HOW HOME CARE IMPACTS HOSPITAL READMISSION RATES 22

ISSUE 6 | 2023

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# EVIDENCE-BASED PRACTICE

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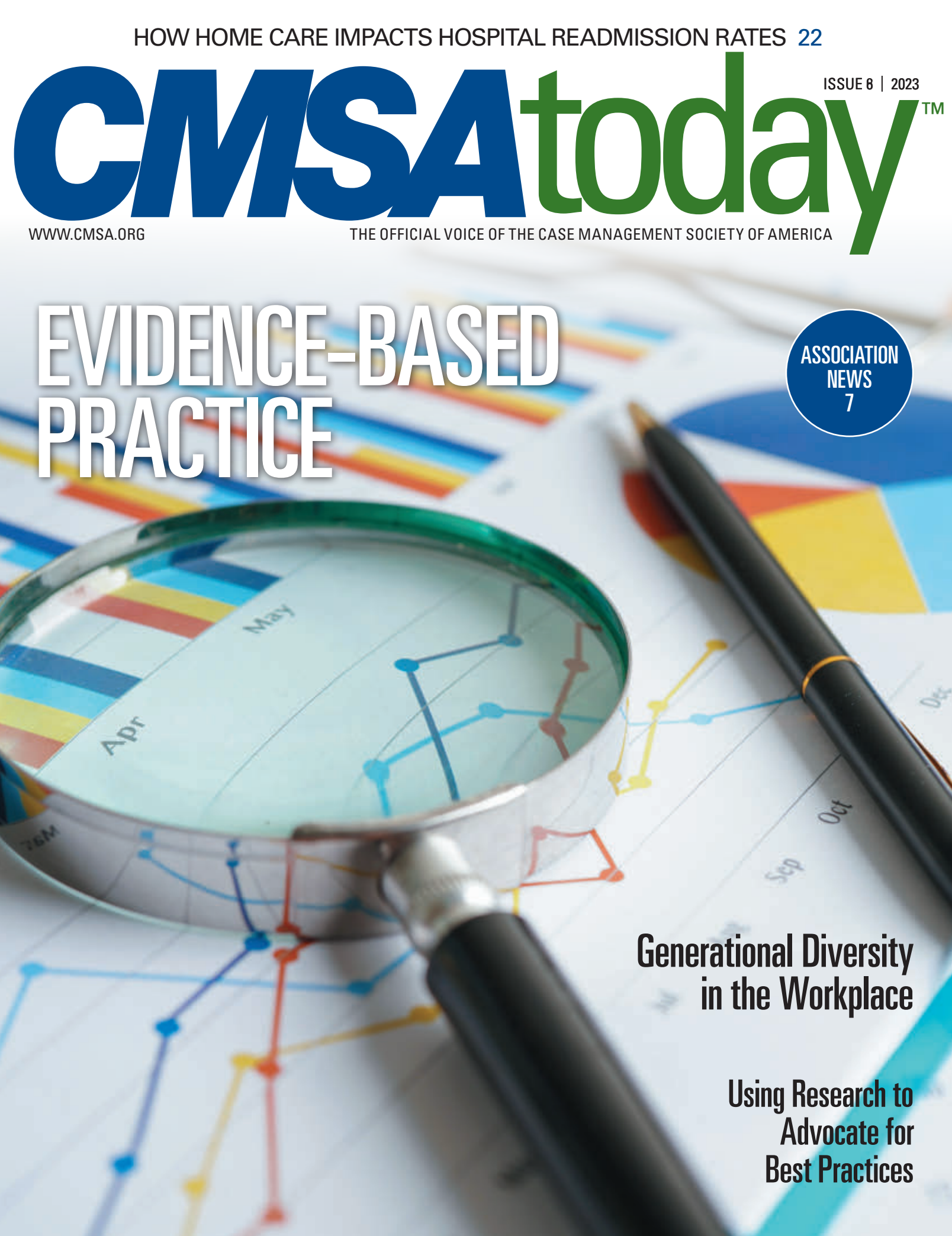


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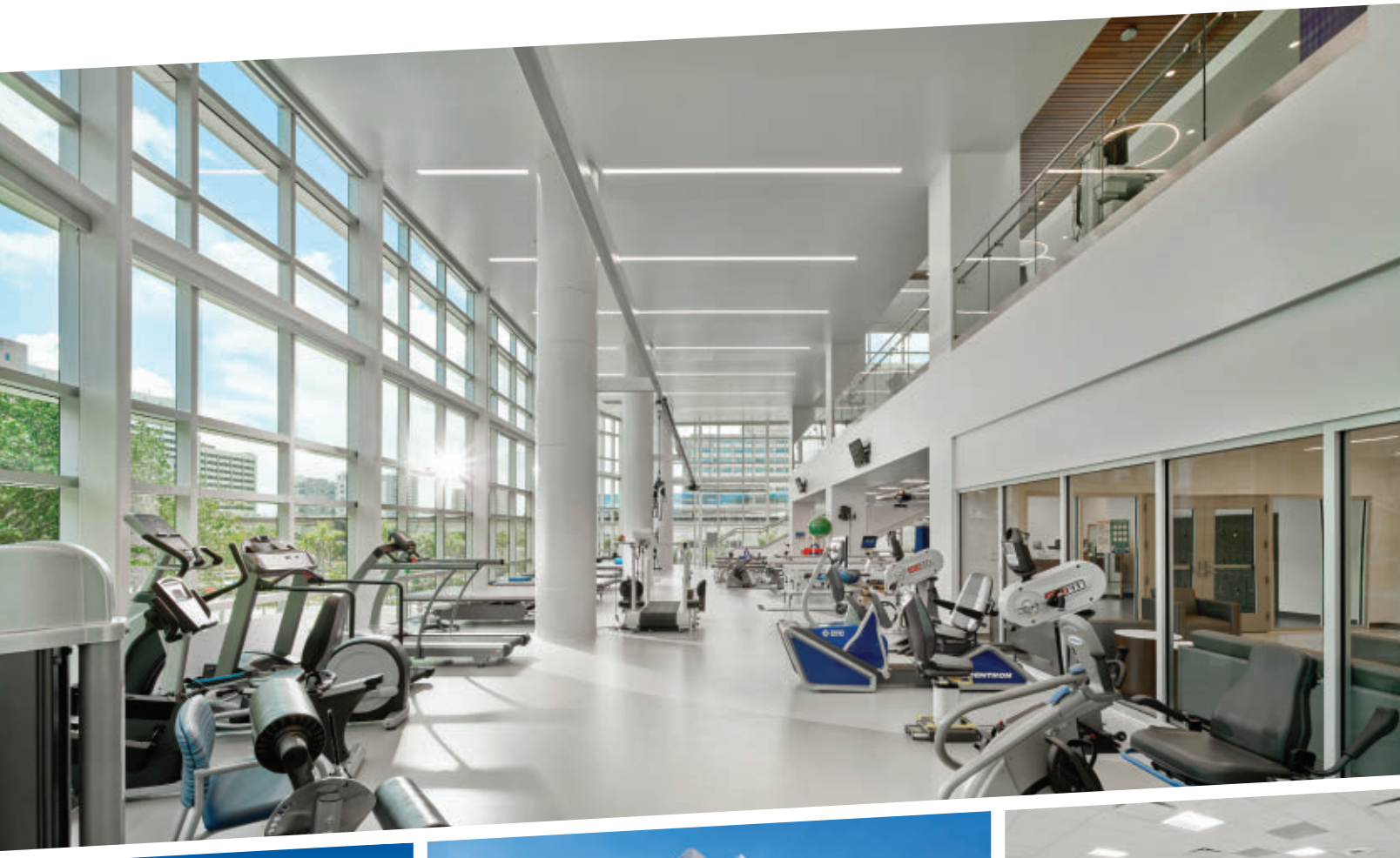

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# ISSUE THEME

## EVIDENCE-BASED PRACTICE

Evidence-based practice integrates clinical expertise, patient values and preferences, and the best available scientific evidence. Within this issue, you will find the cutting edge practices that are helping to move the practice of professional case management forward.

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**BY DR. COLLEEN MORLEY, DNP, RN, CCM, CMAC, CMCN, ACM-RN, FCM**

In the ever-evolving field of healthcare, professional case management plays a crucial role in coordinating patient care and ensuring optimal outcomes. However, to provide the highest quality of care, it is imperative that medical case managers rely on current evidence-based practice.


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# The Vital Role of Evidence-Based Practice in Professional Case Management

EVIDENCE-BASED PRACTICE

**BY DR. COLLEEN MORLEY, DNP, RN, CCM, CMAC, CMCN, ACM-RN, FCM**

This is one of my favorite issues of *CMSA Today*, our annual issue dedicated to the importance of evidence-based practices (EBP) in case management. In the ever-evolving field of healthcare, professional case management plays a crucial role in coordinating patient care and ensuring optimal outcomes. However, to provide the highest quality of care, it is imperative that medical case managers rely on current evidence-based practice. Evidence-based practice integrates clinical expertise, patient values and preferences, and the best available scientific evidence. Within this issue, you will find the cutting edge practices that are helping to move the practice of professional case management forward. So, why is EBP so important? What's all the fuss about?

One of the fundamental principles of evidence-based practice is the consideration of patient values and preferences. In case management, understanding the unique needs and goals of each patient is paramount. By incorporating EBP, case managers can make informed decisions that align with the patient's values, ensuring a patient-centered approach to care. This not only enhances the patient's experience but also increases their engagement in their own healthcare, leading to better adherence to treatment plans.

Professional case managers are entrusted with helping to make critical decisions regarding a patient's care plan, which often involves complex medical conditions and treatment options. Evidence-based practice equips case managers with the tools to critically appraise and interpret research findings, allowing them to make informed and evidence-based decisions. This reduces the likelihood of errors, improves the quality of care and ultimately leads to better patient outcomes.

The cornerstone of evidence-based practice is the incorporation of the best available scientific evidence into clinical decision-making. By relying on well-established research and clinical guidelines, case managers can be confident that their interventions are based on proven methods. This not only leads to improved patient outcomes but also reduces unwarranted variations in care, thus promoting consistency and quality across healthcare systems.

In today's healthcare landscape, resource allocation is a critical concern. Evidence-based practice in case management can help optimize resource utilization by focusing on interventions and treatments that have demonstrated effectiveness. This approach can lead to cost savings for healthcare organizations while maintaining or even improving the quality of care provided to patients.

The field of healthcare is constantly evolving, with new research and technologies emerging regularly. Evidence-based practice encourages case managers to stay current with the latest developments by regularly reviewing and updating their knowledge and skills. This adaptability ensures that patients receive the most up-to-date and effective care available.

Professional case management often involves collaboration among various healthcare professionals, including physicians, nurses, therapists and social workers. Evidence-based practice promotes effective communication and collaboration by providing a common framework for decision-making. This interdisciplinary approach fosters a cohesive and coordinated approach to patient care, leading to better outcomes.

Evidence-based practice is the backbone of professional case management. It empowers case managers to make informed decisions, tailor care plans to individual patient needs and improve the quality and efficiency of healthcare delivery. By prioritizing EBP, healthcare organizations can enhance patient outcomes, optimize resource utilization and maintain compliance with regulatory standards. Ultimately, the adoption of evidence-based practice in medical case management is essential for delivering the best possible care to patients and driving positive changes in the healthcare industry. As you read through this issue, I ask you to take a look at what you are doing within your practice setting and consider sharing your best practices with the wider case management community. Together, we move the profession into the light! ■

**Dr. Colleen Morley, DNP, RN, CCM, CMAC, CMCN, ACM-RN, FCM**, *is the associate chief clinical operations officer, care continuum for University of Illinois Health System and the current president of the Case Management Society of America National Board of Directors. She has held positions in acute care as director of case management at several acute care facilities and managed care entities in Illinois, overseeing utilization review, case management and social services for over 14 years; piloting quality improvement initiatives focused on readmission reduction, care coordination through better communication and population health management.*

*Her current passion is in the area of improving health literacy. She is the recipient of the CMSA Foundation Practice Improvement Award (2020) and ANA Illinois Practice Improvement Award (2020) for her work in this area. Dr. Morley also received the AAMCN Managed Care Nurse Leader of the Year in 2010 and the CMSA Fellow of Case Management designation in 2022. Her first book,* A Practical Guide to Acute Care Case Management, *published by Blue Bayou Press, was released in February 2022.*

*Dr. Morley has over 20 years of nursing experience. Her clinical specialties include med/surg, oncology and pediatric nursing. She received her ADN at South Suburban College in South Holland, Illinois, BSN at Jacksonville University in Jacksonville, Florida, MSN from Norwich University in Northfield, Vermont and her DNP at Chamberlain College of Nursing.*

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# Case Management Fellows

## Making an Impact on the Professional Practice of Case Management

Launched in 2021, the Case Management Fellow (FCM™) program from the Case Management Society of America (CMSA) aims to honor distinguished individuals who have made significant contributions to the professional practice of case management through leadership, innovation and scholarship.

### ELEVATING THE BEST AND BRIGHTEST

The Case Management Fellows represent a diverse and accomplished community of thought leaders who actively identify future trends and address critical issues affecting case management. They serve both the public and case management by advancing the standards of practice through excellence. Earning the FCM™ designation is a mark of high proficiency in the professional practice of case management, demonstrating a commitment to ongoing education and publication while establishing Fellows as influencers shaping the future of the profession.

The program is designed to acknowledge the vital role that thought leadership plays in advancing the field of case management. By identifying and celebrating these accomplished individuals, the program not only honors their achievements but also encourages others to strive for excellence in their professional journey.


## WHO ARE CASE MANAGEMENT FELLOWS?

*Thought Leaders and Ambassadors:* FCMs are the recognized leaders of the case management community. They serve as ambassadors not only for their organizations but for the entire profession. These individuals are visionary thinkers who possess the ability to anticipate and adapt to the ever-changing landscape of healthcare and social services. Their strategic insights and innovative approaches are instrumental in driving positive outcomes for individuals and communities.

*Mentors and Mentees:* Mentorship is a cornerstone of the FCM™ designation. These leaders are committed to nurturing the next generation of case managers. They provide guidance, support and opportunities for growth to aspiring professionals, ensuring a bright future for the field. Through their mentorship, FCMs empower others to reach their full potential and make their impactful contributions.

*Authors and Speakers:* FCMs are not only practitioners but also prolific authors and speakers. They contribute to the body of knowledge in case management by publishing research, sharing best practices and presenting at conferences and seminars. Their work is instrumental in disseminating valuable information, fostering collaboration and inspiring innovation within the profession.

**FCMs are dedicated to serving the public and elevating the standards of practice within the profession, all while demonstrating an unwavering passion for their work.**

*Trailblazers and Facilitators:* At the heart of every FCM is strong leadership. They lead by example, demonstrating the highest ethical standards, compassion and dedication to their work. Their ability to facilitate change and foster collaboration among multidisciplinary teams is instrumental in improving outcomes for the individuals they serve. FCMs are not merely passive observers; they are proactive in identifying emerging challenges and finding solutions.

FCMs are dedicated to serving the public and elevating the standards of practice within the profession, all while demonstrating an unwavering passion for their work. Earning the prestigious FCM™ goes beyond expertise; it reflects a commitment to lifelong learning, continuous education and the dissemination of knowledge through publications and presentations. It is a mark of excellence that distinguishes Fellows as influencers, guiding the growth and evolution of the case management profession.

## FCM MINIMUM QUALIFICATION CRITERIA

- Hold a case management certification from a nationally recognized certifying body.
- Be a current member of CMSA for most recent five years.
- Minimum of 10 years in the professional practice of case management.


- Possess professional licensure or hold an advanced health and human services degree.

## BENEFITS OF THE FCM™ DESIGNATION

Being named a Case Management Fellow carries numerous benefits, both for the honoree and the profession. Here are some of the advantages:

- **Prestige and Recognition:** The FCM™ designation is a prestigious honor that acknowledges an individual's outstanding contributions to the field, making them a recognized leader in case management.
- **Leadership Opportunities:** FCMs have the opportunity to take on leadership roles in shaping the future of case management, influencing policy and driving innovation.
- **Networking:** Fellows become part of a distinguished community of impact-makers, allowing for collaboration, knowledge-sharing and networking with peers who share their passion and commitment.
- **Professional Growth:** The FCM™ designation encourages ongoing learning, research and publication, fostering continuous professional growth and development.
- **Advancing the Profession:** By recognizing excellence, the program helps raise the standards of practice in case management, benefiting both professionals and the individuals they serve.

**Success in case management is earned through dedication and the pursuit of excellence, not through shortcuts or financial means.**

Case Management Fellows (FCM™) embody the essence of leadership, excellence and innovation within case management. Their dedication to advancing the profession, mentoring the next generation and sharing their knowledge through publications and presentations is invaluable. FCMs are not only influencers but also stewards of the profession, ensuring that case management continues to evolve and adapt to the ever-changing healthcare landscape. As they champion the highest standards of practice, they make a lasting impact on the lives of individuals and communities, leaving an indelible mark on the professional practice of case management.

As we celebrate the accomplishments of our Fellows, let us remember that their status is a testament to their unwavering commitment and impact. It is a reminder that success in case management is earned through dedication and the pursuit of excellence, not through shortcuts or financial means.

Become an FCM to honor your contributions, the values of professionalism, integrity and a commitment to improving the lives of those case managers serve. Becoming a Fellow is not a destination but a reflection of the journey you have taken in positively impacting the world of case management.

To apply to become an FCM, visit **www.cmsa.org**. Completed applications and the program fee must be received by January 15, 2024. ■

*As of November 1, 2023*

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## WE APPRECIATE Your Support

# GENERATIONAL DIVERSITY IN THE WORKPLACE

BY JANET S. COULTER, MSN, MS, RN, CCM, FCM, AND, MARYANN OTT, BSN, RN, CCM, CPC


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Leading a generationally diverse workforce is challenging. Effective leaders understand that each generation brings unique strengths, characteristics, values and challenges to the workplace. The generationally diverse workforce also brings different expectations and life experiences to the workplace. That is why it's important for leaders to adapt their management and communication styles. While every individual is unique, there are some common differences and similarities in how each generation perceives their work and their workplace. These differences impact communication, motivation and how they want to be managed. This article will present each of the five generations in the workforce today. Included will be generational differences and similarities, communication styles, the meaning of success, working styles, approaches to problem-solving and decision-making in the workplace and tips for managing and motivating each generation. Interventions to successfully close generational gaps will be presented along with the ethical concepts of nonmaleficence, beneficence, autonomy and fidelity.

There are five generations in the workplace today: Traditionalists, baby boomers, Generation X, millennials and Generation Z.

## TRADITIONALIST: THE GREATEST GENERATION

Traditionalists were born before 1946. They have survived World War I and World War II, Black Tuesday, Pearl Harbor and the Koren War. This generation is united by a common purpose and values (duty, honor, economy, courage, service, love of family and country, responsibility for oneself). Other common experiences shared by this generation include the "Roaring Twenties" (a time of prosperity), Prohibition, the Great Depression (stock market crash), the automobile, big bands, rationing and FDR's New Deal. The main source of entertainment was the radio, which included shows by Abbott and Costello, Milton Berle, Bob Hope, Edgar Bergen and Charlie McCarthy. Their life centered around their family, church and school. They lived before TV, computers, ballpoint pens, frozen food, penicillin, dish washers, clothes dryers and panty hose. This generation is described as hard workers, frugal savers, patriotic, loyal, dependable and respectful. They are concerned about finances, affordable housing, personal safety, declining health, adequate transportation, preparation for death, spiritual needs and elder abuse.

Tom Brokaw, who wrote a book about this generation, stated, "It is, I believe, the greatest generation any society has ever produced."

## BABY BOOMERS, THE LARGEST GENERATION

Baby boomers were born between 1946 and 1964. They are the babies that followed World War II. Over 4 million babies were born each year between 1954 and 1964. This generation is described as "challengers." They challenged the morals and traditions of their parents, schools and government, and they pushed back against the status quo. Many of them came of age in a time when the United States was moving from the Industrial Age to the Information Age, which created a huge generation gap with their parents.

Baby boomers experienced many significant emotional events that shaped their generation. These significant emotional events included the assassinations of John Fitzgerald Kennedy, Martin Luther King and Robert Kennedy, the energy crisis, Watergate, Richard Nixon's resignation, the Cold War and the Cuban Missile Crisis. Baby boomers are "cause" oriented, especially related to the Vietnam War, the civil rights movement and the shooting at Kent State.

Rock 'n' roll took over the music scene with musicians like Elvis, the Beatles, the Monkees and the Rolling Stones. This generation was the first generation to grow up with a TV in the house. The popular TV shows were "Leave it to Beaver," "Father Knows Best," "The Brady Bunch," "Mickey Mouse Club," "American Bandstand" and "The Partridge Family." Economic stability and affluency grew as there were two incomes in most families. Baby boomers were given practically everything they wanted by their parents, who wanted them to have what they never had.

Baby boomers are considered the most educated generation in American history up to their time, with more than 25% receiving college degrees. This generation is described as future and growth-oriented as well as people and experience-oriented.

## GENERATION X

Generation X are those born following the baby boomers and preceding the millennials. This generation includes those born in the mid-to-late 1960s and ending in the late 1970s to early 1980s. Per the 2019 U.S. Census data, there are 65.2 million Generation Xers in the United States. Many of this generation are children of the silent generation and early baby boomers. Generation X are the parents of millennials and Generation Z.

Generation X is often referred to as "latchkey kids" due to a perceived lack of adult supervision after school, as parents were away at work during their formative years. They possess the following traits and characteristics: independent, resourceful, adaptable (with a strong sense of self-reliance), value maintaining work-life balance, may be skeptical of authority and often view work as just "a job to get done."

Many possess digital literacy and are tech-savvy because they grew up at the onset of personal computers and technology. Single-parent households were prevalent during the Generation X years. They witnessed the ups and downs of economic life, having lived through multiple recessions. As a result of such financial turmoil, they can experience challenges managing their cash flow. Generation X grew up under both The Traditionalist and the baby boomer generations, both being very different. As a result, Generation X received mixed influences. It was the norm to come home to empty houses, as both parents were working. Moms were now in the workforce. At this same time, parents' jobs were being downsized. Thus, Generation X places more importance on job security.

Differences between Generation X and other generations include a tendency to be less interested in traditional hierarchies and status symbols. They are more comfortable with change and ambiguity than those in the baby boomer generation and are less likely to rely on established institutions and systems. In comparison to millennials, Generation X is likely to prefer to focus on quality time and efficiency at work rather than work long hours. They also tend to be more self-reliant and less interested in collaborative work, preferring a more independent and self-directed approach. For these reasons, Generation X also became known as the "Me" Generation. Unfounded negative stereotypes of this generation include that they are lazy and coddled.

Significant emotional events for this generation include the fall of the Berlin Wall in 1989, the Great Recession, the Stock Market Crash of 2008, the emergence of music videos (MTV) and the rise of divorce rates. Some noted celebrities of this era are Leonardo DiCaprio, Johnny Depp, Kobe Bryant, Derek Jeter, Tiger Woods, Mariah Carey and the late Lisa Marie Presley.

## GENERATION Y, AKA MILLENNIALS

Millennials, also known as Generation Y, are those born following Generation X and preceding Generation Z. They were born between 1981 to 1996. Most are children of baby boomers and older Generation X. Millennials are the parents of the next generation, known as Alpha. Generation Y has been described as the first global generation and the first generation that grew up in the internet age. This generation is generally known for its elevated usage of and familiarity with the internet, mobile devices and social media. That's why they are sometimes called digital natives. Millennials have suffered significant economic disruption since starting their working lives. Many faced

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**While every individual is unique, there are some common differences and similarities in how each generation perceives their work and their workplace. These differences impact communication, motivation and how they want to be managed.**

high levels of youth unemployment during their early years in the labor market due to the Great Recession. They experienced another economic disruption in 2020 due to COVID-19.

The significant emotional events experienced by this generation included the 9/11 attack on the United States, the 2003 Iraq invasion, the Great Recession and the internet explosion. Growing up they were the "center" of the family. Family life included Mommie and Me activities and having a place at the family table. They were raised on tight activity schedules, and most went on to college. Millennials are also known as the boomerang or Peter Pan generation because of the perceived tendency for them to delay passage into adulthood for longer periods than generations before them. These labels are also a reference to a trend toward living with their parents for longer periods than previous generations. The higher cost of housing and education and the relative affluence of older generations are a few contributing factors to this. The characteristic of this tech-savvy generation is that they are one of the first generations to grow up with computers, cell phones, the internet and digital communication. Another characteristic of Generation Y is that they view the workplace entirely differently than other generations. They are work-life balance oriented.

Millennials tend to be more civically and politically disengaged, more focused on materialistic values and less concerned about helping the larger community than Generation X and baby boomers. They tend to put more emphasis on extrinsic values such as money, fame and image and less emphasis on intrinsic values such as self-acceptance, group affiliation and community. They have also been described as more open-minded and supportive of gay rights and equal rights for minorities. Other characteristics include self-confident, self-expressive, liberal, upbeat and receptive to new ideas and ways of living.

## GENERATION Z

Generation Z, also known as Gen Z or postmillennial, are a highly collaborative group that cares deeply about others. They have a pragmatic attitude about how to address a set of inherited issues like climate change. Their age range is defined as people born between 1997 and 2012. This means they are between 11 and 26 years old in 2023. Some factors that influence this generation are political, economic and technological changes.

Nicknamed "Zoomers," they are called digital natives, being the first generation to grow up with the internet as a part of daily life. Generation Z students prefer independent, self-paced and collaborative learning from various sources. Thus, a learning environment that aligns with Generation Z characteristics must be implemented. They face many challenges that are unique to their generation. Unfortunately, gun violence, police brutality, political unrest, immigration issues, sexual harassment, discrimination, shorter attention spans and increased mental health issues have all become embedded in their daily lives.

Significant emotional events for this generation include the Instagram debut, the terrorist attacks of 9/11, the invention of Facebook, 2012 Sandy Hook school tragedy, 2016 election of President Trump, 2019 TikTok arrival and the 2020 COVID-19 pandemic.

## BABY BOOMERS VS. GENERATION X VS. MILLENNIALS: HOW DO THEY DIFFER AT WORK?

Generation gaps stem from a misunderstanding of shared core values across the generations. Every generation has unique needs and a different view on work. The Traditionalists prioritize stability, hard work and respect for authority. Baby boomers like to work hard and play hard. Millennials prioritize work that aligns with their values, and that includes positive company culture, work-life balance and innovative, inclusive environments. Generation X prioritizes work-life balance, and Generation Z prioritizes a diverse, dynamic work environment.

Baby boomers like hybrid work situations and work-at- home. Millennials feel pressure related to performance and achievements when working from home. Generation X likes the financial benefits of remote working. Generation Z struggles with productivity and work-life balance while maintaining focus when working from home.

## GENERATIONAL VIEWS ON WORK

Traditionalists' attitude toward work was that a career is a job for life. They are usually disengaged from technology. Their motivation is home ownership. Baby boomers view their careers as being defined by their employers. They adapted to technology. They strive for job security. Nearly half of the baby boomers plan to work past age 70,

with financial concerns being the main factor for staying in the workforce. Generation X are loyal to their profession but not necessarily to the employer. They want work-life balance. Generation Y likes to work "with" organizations and not "for" them. They crave freedom and flexibility. Generation Z are career multitaskers who aspire to security and stability. They prefer to communicate with hand-held communication devices and are sometimes described as technoholics.

## WORKPLACE CHALLENGES FOR GEN X

One of the main challenges Generation X may face at work comes from feeling "sandwiched" between older and younger generations. Generation X may find it difficult to relate to the priorities and goals of both their older and younger colleagues, leading to feelings of isolation and disconnection. These gaps between all the generations can create tension and misunderstandings, as they are likely to have different communication styles, work ethics and expectations for the workplace. Another challenge Generation X may face is a lack of mentorship and guidance from older generations. Many baby boomers have retired or are nearing retirement, leaving Generation X without the same level of advice and support that previous generations might have had. Generation X may also find limited opportunities for advancement in the job market, as they may be viewed as "too experienced" for entry-level positions and "too junior" for some senior roles. As a result, Generation X employees may feel stuck in their current positions, leading to dissatisfaction and demotivation. These challenges may negatively impact the satisfaction and productivity of Generation X in the workplace. This sense of disconnect from coworkers can lead to trouble building relationships and working effectively as a team. A lack of mentorship and limited opportunities for advancement might lead to feelings of stagnation and disinterest in their work, resulting in disengagement and decreased productivity. Additionally, feeling overlooked and unsupported in the workplace can affect their job satisfaction, leading to lower motivation and a decreased sense of purpose.

## COMMUNICATION

Traditionalists prefer one-to-one or face-to-face communication. They believe in hierarchy and formal memos and letters. Traditionalists do not seek feedback and believe no news is good news. They feel rewarded by a job well done. This generation is motivated by "Your experience is respected."

Leaders should encourage open communication among all co-workers. This creates an environment that's more inclusive of multiple generations.

Baby boomers like to be a part of a team and love to have meetings. They prefer in-person communication but also use the phone. Baby boomers do not like feedback. Titles and financial rewards are very important to them, and they are motivated by "You are valued and needed."

Generation X are independent thinkers and prefer the entrepreneur concept. They communicate in a direct manner which is usually email and will ask for feedback. Freedom is their best reward, and they are motivated by "Do it your way and don't get hung up with the rules."

Millennials, Generation Y, love to engage with others, and they are usually very participative. They communicate primarily through email, text or voice mail. They want feedback whenever they ask for it, which can be frequently. Meaningful work is their reward, and they are motivated by getting to work with other bright, creative people. A variety of different mediums should be made available for coworkers to connect and communicate.

Leaders should encourage open communication among all co-workers. This creates an environment that's more inclusive of multiple generations. Offer a variety of different mediums through which coworkers can connect and communicate. Promoting intergenerational teamwork, providing opportunities for both young people and older employees to collaborate on projects together and learn from each other is vital when working with a multigenerational workforce. Leaders should encourage co-workers to ask: "How would you do that? I'd love to hear more about it." Recognizing and rewarding unique, valuable contributions of team members of all different ages is paramount to building a team. Providing opportunities for career advancement, leadership roles and implementing reward and recognition programs can provide meaningful benefits in exchange for impactful work.

## MENTORSHIP AND DEVELOPMENT OPPORTUNITIES

Organizations might consider providing mentorship and coaching opportunities for Generation X employees to better support their professional growth and development. For example, they might pair them with experienced mentors from older generations who can provide guidance and advice. Investing in training and development programs that focus on the unique needs of Generation X may also be worthwhile, such as leadership development and digital skills training.

Generation X may place a higher premium on flexibility and finding a balance between their careers and their personal lives. Organizations that can support this in meaningful ways are likely to reap the benefits. For example, offering flexible working arrangements such as remote work options, adequate paid time off and flexible hours may help increase Gen X employee engagement and promote greater job satisfaction and productivity.

## TIPS FOR MANAGING AND MOTIVATING EACH GENERATION.

- Communicate changes clearly and express their impact.
- Provide feedback through coaching and mentoring.
- Foster the concept of community and value.
- Provide generations with opportunities for learning, growth and professional development.
- Provide flexibility and support for personal preferences.
- Make internal policies transparent.
- Promote understanding about the different ways people express similar values.
- Leaders should be competent, strong and trustworthy.
- Value differences and promote understanding across different roles and generations.
- Bring awareness and respect of the different generations.
- Delegate roles and responsibilities based on individual strengths.

## CASE MANAGEMENT INTERVENTIONS TO SUCCESSFULLY CLOSE GENERATION GAPS

- Don't draw conclusions based on generational stereotypes.
- Push back on implicit bias.
- Don't assume everyone sees things like you do.
- Reject the notion that generations are in competition.
- Seek ways for every generation to create value.
- Bust myths; don't use generation as an insult.
- Build intergenerational collaboration and trust.
- Avoid generational shaming, stereotypes and age biases.
- Respect each person as their own individual regardless of generation.
- Ensure an environment where everyone feels welcome to share ideas as well as ask for help.
- Build trust with members of all generations.

## REMEMBER THAT:

- Autonomy matters.
- All generations can benefit from having options and flexibility.
- Connections matter.
- There is value in diversity and sharing knowledge.
- Generational differences are like cultural differences.
- Generations may not work well together unless there is a strategy.
- Attitudes and values form during formative years influenced by what is going on in the world.
- We like to work with those of similar age.
- Everyone has a story!

## SUMMARY

Most organizations have a multi-generational workforce which provides opportunities to share experiences and knowledge. Every generation has something to learn and teach. All generations have similar needs for things like autonomy, independence and connection. Each generation should strive to identify intent and interest behind the attitudes and actions of those from other generations. Understanding all five generations is vital in building bridges to connect the generations, unlock the potential strength of each generation, and develop a strong, diverse and collaborative workforce with satisfying work experiences. ■

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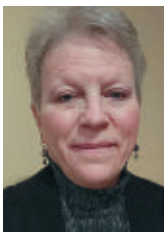
*Janet has been active in CMSA at the national and local levels. She is currently president-elect of CMSA, chairperson of the editorial board of* CMSA Today, *chairperson of the nominations committee, and vice-president of the CMSA Foundation. Janet has presented concurrent sessions and posters at several CMSA Annual Conferences. She has served as a CMSA board of directors member, secretary of the CMSA board of directors, a member of the CMSA executive committee, and CMSA chapter presidents' council representative to the CMSA board of directors. Janet has participated in or chaired several CMSA committees including the CMSA writer's workshop committee, membership committee, and education committee. She has published many articles in* CMSA Today, Care Management, *and the* Professional Case Management Journal. *In addition, she recently published a chapter in* A Practical Guide to Acute Care Case Management: The Day to Day "How To Be An Acute Care Case Manager" Resource *and a chapter in* Improving Lives Together: Case Managers Leading the Way. *She also served as a reviewer for the* Core Curriculum for Case Management Third Edition. *Janet has written several CMSA blogs, two of which were among the top five CMSA blogs read in 2022.*

*Janet continues to be active in the Southern Ohio Valley Chapter of CMSA. She has served as a founding member, board of directors member, vice president, president-elect, secretary, and chairperson of numerous committees. In addition, Janet recently completed serving a fifth term as president.*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# Improving Sepsis Outcomes

## WITH LTACH REFERRALS

Recent data demonstrates that transitioning sepsis patients to long-term acute care hospitals (LTACHs) can improve outcomes and reduce readmissions.

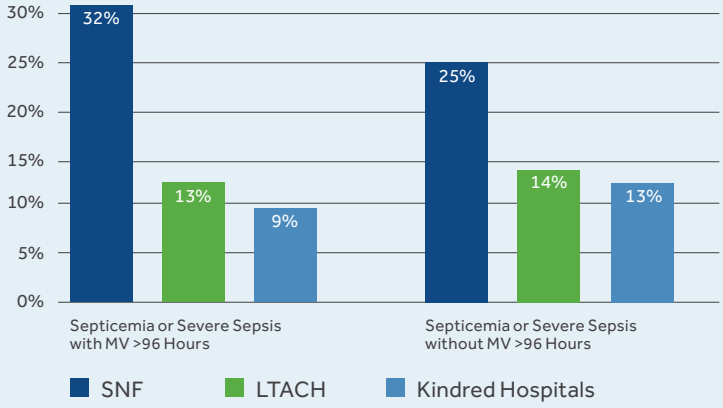
### Understanding the Sepsis Challenge

Sepsis is the costliest inpatient condition, resulting in $41.5 billion in total costs in 2018, and has the highest number of 30-day readmissions.[1,2] The average length of stay (LOS) for sepsis is also 75% greater than for other conditions.[3]

### Improving Outcomes with LTACH Referrals

These challenges may have to do with recovery pathway selections, which have historically favored skilled nursing facilities (SNFs).[4] When comparing post-acute LOS, sepsis patients discharged to LTACHs have shorter stays than those discharged to SNFs. Additionally, data shows that LTACHs have lower sepsis readmission rates than SNFs, with Kindred Hospitals' network of long-term acute care hospitals achieving even lower readmission rates than LTACHs nationally.[5]

**Average 30-Day Readmission Rates, Q2 2021-Q1 2022**




At LTACHs, physician-led care teams specialize in treating critically ill patients with complex conditions. LTACH care includes IV antibiotic therapy, onsite labs and pharmacies, and CMS-compliant infection prevention standards, all of which improve sepsis outcomes. Ensuring sepsis patients have timely access to this specialized acute care can help reduce length of stay and readmissions.

### How Kindred Can Help

Kindred Hospitals, the nation's largest LTACH provider, offers specialized care to medically complex patients.

With Disease-Specific Care Certifications in Sepsis from The Joint Commission and an established treatment protocol, Kindred can play a key role in improving outcomes.

To learn more, visit **refertokindred.com.**

Kindred Hospitals
Empowered by ScionHealth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# EVIDENCE-BASED ASSESSMENTS AND INTERVENTIONS SUPPORTING POPULATION HEALTH

BY LISA SIMMONS-FIELDS, DNP, MSA, RN, CCM, CPHQ, AND LIBBY JACOBSON, MPH


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**Objectives:** Increase care management and patient engagement and decrease average risk scores in care managed populations.

**Background:** Transformational nurse leaders have the capacity to influence the professional competencies and engagement of care management teams and the patients they serve.

**Methods:** The project design is a prospective, mixed method design.

**Results:** Team response and early trends are positive for increased engagement and decreased average risk scores by primary diagnosis.

**Conclusions:** Continued research is recommended to accurately reflect patient risk based on utilization and social influencers of health to ensure care management is supporting the right populations and evidence-based interventions decrease risk and improve outcomes.

## INTRODUCTION

As a follow up to the article and poster presentation on *Sustainable Strategies to Prevent Health Care Worker Exodus,* our Trinity Health ambulatory care management teams continue to assess and trend average patient risk scores. Frequently, care management teams are evaluated based on financial returns on investment (ROI), and there has been much discussion related to regression to the mean. Providing real-time risk assessment ensures our care managers are engaging the right populations and focusing on the patient's individual area of risk. As we know, the underlying causes of a condition can be much more than condition burden or symptoms. Social needs and untreated or undertreated conditions are common contributors to poor health.

As you may recall, Trinity Health collaborated with the Case Management Society of America (CMSA) to provide training of the ambulatory care management teams through the CMSA Integrated Case Management (ICM) program. Ambulatory care managers trained in an integrated approach assess risk in the four domains of health: biological, psychological, social and health system. They use these assessments to develop and create a shared person-centric plan of care. The ICM training provides advanced assessment training, identifying the person's experiences, concerns, and what is contributing to poor health. This results in a plan of care that focuses on what is most important to the person.

Trinity Health leadership's commitment to personalized care delivery supports our mission of being a transforming and healing presence within the communities we serve.

Using evidence-based clinical practice and resources ensures our patients/members are the center of our care, and partnership throughout the continuum helps ensure our members achieve their health goals.

## PURPOSE

The purpose of this quality improvement initiative is to determine whether additional care management education and membership in a national organization, the Case Management Society of America (CMSA), would increase retention, decrease turnover and decrease average risk scores by age and primary diagnosis within our populations managed by our ambulatory care management teams.

## PROBLEM STATEMENT

The ambulatory care managers needed a different solution for onboarding, orientation and ongoing training to decrease turnover and ensure a high degree of competency to increase patient engagement, thereby influencing and decreasing patient risk. The health system cost of turnover is calculated as equivalent to a 12-month CM salary to train inexperienced staff.

Care managers are key members of the care team, supporting member care, transitions of care, care coordination, education, and are well-positioned to improve the member experience, decrease cost, decrease risk and improve patient outcomes. To ensure that we are the employer of choice, we need to recruit high quality applicants, effectively train to ensure competency and retain our CM nurses and social workers.

## LITERATURE REVIEW

For care management leaders, the efficacy of our care management programs depends on ensuring standard evidence-based interventions that engage the patients we serve. As referenced by the Agency for Healthcare Research and Quality (AHRQ, 2014), "the literature review found evidence of care management interventions improving outcomes across all diseases successfully." In a literature review reported by AHRQ, in-person and telephonic care management along with patient activation and self-management education have demonstrated an improvement in utilization, clinical outcomes, processes, cost measures and medication administration.

Doody and Doody (2012) discuss the importance of having transformational leadership that influences, inspires and motivates, ensures intellectual stimulation and provides for individual consideration. Adaptive transformational leadership supports employee engagement and satisfaction, further causing a ripple effect of patient satisfaction and retention. Therefore, as leaders engaging our teams, educating and creating standard work is fundamental.

## INTERVENTIONS

CMSA's philosophy aligned with Trinity Health's in achieving goals for improving health outcomes for the population's services and participation in advanced payment models. CMSA's Integrated Case Management Program (ICM) training teaches care managers how to engage members, create trusted relationships and perform a comprehensive assessment providing whole person care, and the development of a care plan (CMSA, 2020).

Each ambulatory care manager including nurses and social workers along with their leaders received ICM training and have CMSA membership providing access to CMSA's library, tools and webinars. Care managers collaborating with complex patients have a goal to follow five patients for 12 months, recording baseline ICM risk scores and providing quarterly updates on risk scores using RedCap database for the participants within the Medicare Shared Savings Program.

## PROJECT AIMS

The aims of this quality improvement project were to

- Increase competency and skills by training 90% ambulatory care managers and their leaders through the Integrated Case Management course by June 31, 2023.
- Increase access to educational events and training tools through the CMSA membership library.
- Decrease ambulatory care manager turnover rates.
- Increase the retention of ambulatory care managers.
- Improve the risk scores of patients being care managed.

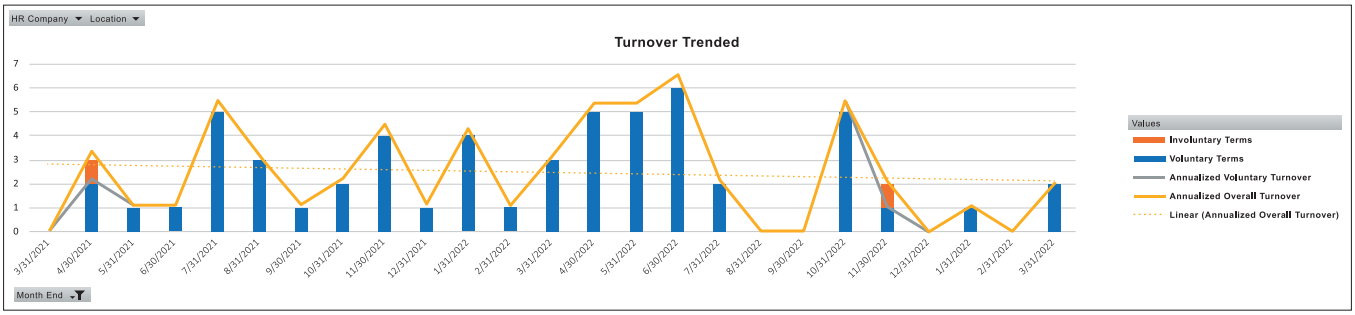
## THEORETICAL FRAMEWORK

The Neumann system model provides a frame of reference for evaluating and addressing health conditions across distinctive settings. The model supports a holistic framework supporting the use of clinical tools to guide assessment of individuals, families, communities and organization to influence clinical practice. "Nurses evaluate the effectiveness of their interventions based on the degree to which clients met their goals" (Whetsell, Gonzalez, & Moreno-Fergusson, 2015).

The ICM model provides for a standard way to identify health risks and health needs using the biological, psychological, social and health system domain. Through the evaluation of historical, current state and vulnerabilities, the CM can better identify areas of risk and priorities when developing a patient-centered care plan.

Turnover Summary - Trended Totals for 25 months of data (data as of 5/11/2023)

| Avg Headcount | Voluntary Terms | Voluntary Turnover | Involuntary Terms | Involuntary Turnover | Total Terms | Overall Turnover | % Terms Voluntary | <3 Months Overall Turnover | <1 Year Overall Turnover | Total Hires | Net Hire Ratio |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 222 | 55 | 24.80% | 2 | 0.90% | 57 | 25.70% | 96.49% | 5.45% | 21.82% | 55 | 0.96 |




SOURCE: TRINITY HEALTH

## METHOD/PROJECT DESIGN AND INTERVENTIONS

The quality improvement project is a prospective, mixed model including self-study and interactive face-to-face virtual training. The program provides multiple strategies to engage patients, risk stratify, and developed a patient-centered care plan to decrease risk and improved well-being. The interventional design included pre-work of reading the CSMA ICM book, three to four hours of online presentations, and three four-hour (half-day) training sessions. Each cohort had a maximum of 25 people to ensure time for individualized and group interaction in reviewing case studies. The audience included a combination of nurses, social workers and CM leaders from the ambulatory care management teams that support the advanced payment models in the clinically integrated networks across the country.

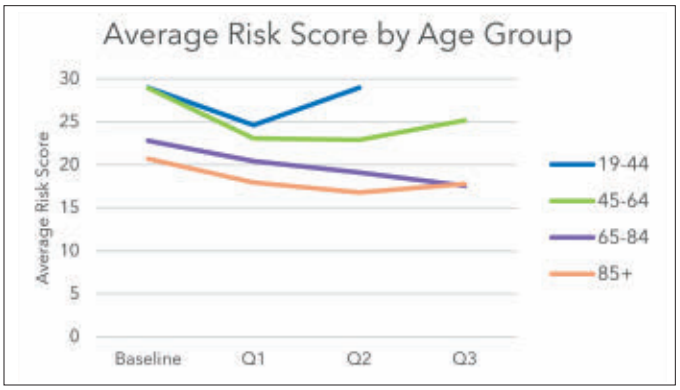
## DATA AND ANALYTICS

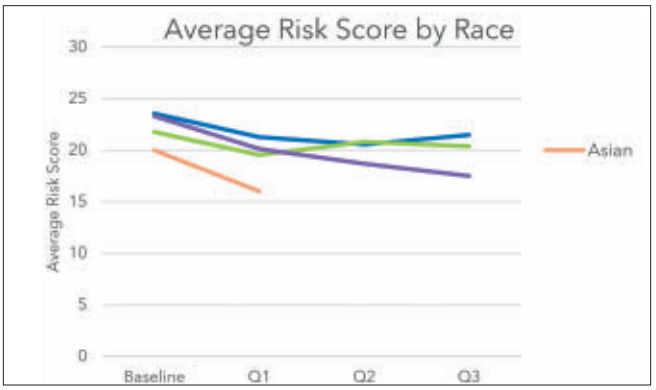
Colleague results show turnover data trends for the ambulatory care management teams include a 25-month look back. As of May 11, 2023, the percentage of staff turnover within less than one year of recruitment is currently 21.82%. There are 55 hires of less experienced care managers. As noted in the graph on page 18, we have significantly decreased our turnover rates since the beginning of this intervention in June 2022. The predominate reason cited for turnover was personal reasons and new jobs.

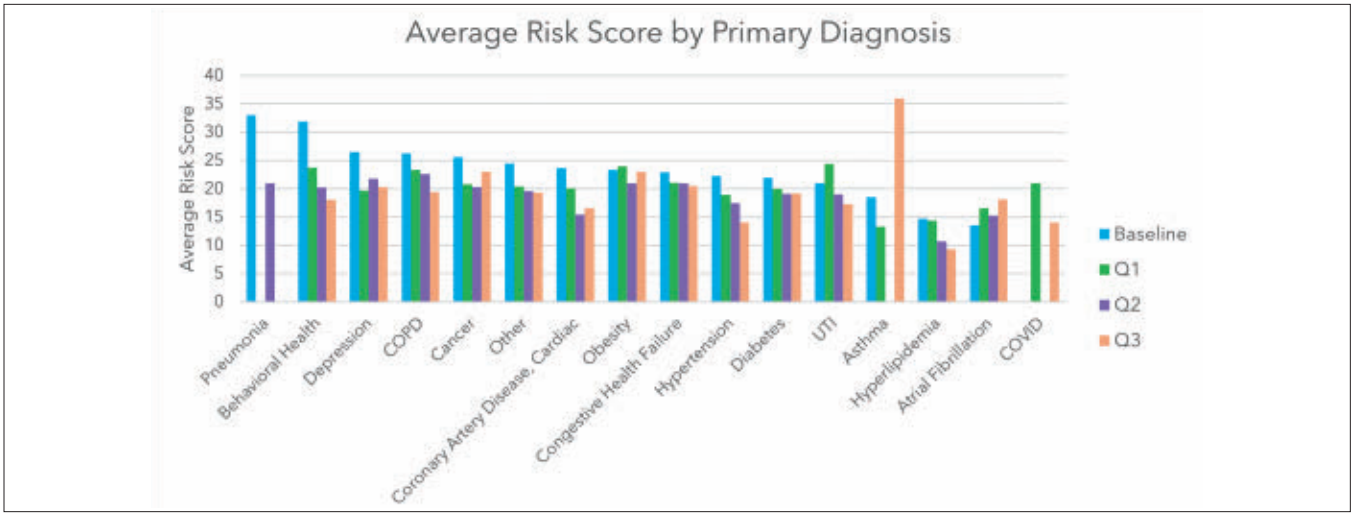
*Continued on page 30*

Clinical results as of the third quarter of the study findings include:

| | |
|---|---|
| Total number of patients submitted by care managers | 259 patients |
| Number of patients who were lost to follow up (care managers recorded as unable to follow up with patient for current collection period, no risk score for current collection period) | 79 patients |
| The risk score analysis between baseline and the current quarter | 83 show improvements in their risk score.<br>79 patients risk score worsened.<br>19 remained the same. |
| Care management program snapshot | 259 patients submitted for the current quarter.<br>150 remain in the program.<br>109 have graduated from the program. |
| Breakdown of the 109 graduated patients | 81 patients' primary reason for graduation was due to program completion. |



# USING RESEARCH TO ADVOCATE FOR BEST PRACTICES

**BY KERRI WIZNER, MPH, CPH, AND KEEMIA VAGHEF, PhD**

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Managing injured or ill working-age people can be complicated when cases have co-occurring conditions or non-diagnostic factors (like the social determinants of health) driving people toward poor recovery outcomes. These complexities consume considerable time for case managers and can lead to longer recoveries, affecting the patient's mental health and self-identity. Additionally, when managing short-term disability cases, once benefits are exceeded there is a higher risk of transitioning to permanent long-term disability programs or even unemployment, both of which have physical, mental and financial consequences for the patient's well-being (Wizner et al., 2021).

To identify common barriers faced when managing complex claims and to offer solutions, we conducted a focus group study to identify actionable risk factors. By understanding these influences, we can offer evidence-based, systemic practices that support case managers' ability to proactively intervene and keep people from going off the rails of recovery.

Our recommendations from this research are that case management organizations should:

1. Have leadership designate a point person who will respond when a case manager reaches out.
   - For example, this can be a human resources person at an employer or a program manager of a clinical staff who can handle requests and understands why quick responses are in the best interest of the patient.
   - Offer information important to this point person's organization, such as job descriptions, benchmark statistics or requests by the patient so that communications are two-way.
2. Create workflow maps based on best practices that outline when and how outreach should be done.
   - This can help staff understand the "big picture," as well as set benchmarks so that case managers can better see when a patient's recovery may not be going well.

Training case managers to watch out for red flags, or creating processes to follow best practices, can help keep patients focused on their medical recovery. This study found that experienced case managers already know major reasons why recovery can be delayed by non-diagnostic factors and offered solutions which would be best applied upstream by systemic changes. Currently, case managers are using their own networks to build relationships on an individual basis. But, if organizational leadership made these recommendations a priority, there are many ways to remove these barriers for case managers. This will likely require advocacy on behalf of case managers to see these changes implemented. Hopefully our research helps you build a strong case for changes that will improve patient outcomes as well as job satisfaction and effectiveness for your own work.

## RED FLAGS

From focus group discussions with experienced case managers, our analysis found three major themes for determining if a case was likely to go beyond recommended recovery durations because of non-medical factors: multiple information sources, type of condition or workplace culture issues. These "red flags" can help case managers decide early on if a case is likely to become delayed.

Umbrellaing these three ideas was the ever-present challenge due to communication barriers, especially between organizations or specialties, which continue to be the bane of workplaces.

The first red flag was if **multiple information sources** were being consulted, such as the emergency department physician, the family physician, physical therapists and pain management teams. For example, participants said severe car crashes should be handled uniquely because they have so many clinicians providing care that it is difficult to get accurate information to properly manage the case. Participants also stated that if the healthcare systems used a third-party records management system, paperwork was often slowed down.

Furthermore, our case managers said that it is difficult to discuss RTW timelines if the patient's medical team had not previously discussed it. One participant guessed that it was a "50-50 chance" that a clinician would give a specific recovery timeline based on the condition, and it was even less likely if the care team lacked an occupational health nurse, occupationally trained clinician or vocational specialist. It was especially stressful when the patient didn't realize that they would lose benefits, and possibly even their job, if they moved from short-term to long-term disability. Often these are emotional conversations that can take several hours. Needless to say, when this task falls to a case manager, it increases their workload.

The second major theme participants cited was that complex cases often followed patterns based on the **type of condition**. Cases that often become complex are the types of conditions with weak definitions, require conservative care first or have variable care options. Also, if the patient has many comorbid conditions. If these types of cases can automatically go to someone with specific experience or are flagged as a case that will take more time than expected, case managers felt they could be better supported.

The third red flag that participants discussed was if there were **workplace culture issues**. Case managers may not have access to this information, as neither the clinician nor the patient is required to share work-specific conflicts related to the condition. But a toxic or stressful work environment can be a major barrier to returning someone to work, especially for mental health or behavioral health claims (Hogh & Viitasara, 2005; Shafi et al., 2019). However, when case managers find that the root cause is related to a workplace culture issue, oftentimes the employers have no direct pathway for the case manager to reach out to the patient's human resource department, which would be better equipped to offer assistance.

This topic was also impacted by the patient's job type and the employer's policies, particularly flexible RTW. For example, jobs that require significant physical labor are harder to go back to when recovering from injury or illness, regardless of the type of diagnosis. If employers were more flexible, like offering light duty or alternative job tasks, patients could go back to work in some capacity sooner. This also requires the employers to respond quickly, which is often difficult when working with large organizations. Some patients could go back to work a few days early, but by the time they get approval, and the paperwork is in place, that window of opportunity has passed. Furthermore, case managers are often limited in their knowledge about the patient's job requirements and access to the employer and require extra time to build a conversation between the patient and employer without the appropriate resources.

## SOLUTIONS

The final question in each session focused on what case managers would change if they had a magic wand at work. Each idea focused on information exchanges:

- communication between case management and employers, especially about establishing modified/transitional duty options and how to overcome workplace culture challenges
- working with clinicians that focus on supporting return to activity and can document alternative strategies until full recovery
- proactive discussions with the patients to establish RTW expectations, possible activity restrictions and to outline their health benefits

## DUPLICATE OUR STUDY

Want to conduct a study like this at your organization? We started with leadership buy-in, discussing why this research was needed and how we could apply the results to help our front-line case managers. We also asked leadership to recommend experienced case managers who would be interested in participating. Simultaneously, we also had a grassroots effort where we asked colleagues to participate and recommend three others we could contact. In the end we invited 26 internal, experienced case managers, including those who handled short-term disability and/or long-term disability, and registered nurses, to participate in a 30-minute focus group. Out of these, 17 agreed to participate, and 11 attended one of the three sessions conducted in the spring of 2023.

We then narrowed our discussion to only three questions: critical turning points that can identify complex cases, major themes differentiating complex versus simple claims and tips for how to prevent or mitigate these factors. Our researchers prompted the questions and summarized some of

*Continued on page 30*

| Key strategies to support recovery of patients who have jobs |
|---|
| More communication between case management and employer for referrals<br>(e.g., HR, management, company leadership)<br>- Modified or transitional duty options<br>- Workplace culture challenges<br>- Assistance programs |
| Work with clinicians that are incentivized or trained to support return to work (RTW)<br>(e.g., occupational health nurses/physicians or vocational specialists)<br>- Document alternative tasks safe to do until full RTW |
| Proactive discussions with the patient as early as possible<br>- RTW timeline and expectations<br>- Possible activity restrictions<br>- Benefit structure |

# HOW HOME CARE IMPACTS HOSPITAL READMISSION RATES

**BY DANA TAYLOR, LCSW AND SYLVIA TREIN**

Beginning in October of 2012, the Social Security Act established standards for the Hospital Readmissions Reduction Program (HRRP) in an effort to measure and increase the quality of care at hospitals across the country. The 21st Century Cures Act of 2019 further refined the process, where hospitals with comparable numbers of patients on Medicare and Medicaid could be measured against each other. The Centers for Medicare & Medicaid Services (CMS) could adjust payments to hospitals based on their performance.

The implications of this, of course, have brought readmission rates to the forefront for administrative and care teams. While it is undoubtedly a positive move to use objective measures to spot problems and make changes for better care—especially of vulnerable populations like elderly patients or those with chronic conditions—care professionals know that readmission happens for myriad reasons that have nothing to do with a hospital's neglect. Patients are readmitted because they forgot part of their discharge instructions, or because they have no one around to check whether they have taken their medication. They become dehydrated, miss follow-up medical appointments or trip and fall at home. All of these risks are mitigated by one powerful resource, which is home care.

## HOME CARE AS HRRP STRATEGY

We know that home care makes a measurable difference in the physical and emotional well-being of patients. Beyond simply meeting daily needs and covering ADLs, home care means regular safety checks and companionship. It means respite for families who daily provide hours of unpaid care for a

JACOB LUND/SHUTTERSTOCK.COM

loved one while balancing work, their own children's care and other demands on their time and energy. Home care brings peace of mind and relief to families with a loved one affected by dementia, impaired mobility or with complex health needs.

There are four facets to home care as HRRP strategy:

1. It allows a care professional to closely monitor the highest-risk patients. *Becker's Healthcare* has found that the patients at highest risk for hospital readmission are those who were hospitalized for heart failure, acute myocardial infarction and pneumonia. These patients are readmitted after a median 10-12 days from discharge, with over 60% readmitted within 15 days.

Hospital readmission is measured within 30 days of discharge, for any reason (not necessarily what caused hospitalization in the first place). Home care for at least 30 days after discharge ensures quick response to symptoms that might arise, hopefully preventing the need for readmission. Patients can be treated quickly in other settings, precluding escalation and crisis situations.

2. A trained professional evaluates the patient's situation holistically, addressing potential threats of different kinds. Care professionals know to look for signs of mental distress, dehydration, malnutrition, hidden injuries and household threats such as broken air conditioning or tripping hazards. They can review discharge instructions and make sure they are followed. They can also facilitate communication between the patient and their family, filling in knowledge gaps on both sides in an effort to ensure the patient is safe and improving in health.

3. Caregivers hold a wealth of experience in supportive tools for patient safety and well-being. This can include therapeutic and strengthening exercises, mobility/hearing/vision aids and emerging technologies that others are using for help with ADLs, communication or supervision. A professional caregiver has many more resources at their disposal than the average untrained family member.

4. Caregivers and agencies have thoughtfully, systematically designed processes and procedures that anticipate the common needs of patients and care clients. Beyond simple compliance, the most successful agencies are able to provide evidence that they are responsive to the needs of the populations they serve—and they are able to show patterns of improvement. There is a direct line from these agencies' goals and metrics to those of HRRP.

CMS sends Hospital-Specific Reports (HSRs) to hospitals every year. These reports collect HRRP data and are the basis for Medicare fee-for-service payment reduction (where applicable). Though hospitals can dispute calculations in these reports, they cannot dispute any claims or data they contain. CMS also provides a searchable database of their data on hospitals, doctors, dialysis facilities, rehab facilities and more. This makes HRRP measurement and vigilance a priority.

With stakes this high, home care agencies can be further incentivized to show healthcare partners how they can help them keep their trends positive.

## WHY DON'T ALL PATIENTS DISCHARGE FROM HOSPITAL TO HOME CARE?

In a perfect world, every elderly pneumonia patient would be discharged straight into home care, where they could be constantly monitored and assisted with all their health and daily living needs. But we know that this is not the case.

Overwhelmingly, the reason is cost. Home care can be cost prohibitive for many families, leading them to try to stand in the gap themselves. The problem is, they are already overcommitted and are untrained for the task. And then there are patients who do not have family, or family nearby. They are largely left alone after discharge, putting them at greater risk of readmission.

Besides discharging to a skilled nursing facility (Werner, et al., 2019), discharging to home care affords patients the best outcomes. So what are families and their social workers or case managers supposed to do next? Short of dipping into savings or acquiring debt, the solution is to find any benefits for which their patient may qualify. The authors of this article represent Veterans Home Care, an organization that works with U.S. military veterans to claim the VA's Aid and Attendance benefit. Regional Director Dana Taylor, LCSW, presented on this benefit at CMSA's 2023 Annual Conference. VHC was founded in 2003 by Bonnie Laiderman, who had faced the problem of inaccessible home care for her own mother and established a tight and well-supported process called VetAssist to bring an underutilized veteran benefit to more families in situations like hers. (You can learn more by visiting the Aid and Attendance page or the blog on **veteranshomecare.com**.)

As Taylor noted to a sympathetic audience at the CMSA conference, benefits to assist with healthcare costs are not easy to come by. Employing a knowledgeable network and expanding one's toolkit with benefits such as Aid and Attendance and other VA opportunities are one way to bring the increased safety and comfort of home care to more vulnerable individuals in an effort to cut their odds of readmission. ■

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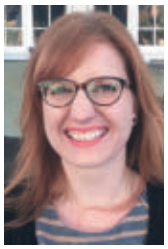
**Dana Taylor, LCSW**, *is a Veterans Home Care regional director. Taylor routinely meets with professionals from home care agencies, hospitals and veterans' organizations as a subject matter expert on the VA Aid and Attendance benefit. She also works directly with veterans and their families. For any questions you may still have, you can email Dana Taylor at* **dtaylor@veteranshomecare.com**.



**Sylvia Trein** *is a freelance writer and editor reporting on diverse topics in healthcare, tech, consumer research and insights and not-for-profits. She is based in Greenville, South Carolina, and Fort Lauderdale, Florida.*

*Veterans Home Care is a private company, not affiliated with the VA or any government agency. Their VetAssist Program offers in-home care and other services right away with no out of pocket costs and no waiting for VA funds to arrive for those who qualify.*

# PATIENT ADVOCATES:
## A CRUCIAL PIECE OF THE ELDER CARE PUZZLE

**BY JENNIFER HALLORAN, PhD, BCPA**

As case managers, we are all too aware of the myriad problems with our current healthcare system. One of the most intractable issues, particularly for elders, involves "frequent flyers," patients who are admitted to the ED or hospital on a revolving basis. Despite the implementation of telephone-based follow-ups and other forms of tracking, this problem has not budged.

This issue is compounded by the reactive model of emergency and response our system is based on. Fee-for-service payment and the devaluation of public health measures encourage responses to healthcare problems only after they have occurred. For any preventive measures, this system generally makes patients responsible through recommending largely ineffective lifestyle changes.

People, particularly elders, often get sicker until a catastrophic event occurs, after which their families and medical staff bring in all their resources. Those resources usually address the immediate catastrophe but do not create conditions that support health maintenance afterward.

So what can we do to address the problem of frequent flyers? One answer: a care and advocacy model developed by Diane Halloran, RN, MPH, the founder and CEO of Everybody Needs A Nurse Patient Advocates in Chapel Hill, North Carolina. Her model supplies a proactive means of maintaining health for elders, while supporting their families as they navigate the healthcare system. In 2017, Diane developed a system of caring for elders based on the nursing model pioneered by Virginia Henderson and others (references 1,2). This system treats clients in a positive, affirming way, while helping them toward their health goals.

This system has had notable success in preventing the recurrence of health emergencies, allowing peaceful last years of life for elders and their families.

Diane bases her system on providing care continuity over extended periods of time—months and years. Her system assigns each client a single registered nurse who serves as the point person for questions and issues that arise.

At Everybody Needs A Nurse Patient Advocates, our nurses can and often do share resources and ideas with one another, but ultimate responsibility rests with a single person, creating a unified experience for the client.

The nurse sees clients weekly from their admission with us until their death, move to hospice or enrollment in memory care.

These weekly visits build very strong relationships with clients and their families over time. We focus on developing trust and consistency throughout the changes that come with aging.

Clients trust their nurses to speak their truth to them in a supportive way. They understand we have their best interest at heart in the face of a fragmented, difficult-to-navigate healthcare and eldercare system.

The service is built on three pillars:

**Weekly home visits**, which enable us to monitor and assess clients' environments, social dynamics and medical treatments. Over the months and years, our continued presence also allows us to build trust and get to know and understand the client. This visit also includes medication management and assessment of side effects, preventing accidental overdoses and ensuring medication effectiveness.

**Visits to doctors**, where our nurse accompanies the client to the doctor, making sure each physician is familiar with the advocate. We encourage our clients to take the lead during doctor visits for as long as they are able. But our RN is present to prompt any forgotten topics and to take notes. We prepare our clients for the appointment in the previous home visit, helping them create a list of questions and concerns and then debrief during the next home visit, helping them implement the doctor's suggestions and prescriptions.

**Communication**, the third crucial pillar. After every visit, the nurse sends a Family Report to family, providers and/or the client themselves. This report contains our observations of not only the medical situation but also the client's appearance, mood and other intangibles. Receiving a weekly report allows the family to trust us to be their "eyes and ears" on their loved one.

### CASE STUDY: ELOISE*—INITIAL ENCOUNTER

We got a call from Eloise's daughter. Her 87-year-old mother had fallen and broken her hip. She was currently in rehab after surgery. She was almost ready to be released when she began experiencing hallucinations caused by an advanced UTI. Eloise lived

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alone at home. She was adamant about not leaving her home, where she had raised her children and lived with her husband until his death.

The response to Eloise's predicament typified our response-based healthcare system. After her fall, the family was called in from different areas of the country. Eloise had immediate surgery to repair her hip, and a good post-op rehab facility had admitted her and given her physical therapy.

However, there was no long-term strategy for once she returned home, other than to wait for the next catastrophe. And, crucially, no one investigated WHY she fell. Although the rehab facility caught her UTI and placed her on an antibiotic, no specific follow-up was planned once she was home.

Eloise's nurse did an initial assessment in the rehab facility and started weekly home visits. She brought in a home care agency we knew and worked with the aides to make sure she was drinking enough to avoid a future UTI. We also reconciled her medications to ensure the new meds she had at the hospital and rehab did not conflict with the medications she had already been taking.

## ELOISE M.—YEAR ONE

After the initial encounter with Eloise, we began our weekly visits. Over the first year, we started to develop a relationship with her. We met her children when they came into town, and we began going to see her doctors with her.

We heard her stories about her life as a child and young adult. About her career and child-raising. Her nurse shared some of her own stories, creating a bond.

We noticed that Eloise had a predisposition for UTIs, even when she was fully hydrated. We arranged with her GP to have a standing order for an antibiotic, and we educated her home care aides to identify her symptoms. They then called us and went over the symptoms, and we could call in the prescription, avoiding multiple visits to urgent care.

## ELOISE M.—YEAR TWO

Over this year, we continued our weekly visits, deepening the relationship with Eloise and her family. After several months, her UTIs were under much better control and her medication issues were worked out.

At this point, the family inquired about whether we would continue to visit weekly, since she was so much better. But we understood that things change quickly for elders and wanted to maintain the trusting relationship we had built. Eloise really enjoyed her nurse visits, so we all agreed to keep on the weekly schedule.

It was good that we did, because over this year, we noticed that Eloise was repeating her stories more frequently and seemed to be losing some of her short-term memory.

## ELOISE M.—YEAR THREE/ YEAR FOUR

These years were transitional for Eloise, as she began to suffer from increasing dementia. Her nurse became one constant in an ever-changing world for her. During this time, she remained very focused on staying in her home. We provided ongoing support to allow her to stay in place:

- We listened to her deep sadness over "losing her mind" and consoled her based on her own belief system, which we knew about from our years of talking to her.
- We talked to her about her anger at her children, who she felt wanted to take away her independence.
- We brought a medication box with a timer to remind her to take her medications in a timely manner and transitioned to managing her medications completely.
- We reminded her of her childhood and young adult stories and refocused her on her beloved family.
- We accompanied her to doctors, prompting her questions and letting the doctor know about the situation at home.
- We arranged for a driving test, so that she would have evidence that she could no longer safely drive, helped the family sell her car and talked with her extensively and in a supportive manner about why she needed to make this transition.

There were many times in this period when Eloise was understandably very upset with her situation. Her nurse was a lifeline, listening to her concerns, providing solutions when possible and redirecting her when necessary. All of this care stemmed from a long-term, ongoing relationship. Anyone coming into the situation at this point would lack the background and understanding to create buy-in with these changes.

## ELOISE M.—YEAR FIVE

During our fifth year seeing Eloise every week, her challenges increased. She still insisted on living in her home and did not want any changes, even as her memory declined sharply.

We needed to offer creative solutions, and work with her increasing sense of losing control. Because we were trusted and recognized—when many others weren't—we were able to provide care when homecare and other providers were given the cold shoulder by Eloise.

Eloise became confused between night and day, calling her nurse at 2 a.m. to ask where she was, when her appointment was at 1:30 p.m. We purchased a clock with day/night settings, so she could keep track.

Eloise became a target for a "driver" who started coming to her home. She felt that they were in love with each other and wanted to marry him. Her nurse worked with the homecare owner to run a background check, found he had a criminal record and got a restraining order. After he stopped coming around, we talked to her about her grief that she had lost her love, supporting her and redirecting her when appropriate.

Eloise was physically very healthy and could look very sharp during a doctor appointment. We were there to make sure the doctor knew she was suffering from dementia and would not retain what the doctor said, although we ensured she remained the focus of the doctor's remarks.

During all these years, we continued with our Family Reports so the family knew exactly what we saw. We conveyed the good work of the homecare agency and assured that Eloise was clean and presentable. When any misunderstanding or conflict arose between Eloise and a home care aide, we were able to intervene and either work with the aide or facilitate change.

## ELOISE M.—YEAR SIX

At the beginning of Year Six, Eloise's memory dropped significantly. She no longer knew her surroundings and no longer cared about living in her house.

Although she forgot her nurse's name, she still greeted her warmly every week and thought of her as a friendly presence.

We began to talk with Eloise's children about relocating her to a memory care facility. Her 24-hour homecare was not enough, as she was now on a very disarranged sleep schedule.

But Eloise stopped eating. We understood that she was preparing to go. Her nurse called our local non-profit hospice, and Eloise was enrolled. They took over her care, and we discontinued our visits after six good years.

Eloise never fell again, after her initial reason for coming to us.

## CONCLUSION

Eloise's experience with our patient advocacy service made a huge difference during the remainder of her life. She was never hospitalized again, she never fell, and even as her medications and life events changed, she remained safe in her own home until her death.

The care she received from her nurse offered Eloise and her family many advantages that our healthcare system often overlooks and fails to provide:

- Respect
- Trust
- Dignity
- Continuity of care
- Understanding

*This individual is an amalgam of several clients we have seen since 2007. All identifying features have been changed to preserve anonymity. ■

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**Jennifer Halloran, PhD, BCPA,** *serves as the director of operations for Everybody Needs A Nurse Patient Advocates in Chapel Hill, North Carolina. She joined Everybody Needs A Nurse shortly after its founding in 2007, contributing pioneering strategies and creative vision. She is a strong champion for patient advocacy, believing that it solves many problems with our healthcare system. Jennifer has also started Thrive, a branch of the business that offers communication and business strategies to individuals and companies looking to incorporate patient advocacy. Through her experience in the senior care field and as a business manager, Jennifer brings creative solutions to help our senior and business clients thrive.*

*Before joining Everybody Needs A Nurse, Jennifer received her PhD in English and taught at the University of North Carolina, Chapel Hill and Duke University.*

# SOCIAL WORK NAVIGATION PROGRAM IN EMERGENCY DEPARTMENT TO ADDRESS SDOH NEEDS


**BY DIANE SHIFLEY, PT, DPT**

Social determinants of health (SDOH) have a major impact on people's health, well-being and quality of life.[1] In May 2022, NorthShore-Edward Elmhurst Health, an integrated health system in Northern Illinois, recognized that patients were being bedded on the inpatient units from the emergency department who did not require the level of inpatient care. These patients were identified to have complex psychosocial or placement needs that current resources could not address nor coordinate in the emergency department. In response, an emergency department social work navigation program was developed to provide care coordination to patients with complex psychosocial needs in the emergency department. The goal of this program is to provide high quality care coordination, minimize unnecessary admissions, improve care transitions and enhance the patient experience by addressing the patient's social determinants of health needs within our community we serve.

When patients entered the emergency department, they were identified by a readmission risk score, natural language processing and/or direct staff referral. Once identified, the patients were displayed on a list within the EMR to alert the social work navigator. The social work navigator then responded either in person or via phone and performed a comprehensive assessment with the patient. The assessment, in addition to a comprehensive social work assessment, had a hyper focus on SDOH screening domains which included transportation, financial, housing and food.

During the time frame from May 2022 to March 2023, 1,465 patients had a SDOH assessment completed, with 599 patients being able to be discharged from the ED. Of the 1465 patients, 312 screened positive for at least one SDOH need (21%). In February 2023, we implemented a natural language processing (NLP) program to better identify patients with SDOH needs for a SW navigator assessment. Through the use of NLP, 65% more patients were identified as appropriate for a SW navigator assessment. NLP was validated, correctly identifying patients on average 52.2% of the time.

This program demonstrates that utilizing a multimodal referral process is successful in identifying patients' social determinant of health needs in the ED. Identifying these patients in the ED allows for intervention from the SW navigator and possible prevention of an unnecessary admission. Throughout the duration of the program, recruitment to fill social work navigator positions was challenging. As a result, limited hours of availability in the ED ultimately affected the volume of patients we were able to perform assessments on and provide interventions for. Additionally, we would like to expand this program to include a more in-depth look at the impact of the interventions on readmissions rates, and the long-term cost of care for our patients we serve. Overall, we recognize that providing social work assessment and intervention by addressing a patient's SDOH needs is a valuable and positive contribution to our patients, community and healthcare system. Our current efforts will be to continue to build a more robust and comprehensive program to meet the needs of our emergency departments, patients and community we are so privileged to serve. ■

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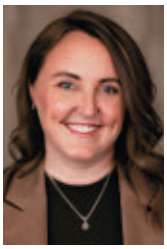

**Diane Shifley, PT, DPT**, *is a physical therapist. She received her BS from Western Illinois University with a major in biology emphasis in zoology and a minor in psychology. Following, she attended Midwestern University and graduated with a doctorate in physical therapy. Diane began her career in outpatient orthopedics and home health. In 2017, Diane joined NorthShore University HealthSystem and is now the senior director in the Cross Care Continuum with specialized focused on post-acute care.*

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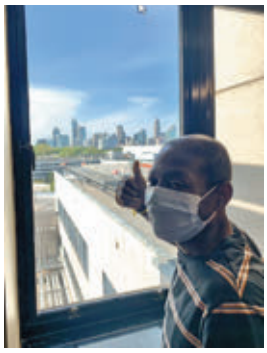
# A ROAD LESS TRAVELED: BRIDGE TO HOME

**BY JENNIFER CLINE, PT, DHSC, MS, AND SHONA METCALF, RN, BSN, MSN, CCM, IQCI**

Benjamin Anthony was in an unfortunate situation as he developed a drug addiction and was homeless. Benjamin then suffered a stroke and ended up at Carolinas Medical Center (CMC) in Charlotte, North Carolina, a facility of Advocate Health. CMC is a level 1 trauma quaternary care center providing a safety net for all patients in the metropolitan area. Benjamin had Medicaid and had been denied an inpatient rehabilitation due to being homeless, yet he was dealing with right-sided weakness and aphasia due to his stroke. Fortunately, CMC has a Bridge to Home (BTH) program, which serves unfunded or underfunded patients by giving them two to three hours of therapy daily for approximately two weeks. Mr. Anthony needed to perform stairs to access his new living arrangements. After two weeks of intensive therapy, he climbed the stairs. This was a massive accomplishment, to navigate and walk up a flight of stairs. Additionally, case management was able to find stable housing for Mr. Anthony, so he did not have to return to the shelter. Mr. Anthony said, "This program helped me have a new life. I quit smoking and will start dancing again."

Since its inception in 2019, the BTH has served over 250 patients. It started out as a pilot at Carolinas Rehabilitation, as CMC sent patients to the on-campus inpatient rehabilitation facility for the day. The pilot was so successful that CMC administration approved converting a waiting room in the hospital to a therapy gym. Two additional full-time therapists were approved and were able to treat the patients in the BTH program. The program moved to CMC and became an in-house rehabilitation option for underserved patients.



*Mr. Benjamin Anthony*

"The Bridge to Home Program has been absolutely transformative for patients with limited disposition options and cognitive or physical barriers to discharge. The program has achieved substantial improvements in participating patients that had otherwise plateaued, enabling them to be discharged from the hospital when they could not be discharged before being enrolled. The program not only improves the outcome of participants but enhances throughput for patients who would otherwise have limited options." — Dr Addison May Chief, MD, MBA, FACS Division of Acute Care Surgery

The magic occurs with the relationships between therapy and case management. Case management identifies potential candidates who will not be accepted into traditional inpatient rehabilitation free-standing facilities. Case management and therapy agree that these patients need acute rehabilitation to transition to the next level in their care. In-hospital lead therapists screen the referred patients from case management, and, together with the entire interdisciplinary team, a decision is made as to whether the patient can improve their functional status and have support at home to be accepted into BTH.

Once the patient is accepted, the team communicates updates and any equipment needs. If a patient needs equipment to discharge safely with family, the therapists make the recommendations and the case manager fills out an application for ASSIST ME, a nonprofit volunteer organization that repurposes used equipment. From 2019-2022, CMC issued $102,000 worth of repurposed equipment to the Bridge to Home recipients, helping 60% of the patients. If ASSIST Me does not have the necessary equipment, CMC purchases it for a safe discharge. CMC has a relationship with a contractor who builds ramps for patients needing one to access their home upon discharge from CMC. The team has also held clothing drives for patients including shoes, and volunteer services also assist with any clothing needs the patients may have.

Maggie Kruez stated, "I loved my time working in the BTH program! It was so rewarding to work with such a great team to take some of the most medically and socially challenged patients in the hospital and find creative ways to maximize their independence and facilitate their discharge. We developed such good relationships with our patients and even recently had a visit from our very first patient who had a very devastating brain injury and has made such amazing progress!"

Results from 2019-2022 showed that 72% of patients served were male, 49% sustained a stroke or brain injury, 20% had a traumatic or non-traumatic spinal cord injury and 76% spoke English, with 26% speaking Spanish. In terms of insurance, 78% had Medicaid, Medicaid pending, or self-pay. Eighty percent of patients were discharged home, and only 6.9% were readmitted within 30 days. As measured by the "6-clicks" scale,

PHOTOS PROVIDED BY CAROLINAS MEDICAL CENTER STAFF

mobility and activities of daily living scores improved significantly. The improvement was statistically significant and showed that the intense therapy made a remarkable functional difference.

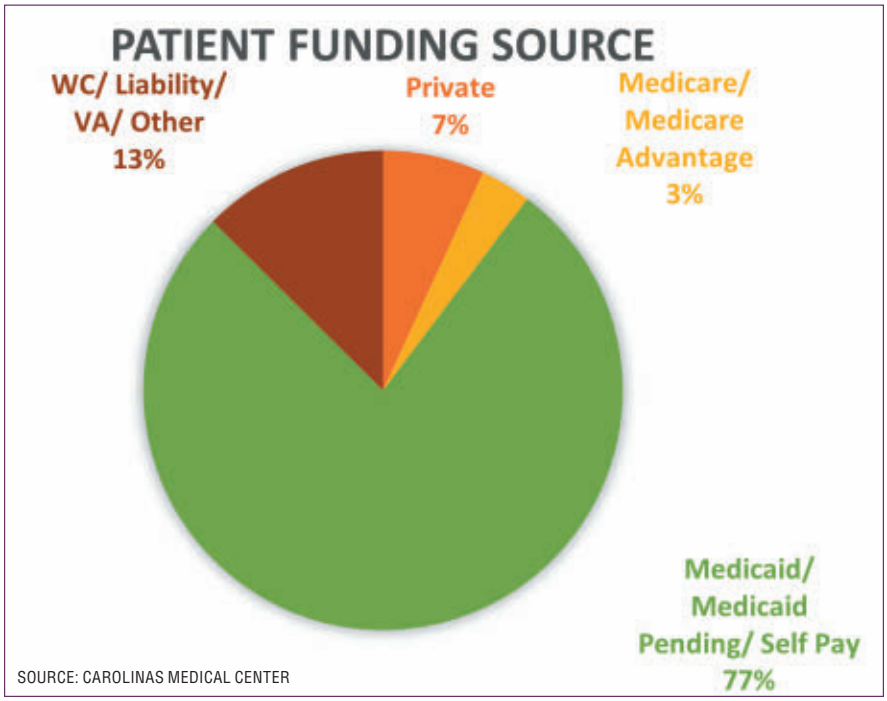
Another patient was Pearlie Gillian, (pictured below) a patient who suffered a stroke and had no health insurance. She needed the help of two therapists to even move in bed. She started the Bridge to Home program within a week of having her stroke, and after two weeks of intense therapy, she was discharged home walking short distances without help, and her family was trained in assisting her.

*Ms. Pearlie and her son*

The program has truly given hope to the case managers and therapists feeling as if there was nothing they could do for these vulnerable, complicated patients. Case managers commented, "Bridge to Home has played a crucial role in optimizing patients' success towards a safe transition to home in an efficient time frame. The therapists go above and beyond in tailoring the patient's care plan towards the patient's responsibilities as well as interests in their home environment. They include the patient's family in their education and training and do a great job with the entire disciplinary team. This program has been so beneficial to our patients because they were not able to receive inpatient rehab."- Christie Stalnaker and Marylou Thompson

"At the end of every workday, I ask myself if I made a difference in someone's life today ...because I work in the Bridge to Home program, my answer is yes, yes, yes!! We turn the impossible to possible for so many people."- Michelle Molina

The Bridge to Home program has brought so much hope to so many patients who have had devastating injuries. All the treaters ask to work on this program as the rewards are so fulfilling and it has touched so many lives. "I am excited to be part of this program that has the potential to make an impact and change the way we provide care in our healthcare system."- Kasey Orita




SOURCE: CAROLINAS MEDICAL CENTER

*Michelle Molina OTR with former patient*

The Bridge to Home program has saved CMC close to $1 million/year in revenue by decreasing the length of stay by at least two weeks for this patient population, but more importantly it provides so much hope for a bright future for so many patients and families. The Bridge to Home program truly reflects the Advocate mission statement by giving "hope, health and healing for all." ■

**Jennifer Cline PT, DHSc, MS**, *is director of therapy at Carolinas Medical Center in Charlotte, North Carolina.*

**Shona Metcalf, RN, BSN, MSN, CCM, IQCI**, *has had over 30 years of nursing experience. She completed her bachelor's degree in 2007 and then master's in nursing at Kaplan University in 2010. She has several certification's including a Certified Case Manager certification. Shona's career has been in various roles, but the last 23 years have been in case management and leadership. She is the director of clinical care management at Atrium Health Carolinas Medical Center, a facility of Advocate Health. She leads a team of one hundred nurses and social workers assisting patients on their transition to the next level of care. As a lifelong learner she has mentored many MSN candidates over the years and encourages certification and education to all her team members. She has presented posters and education sessions on various levels as well as conferences.*

EVIDENCE-BASED ASSESSMENTS … *Continued from page 19*

In summary, there were a total of 16 cohorts (319 care managers trained) with a maximum of 25 CM per cohort training session (June 2022 – April 2023). Current retention rate for all cohorts is an overall 96%.

As noted in the graphs on page 19, the average risk scores for the third quarter of the study were trended and quantified by age group, race and diagnosis.

The Epic risk score for hospital admission and ED visit was compared to the ICM-CAG risk score. Although there was no clear and consistent correlation between Epic risk score and the ICM-CAG total risk score, it is worth noting that only patients with a "high" Epic risk score received a total risk score of 40 or higher (range is 0-60 for the study sample). Of note, the study was carried over two performance years. Medicare Shared Savings Program attribution may also factor into the interventions.

## CONFLICT OF INTEREST AND PERMISSIONS

There are no conflicts of interest. The QI project aligns with the Catholic health system mission, vision and strategy and supports patient-centered relationship-based care through assessment and patient engagement leveraging motivational interviewing. Providing evidence-based learning opportunities for care management leaders and colleagues promotes safe care and continuous quality improvement.

## LIMITATIONS

Limitations include the timeline of the intervention and the need for continued monitoring and evaluation. There are three clinically integrated networks that were not included in the turnover and retention graphs from the System Office Human Resource data.

## SUMMARY AND CONCLUSIONS

The ambulatory care management team continues to be very appreciative of the CMSA ICM training and membership. Creating team expectations and building upon knowledge and skills supports our goal to continue to advance CM engagement and competency. Leveraging a national system approach facilitates overall improvement in interventions, care plans and patient care delivery.

Recommendations include continued monitoring of turnover and retention rates to ensure sustainability. Future state needs include evaluation of the efficacy within CM interventions to ensure decrease and/or mitigate risk.

## ACKNOWLEDGMENTS

The author thanks Rebecca Perez, MSN, RN, CCM; Michele Lee, Amy Black, Tom O'Grady, Sheila Johnson, MBA, RN; Emily Brower, MBA; Gay Landstrom, PhD, RN, NEA-BC, FACHE; Ryan Berger, Michelle Fitch, and the CM leaders and national teams for their commitment and support of the training and quality improvement initiative. ■

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USING RESEARCH TO ADVOCATE … *Continued from page 21*

what participants said during the sessions, but mostly let the discussion occur naturally.

Our participants had between 5 and 15+ years of experience, were predominantly women and participated via a virtual video call. These three focus groups were lively discussions, and while each group touched on different topics, our analysis was able to pull out the three major "red flag" themes. ■

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**Keemia Vaghef, PhD**, *is the director of analytics consulting at Alight where she specializes in analyzing absence management trends and offering collaborative solutions customized to client needs. Keemia has over 10 years of experience analyzing data, summarizing key trends, and presenting important metrics to a variety of companies and industries. With her doctorate (PhD) in industrial-organizational psychology, she links relevant statistical findings to significant contextual workplace drivers. She continues to present thought leadership material on behalf of Alight for the betterment of the absence management industry. Additionally, she has published research focusing on workplace factors that impact productivity through best practice.*

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