hospitals taking in many patients with COVID-19, there is concern quality of care has declined, as performance numbers are looking worse than prior years.

“I’ve gotten calls from clients at The Center for Case Management, and many are saying, ‘We are looking worse this year than we ever have,’” Higgins shares. “But patient flow issues due to longer length of stay doesn’t necessarily mean the care has changed. It means that the patients are qualitatively different than what we’re used to.”

But how can hospitals adjust and know how to appropriately benchmark their performance,

especially in an unstable situation like COVID-19, with its ever-evolving variants? Higgins recommends hospitals keep in mind the higher mortality rate and longer length of stay of patients with COVID-19 — a reality that can quickly drive entire hospital statistics higher, as these patients have an “outsized influence on overall mortality rate.”

Data from APACHE revealed that in a group of 43 hospitals throughout the country that contribute to the database, length of stay has increased. Ventilator days averaged 10.4 days for patients with COVID-19 vs. 4.3 days for typical viral pneumonia patients.¹

“The APACHE research team has determined that standardized ratios are about 1.5 times higher for COVID-19 vs. viral pneumonia patients,” Higgins explains. “But it’s a changing situation with alpha vs. delta vs. omicron variants, evolving therapeutic interventions, and the impact of vaccination, which is shifting population characteristics.”

The effect of the pandemic on non-COVID-19 patients also should be considered.

“Due to hospital capacity constraints, even non-COVID patients have been found to have a higher mortality rate and longer length of stay,” Higgins notes. “People had been delaying care and coming in later. We have ongoing staffing shortages that are spreading nurses and doctors thinner. Even in the ICU, the usual 1:2 nurse-to-patient

ratio might be stretched to a 1:3 ratio, or worse.”

The lack of ICU beds, longer ED waits, and delays in care for patients who must bypass the nearest hospital when on diversion all potentially contribute to a higher mortality rate for non-COVID-19 patients, Higgins says.

“We have preliminary evidence from the APACHE database that SMR in non-COVID patients increases during times of high COVID census,” he explains. “These data have been published as a letter,² and we’re currently preparing a more detailed study for publication.”

Case Management Concerns

Case managers should note the effects of COVID-19 extend beyond the hospital setting, affecting case management work in several ways. Case managers should remember the following:

- Capacity constraints are extending to home healthcare, skilled nursing facilities, and other post-acute areas, affecting discharge planning.
- There is more competition for a limited supply of resources, which also can cause delays. Even durable medical equipment and drug availability have been disrupted.
- Staff shortages and capacity issues prevent patients from moving

from the ED to an inpatient or observation bed.

- Length of stay is affected not only by the higher severity of COVID-19 patients, but also by shortages and lack of resources.
- Margins and finances will look different, as it is harder to care for patients in an economically sustainable manner when they are waiting around the hospital longer.

There is not much case managers can do beyond “casting a wider net as to where to place patients,” Higgins says. “They should also expect that this will be a longer and more difficult process to get from acute to post-acute. Hospitals and case managers alike should also adjust their expectations, but we are not yet sure if we’ll ever get back down to pre-pandemic levels of performance due to patients delaying healthcare. It may be a permanent increase.” ■

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Best Practices in Utilization Management

By Jeni Miller

The increasing complexity of healthcare has taken the field of case management along for the ride, and with it the practice of utilization management.

“The four roles of case management have become more complex — utilization management, discharge planning, care coordination, and resource management,” says **Beverly Cunningham**, RN, MS, ACM, partner and consultant at Case Management Concepts, LLC. “Each requires increased balanced, significant interventions by the case manager, taking more and more of the limited time a case manager has in his or her day to focus on these four roles.”

Utilization management (UM) has become much more comprehensive, notably with payers. “Payers have ‘loose’ rules and regulations, meaning they seem to change the rules as it fits each circumstance/patient,” Cunningham explains. “Each payer has their own rules and regulations, and seem to do whatever it takes to not pay for services rendered to their members. Medicare has also become more prescriptive in their expectations for utilization management.”

With these regulatory challenges, case managers must “spend more time collaborating with physicians to ensure documentation in the medical record accurately describes the severity of illness and next steps in the medical plan for the patient,” Cunningham says. “It is much more difficult for physicians to understand the expectations of the various payers.”

One helpful asset is the physician advisor, which Cunningham recommends for each hospital,

as the role requires significant knowledge, excellent communication skills, and perseverance, “especially when working with payer medical directors.” Larger hospitals might need multiple physician advisors.

Another challenge includes the emerging practice in some hospitals of removing UM from the bedside,

“THE FOUR ROLES OF CASE MANAGEMENT HAVE BECOME MORE COMPLEX — UTILIZATION MANAGEMENT, DISCHARGE PLANNING, CARE COORDINATION, AND RESOURCE MANAGEMENT.”

making it a remote position. This often happens because payers have many varied requirements, yet it results in a greater challenge to the case manager on the unit to understand the expectations for each payer.

“This is especially challenging with a large case load,” Cunningham says. “As UM has separated from the traditional role of the unit case manager, there is an increased need for collaboration between the staff doing UM and the case manager on the hospital unit. Additionally, the physician now has to communicate with [both] a case manager on the unit and the UM staff. A sense of urgency is critical [for both UM

and discharge planning] as patients are transitioned through a hospital. When there are several case managers — on the unit and the UM staff — that urgency is often lost.”

Best Practices

Regardless of these challenges and changes, case managers have a great opportunity to employ several best practices to bring consistency to the UM process, and successfully contribute to the overall management of each patient’s stay.

- **Bring clarity to the UM role.**

While there is no cookie cutter answer to the best model of UM, says Cunningham, it is important to thoroughly vet the appropriate role in each hospital. This is especially helpful when onboarding new staff. Likewise, setting clear goals for the organization and team can help promote a healthy environment.

- **Hire appropriate clinical staff.** “If the UM team has a strong clinical background, then a clearer understanding of the disease process will help plan for effective use of resources,” says **Pat Wilson**, MBA, BSN, RN, director of care transition management at Texas Health Presbyterian Hospital. “A cohesive team will support and help one another so collaboration becomes the norm.”

- **Orientation is critical for success.** Cunningham and Wilson agree staff must undergo adequate orientation and an annual competence review. “If the UM employee is hired from outside your organization, assigning a mentor who can translate the culture will lead to positive relationships with

the physicians and care team,” Wilson says. Connecting with the recommendation above to bring clarity to the role, it also is important to define the expectations of the role, ensure it mirrors the job description, and ensure the team has the resources necessary for positive outcomes and cost-effective patient management.

• **Recognize the multidisciplinary nature of UM.** While UM is a case management role, the entire multidisciplinary team contributes to it. “While a case manager and social worker may be [handling] timely coordination of care in preparing the patient for discharge, delays can occur by other hospital staff,” Cunningham explains. “If nursing does not ambulate a patient, or even get them in a chair for meals, their progress will be slowed, and can delay their discharge. Medication errors may extend the hospital stay. For example, delayed tests from radiology can delay either discharge of a patient or delay the physician’s determination of next step in treatment of a patient. Additionally, lack of availability of weekend testing and surgery can delay a patient’s discharge.”

• **Prioritize continuing education.** Cunningham and Wilson recommend periodic and ongoing education of staff, especially when rules and regulations change. Regular feedback for staff also enhances education opportunities.

• **Establish an effective physician advisor program.** “It’s important to maintain an active participation with patient access, physician advisors, and utilization review if this is not within the scope of the case manager,” Wilson suggests.

• **Say yes to rounds.** Cunningham suggests case managers should participate in “case management leadership rounding with staff to increase awareness of their challenges

and any compliance errors that may be occurring.” Daily multidisciplinary rounds are “an absolute must,” she adds. Bedside rounds are optimal. UM staff also should participate. Wilson agrees, stating this offers an “opportunity to address any barriers for discharge with the team” as well as presenting “a united front with the patient and family.”

• **Communication.** Wilson emphasizes the importance of written and spoken communication, and encourages case managers to “listen, listen, listen.” Case managers should hone the skills and ability necessary to “meet people where they are, [including] the physicians, care team, patients, families, and post-acute providers,” she adds.

• **Attention to detail.** “Ensure your managed care contracts contain appropriate UM verbiage,” Cunningham says. “If you don’t have it in the contract, the payer has no guidance for your expectations.”

Case managers should strive to be aware of “payer mix and demographics, and build a strong body of community resources that is refreshed at least quarterly,” Wilson adds.

• **Organization, boundaries, and responsibility.** Since case managers face multiple competing priorities throughout the day, staying organized will alleviate the stress, keep the case manager on track, and prevent crises, Wilson says. Setting boundaries are important, and there are limitations in every situation. “Do the best you can today, and take responsibility for your actions, both the good and the bad,” she notes.

While the list of best practices may seem unattainable at first, Cunningham suggests case managers identify a mentor in the department if one has not been assigned. Other allies include supervisors, and even physicians, both of whom the case manager should strive to collaborate with daily.

In the meantime, understanding the big picture of UM and what it entails, and continuing to learn how to incorporate it into the daily routine, will help case managers become more proficient. The result will be fewer denials, less confusion for the team, and a decrease in delays in care — all of which lead to a better patient, staff, and hospital experience. ■

CE OBJECTIVES

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

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

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CE QUESTIONS

1. COVID-19 caused major staffing problems at health systems nationwide. Licensed practical nurse staffing declined what percentage when compared to pre-pandemic rates?
 - a. 10%
 - b. 15%
 - c. 20%
 - d. 25%
2. To prevent staff illness and infection from COVID-19, the Infectious Diseases Society of America suggests:
 - a. vaccination, boosters, and social distancing.
 - b. vaccination, masking, staying home when sick, and testing.
 - c. masking, social distancing, and testing.
 - d. vaccination and masking.
3. Which was one of the biggest challenges for hospitals affected by the omicron surge?
 - a. Procuring enough personal protective equipment (PPE) for staff and patients.
 - b. Patients waiting in the ED for inpatient beds.
 - c. ICU bed turnover.
 - d. Handling patients on ventilators.
4. Which can contribute to a delay in the patient's discharge?
 - a. Collecting the patient's discharge documents
 - b. Waiting for the patient's family
 - c. Delayed tests
 - d. Delayed patient meals
5. Researchers found people who were diagnosed with dementia but were unaware of their diagnosis were at a higher risk of:
 - a. transfer to a skilled nursing facility.
 - b. isolation and loneliness.
 - c. chronic disease.
 - d. hospitalization.
6. Which of the following is a tactic case managers can use to help older patients ease their loneliness and feelings of isolation?
 - a. Ensure patients have internet access and know how to use it.
 - b. Provide patients with daily check-in text messages.
 - c. Provide patients with hospital discharge kits of books, stuffed animals, and crafts.
 - d. Ensure patients can access a primary care provider.
7. The results of a recent study revealed what hospital nurses needed most from their employers and managers during the pandemic were timely COVID-19 information, emotional support, and:
 - a. leadership that is physically present.
 - b. safer working conditions, including adequate PPE.
 - c. appreciation for their hard work.
 - d. small gestures of appreciation, like bringing food to the units.