Case management plays critical role in Boston Marathon bombings

Learning objectives

- Describe the immediate situation into which several Boston hospital case managers were drawn in the aftermath of the Boston Marathon bombings
- Discuss the role of the case manager in caring for the victims of a disaster such as the Boston Marathon bombings
- State the impact of a large-scale incident on the care provided by the case managers

At 2:50 p.m. on Monday, April 15, two bombs went off at the finish line of the 117th annual Boston Marathon. Three people were killed, hundreds were injured, and local case managers needed to help deal with the crisis.

At Tufts Medical Center, which is close to the marathon’s finish line, ED staff formed a huddle in those first moments after the news broke. “Secretarial staff, security, case managers, physicians, we all gathered to talk about what we needed to do to prepare,” says Margaret McDonagh Gallagher, RN, BSN, CCM, a Tufts ED case manager. “Then everyone accelerated their usual roles.”

For case managers, that meant looking at available beds and working to free up space for incoming patients.
ONLINE

Study: Nurse staffing ratios have impact on pediatric readmissions

A new study found that pediatric nurse staffing ratios are significantly associated with hospital readmission for children with common medical and surgical conditions. The study, led by a nurse scientist at Cincinnati Children’s Hospital Medical Center, is believed to be the first to examine the extent to which hospital nurse staffing levels are related to pediatric readmissions.

http://qualitysafety.bmj.com

New mobile app targets hospital readmission rates

A new mobile app developed by University at Buffalo, SUNY hopes to help reduce hospital readmission rates. Currently a prototype, the “Discharge Roadmap” app is designed to allow patients and their caregivers to fully participate in the discharge planning process. The app will store postop care information and track prescriptions and follow-up appointments.

http://news.wbfo.org

Quick Hits

FROM THE FIELD

“We were trying to clear out. We didn’t know how many patients there were or how bad it was going to be.”

Nancy Sullivan

“The importance of paying close attention to the emotional status and emotional needs of staff members can’t be underestimated.”

Joanne Hogan, RN, MS

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"We were trying to clear out. We didn’t know how many patients there were or how bad it was going to be," says Nancy Sullivan, executive director of Massachusetts General Hospital (MGH)/MGPO case management at MGH.

“It all happened very quickly once the bombing occurred. Victims began arriving less than 15 minutes later," says Joanne Hogan, RN, MS, associate chief nurse of ambulatory nursing and care coordination at Brigham and Women’s Hospital in Boston.

One thing working in their favor was that most hospitals in the area were already either on alert or had extra staff on hand to handle the traditional influx of injured or dehydrated patients running the marathon.

When news of the bombings came, staff were put on lockdown and told not to leave, says June Stark, director of clinical resource management at Tufts Medical Center. “It helped me a lot because I didn’t have to say, ‘You stay and you can go,’ or decide what percentage of staff I needed, because I had everybody,” she says.

**Working to discharge patients**

In both the ER and up on the units, case managers worked with nurses and physicians to find patients who were ready to be discharged and healthy enough to leave. “We have an electronic board that shows beds in real time,” says Stark. The goal was to make the information on that board as accurate as possible, she adds.

Case managers went through the units and asked the nurses to give further detail on potential discharges, reclassifying those who probably wouldn’t be ready to leave, so staff members had a more accurate count of what beds might become available, says Stark.

“The key for us [at MGH] was trying to see if we could identify patients on the units that could be moved safely to another level of care,” says Peter Moran, RN, BSN, MSN, CCM, emergency room case manager at MGH.

Local SNFs and other postacute care providers were calling to offer beds, offering to take patients who had been scheduled for discharge a day early, says Moran. Facilities were also willing to accept patients later in

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**Treating emotional scars after tragedy**

**Learning objectives**

- Describe the difference between the emotional needs of the trauma victims, their families, and responding staff
- List several wellness strategies to include in the recovery process
- Identify warning signs of difficulty with recovery

Healthcare workers treating patients in the wake of the Boston Marathon bombing faced injuries they have never seen in the past: traumatic amputations, wounds filled with metal shrapnel, burns, and blown-out eardrums.

The majority of Boston Marathon bombing victims were young and healthy, says Peter Moran, RN, BSN, MSN, CCM, emergency room case manager at Massachusetts General Hospital (MGH) in Boston. Many victims face a long recovery, both physically and emotionally.

But they are not the only ones recovering from this incident. “The importance of paying close attention to the emotional status and emotional needs of staff members can’t be underestimated," says Joanne Hogan, RN, MS, associate chief nurse of ambulatory nursing and care coordination at Brigham and Women’s Hospital in Boston.

Healthcare workers not only must deal with the same emotions as the rest of Boston residents after an attack on their city, but they also had to go to work and come face-to-face with the victims. "I think it was very hard for the staff members who were actually in the room with the acute trauma," says Moran. “It doesn’t really make a lot of sense. I think there are still staff members that are traumatized by the experience.”

When a crisis like this hits locally, people are affected on a very personal level, says June Stark, director of clinical resource management at Tufts Medical Center. “It really was six degrees of separation. The family that lost an 8-year-old boy was a neighbor of a staff member," she says. The mother of a police officer who was shot but luckily survived also works at the facility.

A case manager from one facility was running the race, but
the day than they normally would have, he says.

Insurance companies understood the importance of moving quickly in this situation.

“The insurance companies were saying yes, if they’re ready to go they don’t need authorization,” says Moran.

“I’ve been doing this a long time. I’m used to needing to jump through hoops to satisfy the rules and regulations and the insurance companies,” says Moran. The fact that these same rules were temporarily suspended in some ways made caring for these patients easier than other situations.

Other roles for case management

Case managers weren’t only working to free up beds, they were also there to back up social workers and work out kinks in throughput issues, says McDonagh Gallagher.

Blast survivors weren’t the only patients affected by the bombings. Stark had one patient who was evacuated from her home in the bombing area and was temporarily homeless and in need of medications for a chronic disease. Case managers worked to make sure she was taken care of and that she had a temporary placement, says Stark.

Case managers also needed to provide direct support to patients. The injuries that bombing patients suffered were severe and life changing, the type of injuries that one would only normally see in a war zone, Moran says. They included traumatic amputations, shrapnel wounds, and ruptured eardrums.

These victims went through a tremendous trauma, says Cheryl Ventola, RN, CCM, care coordinator at Brigham, who worked on the unit that treated most of the marathon victims. It was difficult for them or their family members to retain information given to them, she says. “I could have a conversation with families on Monday about rehab or treatment and they might write everything down. And then we’d have the exact same conversation again a few days later,” Ventola says. “They were just on overload. They had so much coming at them.”

Staff were not only handling medical issues, but also

Coping with grief

It’s important to give people an outlet and a way to cope with their emotions, says Nancy Sullivan, executive director of MGH/MGPO case management at MGH.

MGH has held interfaith services and afternoon wellness sessions where patients can drop in and have a chair massage or acupuncture. “We also did a session at a staff meeting with the employee assistance program here, which gave staff members an opportunity to talk,” says Sullivan. “It was a good chance for people to be able to talk about what it was like and what they were doing to help themselves.”

Other Boston hospitals have offered similar programs from debriefing sessions and spiritual services to visits from clergy.

“Overall, people are doing okay,” says Sullivan. The facility’s case managers have found it helpful to listen to inspiring stories from victims who are determined to recover and move on from the tragedy. A visit from President Obama also helped buoy spirits, says Sullivan. “He was very generous and visited privately with patients and took time to talk to the caregivers. He was really inspiring and encouraging,” she says.

Although formal support programs are important, Margaret McDonagh Gallagher, RN, BSN, CCM, a Tufts ED case manager, says she really appreciated some of the smaller, more informal measures—things like local restaurants sending lunch to the department or a hospital in Colorado where a theater shooting took place sending a fruit basket. “To me that was really moving. It made me think, they got better, they’re still providing care. We’re still providing care,” she says.

Cheryl Ventola, RN, CCM, care coordinator at the Brigham and Women’s Hospital in Boston, agreed. “On the eighth floor where a number of patients were treated, lunch just appeared every day. I know that sounds crazy…but it was such a relief to go back and it was there. It was just one more thing we didn’t have to think about,” says Ventola.

Treating emotional scars after tragedy (cont.)

luckily was not injured. “Talking to staff members, it seemed like everyone knew someone who was there or was directly affected,” says Stark.

Cheryl Ventola, RN, CCM,
dealing with FBI advocates and watching the bombing investigation unfold. “I think they could only take in so much,” she says.

Ventola also found it was not only important to be patient, but also to anticipate potential triggers for these individuals. For example, a patient who is being discharged to a rehab facility might have an emotional stress reaction to being placed in an ambulance, she says.

**A second wave of catastrophe**

While in many cases the strain of an event eases after the initial confusion, in Boston problems continued for several days.

“Patients kept coming,” says Stark. In the shock of the initial event, many of these patients were afraid and just wanted to get home, coming back for treatment days later.

And the bombers still hadn’t been found. Tufts had to evacuate its ER and call in a SWAT team for a potential threat that was later discounted, says Stark. Brigham had to contend with a bomb scare on Tuesday. Hospital staff worked side by side with armed men in fatigues.

And it only got worse as the week wore on. Late in the evening on Thursday night, the two bombing suspects allegedly killed a local police officer, setting off a confrontation where another police officer was injured and one suspect was killed. The second suspect escaped, triggering an extensive manhunt that dragged into the following evening. City officials put Boston and surrounding communities on a mandatory lockdown, suspending public transportation and conducting door-to-door searches. Patients in local hospitals were told not to leave and hospital staff members had to find a way into the city, carpooling or walking, despite the ban.

“Friday orders were that patients could not be sent out of the hospital, yet we still had patients coming in,” says Moran. Case managers worked to ease the strain as pressure built. “But at 3 p.m., that pressure was relieved when we got permission to discharge people, except to certain affected areas,” says Moran.

**Taking the positive from a tragedy**

Despite the chaos and confusion, local case managers say the situation could have been much worse. “The fact that this happened in Boston where there are so many hospitals in the immediate vicinity helped keep the death toll down,” says Moran.

And the local community rallied to provide support. People who had completed the 26.2-mile marathon were coming into the hospital to donate blood.

“There was a sense of pulling together. Many of the injured are uninsured, so the people treating them aren’t sure how they’re getting reimbursed,” says Moran. “But that wasn’t an issue, people just wanted to get them what they needed. Vendors, prosthetic providers have all said we’ll give them whatever they need.”

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**Disaster planning played a role in success of emergency response**

**Learning objectives**

- Describe the significant role that case managers play during a large-scale crisis
- Outline a disaster preparedness plan for inclusion of the case manager using lessons learned from the Boston Marathon bombing disaster

When two bombs went off eight seconds apart at the finish line of the Boston Marathon, there were many emergency plans in place. “There’s an emergency disaster plan in place for both the city and the marathon itself,” says Peter Moran, RN, BSN, MSN, CCM, emergency room case manager at Massachusetts General Hospital (MGH) in Boston. In addition, each hospital has its own emergency process in place.

“I think our emergency preparedness training was invaluable,” says Joanne Hogan, RN, MS, associate chief nurse of ambulatory nursing and care coordination at Brigham and Women’s Hospital in Boston. “Everyone knew their roles. The response was well scripted and well known.”

Hogan, like other case management professionals, is
involved with emergency planning at her facility. And when the blast occurred, she jumped into the role that had already been established for her.

But while plans laid the groundwork for the response, staff members did need to evolve their plans to meet the needs of this particular tragedy.

“I felt that yes, we had a plan in place and we operationalized that plan. But we did make some modifications as we went. I think you have to do that to adjust for the situation,” says June Stark, director of clinical resource management at Tufts Medical Center in Boston.

Others agreed. “We learned things on Monday that we were able to apply on Friday when the city was put on lockdown while police searched for the remaining bombing suspect, who had evaded police after his brother was killed in an initial confrontation,” says Nancy Sullivan, executive director of MGH/MGPO case management at MGH. (See p. 7 for an excerpt of a sample checklist used by MGH’s case management department.) On an individual level, case managers focused much of their energy on working to discharge patients who were ready to go home to open up beds for injured bombing victims. But they were also called at times to help in other areas where needed.

During a crisis it is important to be flexible, says Margaret McDonagh Gallagher, RN, BSN, CCM, a Tufts ED case manager. But there’s a difference between being flexible and getting pulled in 50 different directions while letting more important duties lapse. For this reason, it’s important that you stay focused on where your services are most needed and stick to that role, she says. “For myself, I stayed in the ER; I knew I was more useful being there,” says McDonagh Gallagher. “Stay strong on what your role is with some flexibility.”

Lessons learned

During a disaster, it’s often the small lessons learned that can help with future planning. Below is a list of lessons that the Boston bombing taught local case managers that you may want to incorporate into disaster planning at your organization.

- **Choose a spokesperson for your case management department.** Sullivan says that one person should be designed as a communication liaison, working with other staff members within the hospital. MGH found that this helped ensure there was one consistent voice during the disaster when information was changing rapidly minute to minute. “We didn’t want staff members sending out different messages,” she says.

  And in this particular crisis, it was important to give the most up-to-date, consistent information. For example, on April 19, throughout the day staff members had to be updated on which areas patients could and could not be discharged to and provided with regular updates on whether ambulances or taxis were working, says Sullivan. Having one voice conveying this information cut down on misinformation.

- **Set up a recorded phone line for employees and include detailed information.** Record a voice mail message that workers can access by phone to get up-to-date information, Sullivan says. For example, on April 19 many workers at the hospital were confused as to whether they should remain in lockdown or head to the hospital. With public transportation shut down, many were also unsure if they could drive into the city and whether there would be available parking. “Communication didn’t work as smoothly as it could have,”

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- Complete and submit the evaluation

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Sample checklist

At Massachusetts General Hospital, staff members are given carefully crafted checklists to make sure they stay on track with tasks during an emergency response. Below is a sample checklist that you can use to develop your own.

**Case management department**

Emergency operations plan task list/evaluation tool

Date: _______________  
Time: _______________

Executive director of case management  
Name: _______________________________

**Goal:** Evaluate the information received from MGH Emergency Notification System relative to an emergency status and coordinate case management activities with hospital emergency response activities. Activate departmental plan as needed.

<table>
<thead>
<tr>
<th>Complete</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Notify administrative team (nurse managers)</td>
</tr>
<tr>
<td>2.</td>
<td>Convene in department headquarters FND 7, Room 746 (or alt. headquarters—Whittier Place/IMA of)</td>
</tr>
<tr>
<td>3.</td>
<td>Implement departmental plan (Section 2.0-9.0)</td>
</tr>
</tbody>
</table>
| 4. | Maintain close communication with inpatient area supervisor (Gray/Bigelow 1030—no phone)  
(use “Command Post Communication Log”) |
| 5. | Reassess department status and current functions frequently |
| 6. | Define other duties for department staff as needed (refer to “Emergency Assignment Tool” as needed) |
| 7. | Terminate departmental plan when notified by inpatient area supervisor (Section 10.0) |
| 8. | Conduct debriefing session with case management staff when feasible (Section 11.0) |
| 9. | Evaluate case management dept. activities and convey evaluation to incident commander |
| 10. | Complete HICS forms as needed (see “Starter Kit” for copies) |

says Sullivan. A simple recording stating that employees should report to work and that parking would be available would have been helpful.

- **Allow staff members to check in with family.** “When the bombs went off, the nurse manager in the ED knew we only had a few minutes before patients would start arriving, and she told people to call their families and let them know that they were okay,” says McDonagh Gallagher. This way, staff could focus on their jobs and not be worried about their loved ones.

- **Turn off the television.** At Tufts, they will consider turning off the televisions if a future event occurs because the nonstop news broadcasts can add more tension to the scene and also bring more confusion as the news media struggles to sort through conflicting information, says McDonagh Gallagher.

- **Stay vigilant.** Unlike the months and initial years after 9/11, when people were hyperfocused on emergency drills and preparedness, years had passed without a major terrorism incident and people had relaxed a little, says McDonagh Gallagher. The potential for disaster needs to remain at the forefront, she says. “I think we always need to review all of our emergency policies and make sure they’re still relevant.”

- **Brainstorm potential scenarios.** Hospitals should review all emergency policies and make sure that all case managers are familiar with their specialized role within the hospital incident command system. Think about different scenarios, even unlikely ones, and prepare for them.
Sample checklist (cont.)

Executive director of case management

Name: _______________________________

Task list (after hours: 5:00pm–8:00am)

Goal: Evaluate the information received from telecommunications department relative to an emergency status if between hours of 5 p.m. and 8 a.m. and activate departmental plan as needed.

<table>
<thead>
<tr>
<th>Complete</th>
<th>Task</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Report if needed to the hospital</td>
</tr>
<tr>
<td>2.</td>
<td>Assess scope of emergency, functions needed, staff required &amp; need for disaster message on phone line #6—3666 (see disaster phone line instructions &amp; “Temp. message” info. in “Starter Kit”)</td>
</tr>
<tr>
<td>3.</td>
<td>Utilize the current call list of case management dept. staff (“First Call List”) able to report after hours</td>
</tr>
<tr>
<td>4.</td>
<td>Remind staff to display their MGH photo ID badge at all times</td>
</tr>
<tr>
<td>5.</td>
<td>Have staff report to case management headquarters, FND 746 using available entrance</td>
</tr>
<tr>
<td>6.</td>
<td>Implement executive director of case management’s tasks #2–11 above</td>
</tr>
<tr>
<td>7.</td>
<td>Define assignment utilizing “Emergency Assignment Tool” as needed</td>
</tr>
<tr>
<td>8.</td>
<td>Complete HiCS forms as needed (see “Starter Kit” for copies)</td>
</tr>
</tbody>
</table>

Nurse manager(s)

Name: _______________________________

Task list

Goal: Participate on CM administrative team and function as administrator on-call after hours as assigned. Work with the case management staff to facilitate appropriate patient discharges and the support staff to maintain and organize routine operations.

<table>
<thead>
<tr>
<th>Complete</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Convene in department headquarters FND 7, Room 746</td>
</tr>
<tr>
<td>2.</td>
<td>Implement departmental plan (Section 2.0-9.0) per executive director of case management</td>
</tr>
<tr>
<td>3.</td>
<td>Assist case managers in identifying and resolving actual &amp; potential barriers to discharge (utilize “Emergency Response/Discharge Pending Log” and/or MCCC ADA as needed)</td>
</tr>
<tr>
<td>4.</td>
<td>Act as liaison with patient care units/discharge holding units to allocate staff as needed</td>
</tr>
<tr>
<td>5.</td>
<td>Notify case management staff members of need to continue to work on units and/or treatment areas in an emergency situation</td>
</tr>
<tr>
<td>6.</td>
<td>Nurse managers circulate to units to assess workflow and staffing needs as appropriate</td>
</tr>
<tr>
<td>7.</td>
<td>Assess availability of CMSU support staff</td>
</tr>
<tr>
<td>8.</td>
<td>Assess nonacute resources in anticipation of discharge planning needs (utilize “Non-Acute Resource List/Bed &amp; Visit Availability Log”); contact partner’s nonacute affiliates first</td>
</tr>
<tr>
<td>9.</td>
<td>Organize and maintain routine operations to support patient discharges from units and ED</td>
</tr>
<tr>
<td>10.</td>
<td>Facilitate transfers to nonacute facilities &amp; procurement of home care resources as needed</td>
</tr>
<tr>
<td>11.</td>
<td>Assess need to continue ongoing utilization review and contact payer groups as appropriate</td>
</tr>
<tr>
<td>12.</td>
<td>Complete HiCS forms as needed (see “Starter Kit” for copies)</td>
</tr>
</tbody>
</table>

Source: Nancy Sullivan, executive director of MGH/MGPO case management, Massachusetts General Hospital. Reprinted with permission.
Helping staff members cope

In the wake of a traumatic event, you may need to provide support to patients or your case management staff. Below are some tips from the Centers for Disease Control and Prevention to help guide you through the process.

What is a traumatic event?
An event, or series of events, that causes moderate to severe stress reactions is called a traumatic event. Traumatic events are characterized by a sense of horror, helplessness, serious injury, or the threat of serious injury or death.

Traumatic events affect survivors, rescue workers, and friends and relatives of victims who have been directly involved. In addition to potentially affecting those who suffer injuries or loss, they may also affect people who have witnessed the event either firsthand or on television. Stress reactions immediately following a traumatic event are very common; however, most of the reactions will resolve within 10 days.

How do you interact with patients after a traumatic event?
The clinician should be alert to the various needs of the traumatized person by:

- Listening and encouraging patients to talk about their reactions when they feel ready.
- Validating the person’s emotional reactions. Intense, painful reactions are common responses to a traumatic event.
- De-emphasizing clinical, diagnostic, and pathological language.
- Communicating person to person rather than “expert” to “victim” using straightforward terms.

What can you do to help patients cope with a traumatic event?
Explain that their symptoms may be normal, especially right after the traumatic event, and then encourage patients to:

- Identify concrete needs and attempt to help. Traumatized persons are often preoccupied with concrete needs (e.g., How do I know if my friends made it to the hospital?).
- Keep to their usual routine.
- Identify ways to relax.
- Face situations, people, and places that remind them of the traumatic event—not to shy away.
- Take the time to resolve day-to-day conflicts so they do not build up and add to their stress.
- Identify sources of support including family and friends. Encourage talking about their experiences and feelings with friends, family, or other support networks (e.g., clergy and community centers).

Who is at risk for severe and longer-lasting reactions to trauma?
Some people are at greater risk than others for developing sustained and long-term reactions to a traumatic event, including disorders such as post-traumatic stress disorder (PTSD), depression, and generalized anxiety. Factors that contribute to the risk of long-term impairment such as PTSD include:

- Proximity to the event. Closer exposure to actual event leads to greater risk (dose-response phenomenon).
- Multiple stressors. More stress or an accumulation of stressors may create more difficulty.
- History of trauma.
- Meaning of the event in relation to past stressors. A traumatic event may activate unresolved fears or frightening memories.
- Persons with chronic medical illness or psychological disorders.

What can you do to treat patients in response to a traumatic event?
Helping survivors of traumatic events, their family members, and emergency rescue personnel requires preparation, sensitivity, assertiveness, flexibility, and common sense.

- Refer patients to a mental health professional in your area who has experience treating the needs of survivors of traumatic events.
Addressing insurance complexities of a foreign representative

Mr. Norman comes to the U.S. as the secretary/assistant to a foreign diplomat. During his trip to Washington D.C., Mr. Norman contracts an antibiotic-resistant pneumonia, which leads to an acute illness. EMTs rush him via ambulance to the local hospital ED, telling staff there that he is in critical condition. As staff members roll his stretcher through the door, Mr. Norman begins gasping for breath. A rapidly attached oxygen monitor reveals significantly dropping oxygen saturation. Before the evaluating ED physician realizes it, the patient requires intubation and is rushed to the medical respiratory ICU. Mr. Norman’s condition continues to deteriorate, necessitating urgent critical care medical interventions. His final diagnosis is septic shock, and life-sustaining measures continue throughout the next days.

The case manager, upon initial encounter, quickly assesses the case and realizes that the patient has no significant others in the country. She puts her efforts into finding relatives and learns that Mr. Norman is married. Using the contacts provided for her by Mr. Norman’s employer, Cheryl, the case manager, reaches out to his wife. Mr. Norman’s wife is so grateful and with Cheryl’s support plans to arrive in Washington in a few days. In the meantime, Cheryl provides medical updates on Mr. Norman’s condition.

During these phone calls to his wife, Cheryl learns about Mr. Norman’s insurance. He is self-insured, which initially seems like a promising resource to support his medical care. But she later learns that his insurance is “capped.” With further research into this type of insurance with the help of the hospital’s financial counselors, it turns out that his “insurance cap” is extremely limited. In fact, his insurance dollars are only able to cover the first two days of his complex stay.

Mrs. Norman arrives on the third day of her husband’s hospital stay. She finds her husband clinging to life. She is dedicated, staying nearby as a constant support to her husband. Cheryl gets to know her well, as Mr. Norman’s stay reaches 30 days. The good news is that Mr. Norman’s condition has greatly improved, although he is still intubated, and he is ready to transition to the next level of care at a rehabilitation center. Rehabilitation for this patient is essential, as his condition has caused a severe physical deconditioning and because he is still intubated therefore needing long-term, chronic weaning. The bad news is that Mr. Norman’s insurance does not include a rehab benefit.

Cheryl starts the intricate search for a rehab facility that might be willing to take over his care. However, no facility will offer free care to this patient. Cheryl turns to the office of the foreign diplomat for whom Mr. Norman works, as well as the foreign consulate. She spends long hours on the phone going through the chains of command and protocols, but with no resolution. It seems that no health insurance options are available to this patient. The next intervention is to discuss finances with Mrs. Norman to determine whether she can self-pay for the rehab stay. She agrees, but upon checking with all the major rehab facilities in the area, they all want $2,000 per day for his stay.

Mrs. Norman is overwhelmed and Cheryl feels like she has exhausted all her options. It is at this point that the director of case management is updated on the status of this case. A little annoyed that she has not been informed earlier, Nancy, the director, is at least relieved that she is now included. Nancy begins working closely with Cheryl on the case. Together they make one more pass at the consulate, but no progress is made. Nancy has only one option, to request a favor from the rehab facility that received the highest volume of her hospital’s referrals. This rehab center agrees to provide care to Mr. Norman at a lower daily rate, one that the Normans can afford. Nancy also has to agree to partner with the rehab center once Mr. Norman reaches the point of discharge and is ready to return to his native country. Mr. Norman is transferred the next day and a plan is established in which Nancy and Cheryl are informed of his progress.