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HOSPITAL HOME HEALTH

the monthly update for executives and health care professionals

March 2010: Vol. 27, No. 3 Pages 25-36

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Financial Disclosure:
Editor Sheryl S. Jackson, Managing Editor Karen Young, Associate Publisher Russ Underwood, and Consulting Editor Marcia Reissig report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

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Deaths, injuries associated with Negative Pressure Wound Therapy

Staff and patient education critical to avoid complications

Six deaths and 77 injuries associated with the use of Negative Pressure Wound Therapy (NPWT) over the course of two years have prompted the U.S. Food and Drug Administration (FDA) to issue an alert to health care providers.

Bleeding was reported in the six deaths and in 17 of the injury reports. Other complications that resulted in injury included infection, and 32 reports indicated retention of foam dressing pieces that adhered to tissues or were embedded in the wound. Although injury reports came from hospitals, nursing homes, and home health agencies, the six deaths occurred in nursing homes or at home.

Although the alert did not change wound care protocol at Bayada Nurses in Towson, MD, an inservice program was given to all staff members, says **Sue Grafton**, RN, CWOCN, the wound care nursing specialist at the agency. "We provided up-to-date information on the use of negative pressure, and we reiterated the proper use of the device," she says.

EXECUTIVE SUMMARY

Reports of bleeding and infections that led to six deaths and 77 injuries associated with Negative Pressure Wound Therapy (NPWT) prompted the U.S. Food and Drug Administration to issue an alert that warned health care providers to pay close attention to risk factors such as medication that acts as an anticoagulant and debris left in the wound after dressing changes. Home health agencies re-educated nurses on the proper procedures and patient screening for appropriateness for NPWT following the alert.

- Offer inservices at orientation and periodically to nurses who do not regularly care for patients on NPWT.
- Give patients and families clear instructions on how to recognize symptoms of a serious complication and what steps to take.
- Follow guidelines on contraindications for NPWT carefully.
- Be ready to contact physicians if NPWT was ordered for a patient whom the home health nurse believes might not be able to safely handle the treatment.

Even nurses with a lot of experience with NPWT benefit from updated inservices, she points out. When people become comfortable with a procedure or treatment, they can develop shortcuts or forget to pay close attention to details, she explains.

Staff members are reminded of contraindications for NPWT, says Grafton. "We don't want the patient to have a history of anticoagulation or to be on medications that prevent coagulation," she says. "We also don't want to use NPWT for a wound that may have cancerous cells in the margin," she adds.

Infection is also another concern, points out Grafton. "It is critical that no pieces of foam dressing or gauze be left in the wound after a dressing change," she points out. "We use contact layer dressings to prevent pieces of dressing adhering to the tissues," she adds.

A functional issue that eliminates a patient as a candidate for NPWT is the inability to manage the equipment, especially if there is no family or other in-home caregiver, says Grafton. "We need to know that there is someone who can help if the machine malfunctions at night," she adds. "We also do not recommend NPWT for patients at high risk for falls," she says. *(See other contraindications on p. 27.)*

Grafton educates nurses about NPWT at orientation and periodically through agency-wide inservices, but she also has small classes for nurses who were trained on the treatment modality but have not had a patient needing NPWT for a couple of months. "We'll have the nurses come in for a refresher course — just to make sure they can handle a patient who needs NPWT," she says.

At orientation, Grafton identifies nurses who have never administered NPWT, and in addition to the inservice, she goes on three home visits with NPWT with them. Even after the three visits, Grafton is available to help nurses who may have a case with which they are not comfortable. "If I'm not available to make the visit, our vendor provides someone to go with the nurse," she says.

In fact, the ability of vendors to act as back-up to the wound care specialist is an important feature to examine when evaluating vendors, suggests **Sharon Burt**, RN, CWOCN, director of wound, ostomy, and continence nursing at Physician's Home Health in Colorado Springs, CO. "Most home health agencies that have a certified wound, ostomy, and continence [nurse] on staff only have one," she says. This makes the availability of someone else, who can provide some teaching or additional consultation, critical, she adds.

Patient education ongoing

Although the information in the FDA alert was not "new" news to wound care specialists, Burt sees it as a chance to remind people that NPWT can have serious complications. "Even when a nurse is well-trained and experienced with NPWT, I don't believe that the potential for injury with this treatment is in the forefront of everyone's mind," she explains. "Not only is staff education

Hospital Home Health® (ISSN# 0884-8998) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to *Hospital Home Health*®, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: customerservice@ahcmedia.com. World Wide Web: http://www. ahcmedia.com. Hours: 8:30-6 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $83 each. (GST registration number R128870672.)

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for nurses, managers, directors, and management involved in hospital-owned home care agencies, including health care professionals involved with home care issues such as end-of-life care, pain management, multicultural issues, elder care, and similar issues. It is in effect for 24 months from the date of publication.

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important, but I also believe we need to improve patient education," she adds.

Patient education is always a focus of home health care, but there is a need to go in more depth when teaching patients and families about NPWT, says Burt. "We need to describe frank bleeding and how they should react," she says. If a patient or family caregiver sees blood, the machine should be turned off and the home health agency called, she says.

When teaching family and patients, don't assume that they will remember everything, warns Grafton. "We re-teach all aspects of NPWT at each dressing change," she says. "We keep the language simple, and we give patients a clearly written form that identifies signs of potential problems and tells them what to do," she adds.

Grafton has not had any patients ask about issues related to the FDA alert, but she says patients will question the need for NPWT if it is not suggested by the hospital or by physicians prior to admission to home health. "We have to explain the benefits of healing the wound more quickly and explain the process," she says.

At the same time, Grafton encourages her nurses to call physicians if they believe a patient for whom NPWT was ordered has one or more contraindications for the therapy. "Nurses must be empowered to evaluate the patient's ability to undergo treatment safely and to contact physicians if they see reasons to reconsider the treatment," she adds.

Although complaints about NPWT are not frequent, they typically relate to the device's interference with daily activities, says Grafton. "When a patient complains about the noises the machine makes, we can improve the seals or even cover the device," she says.

Complaints about the difficulty using a walker while carrying the machine required a little more creativity, Grafton says. "The complaints stopped after we found a way to create a little sling that hangs on the walker and holds the machine!"

SOURCES

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RESOURCES

To see a copy of the FDA alert, go to www.fda.gov, select "medical devices" on the left navigational bar, then choose "public health notifications" under the "safety, recalls and alerts" heading. Scroll down to "Serious Complications Associated with Negative Pressure Wound Therapy Systems" issued on November 13, 2009.

Pay attention to the contraindications for NPWT

FDA identifies top concerns

The U.S. Food and Drug Administration Alert warning of the deaths and injuries that resulted from the use of Negative Pressure Wound Therapy (NPWT) outlined the following cautions: NPWT is contraindicated for patients with these conditions or wound types:

- necrotic tissue with eschar present;
- untreated osteomyelitis;
- non-enteric and unexplored fistulas;
- malignancy in the wound;
- exposed vasculature;
- exposed nerves;
- exposed anastomotic site;
- exposed organs.

Risk factors and characteristics that should be considered before implementation of NPWT:

- patients at high risk for bleeding and hemorrhage;
- patients on anticoagulants or platelet aggregation inhibitors;
- patients with:
  - friable vessels and infected blood vessels;
  - vascular anastomosis;
  - infected wounds;
  - osteomyelitis;
  - exposed organs, vessels, nerves, tendon, and ligaments;
  - sharp edges in the wound (i.e. bone fragments);
  - spinal cord injury (stimulation of sympathetic nervous system);
  - enteric fistulas.
- patients requiring:
  - MRI;

– hyperbaric chamber;
– defibrillation.

- patient size and weight.
- Use near vagus nerve (bradycardia).
- Circumferential dressing application.
- Mode of therapy — intermittent versus continuous negative pressure. ■

Emotional stress is higher with dementia care

Staff members need extra support, guidance on self-care

[Editor's note: This is the second of a two-part article that discusses best practices for the care of patients with dementia. Last month, we looked at an overview of the challenges presented by dementia patients and techniques that improve care. This month, we look at additional tips to increase patient compliance and ways for home health workers to handle the stress of dementia care.]

It is not uncommon for a home health patient to have dementia in addition to the medical diagnosis that is the reason for admission to home health. Being able to recognize and overcome the challenges presented by dementia is important to being able to ensure a good outcome for the patient, according to sources interviewed by *Hospital Home Health*.

Taking care of home health staff members who care for patients with dementia is as important as taking care of the patients themselves, suggests **Elizabeth Gould**, MSW, director of quality care programs at the Alzheimer's Association. At least this is part of the input received from members of the task force that worked on the Alzheimer's Association's Dementia Care Practice Recommendations for Professionals Working in A Home Setting. *(See resource, right.)*

"Although the best practices suggested by the task force working on the recommendations focused on care for patients with dementia, several suggestions were made to include care for the home health provider," says Gould. Caring for a patient with dementia can be more challenging than most home health patients, so it is important to provide support to prevent home health provider burnout, she explains.

"I found it interesting that a number of people who reviewed the recommendations suggested inclusion of a section on provider self-care," says Gould. "Being aware of the stressful effects of caring for a patient with dementia is especially important for home care providers, because there are fewer boundaries between personal and professional relationships," she says.

Some of the tips for home care provider self-care include:

- Be aware of the physical and emotional impact of caring for someone with dementia.
- Talk to someone or write about your feelings to reduce stress.
- Regularly affirm your successes in improving your patient's quality of life, no matter how small the success might be.
- Nurture your sense of humor.
- Set boundaries between your professional and personal life by not sharing your home or personal cell phone numbers.

Because home care staff members can become close to the family, the last tip about setting boundaries is very important, points out Gould. "A nurse or aide may not want to offend the patient or family by refusing to give them a home phone number, but the agency should have a policy that does not allow staff members to do so," she suggests. "If there is a policy, the employee can explain to the family that it is not allowed by the agency, and the refusal is more easily accepted by the family," she adds.

RESOURCE

To download a free copy of the Alzheimer's Association's Dementia Care Practice Recommendations for Professionals Working in A Home Setting, go to http://www.alz.org/national/documents/Phase_4_Home_Care_Recs.pdf. ■

Simplify information and tasks to improve compliance

Keep discussions with patients friendly vs. clinical

Although every patient with dementia has different symptoms and behaviors, and each is at a different stage of the disease, there are some techniques that home health clinicians and aides can use to make the home care visit go more smoothly, says **Peter Notarstefano**, director of home and community-based services for the

EXECUTIVE SUMMARY

Providing care for patients with dementia requires extra time, patience, and creativity to ensure compliance with instructions and a good outcome. Suggestions from the Alzheimer's Association task force that developed Dementia Care Practice Recommendations for Professionals Working in A Home Setting also addressed ways to help home health nurses and aides handle the stress of working with dementia patients.

- Set boundaries to define personal and professional life.
- Understand that caring for a dementia patient can be especially emotional and stressful.
- Maintain a strong sense of humor.

American Association of Homes and Services for the Aging in Washington, D.C.

- **Engage the patient in friendly conversation.**

Talk about the patient's hobbies, interests, or favorite memories as a way to develop trust and establish yourself as a friend who is there to help.

- **Don't overwhelm patient with information.**

"We want to tell patients what we'll be doing during the visit, but take little steps," suggests Notarstefano. "Talk about what you will do just before you do it; don't list all 15 things at once," he says. Be conversational, and keep the language simple, he adds.

- **Send same staff members whenever possible.**

Although scheduling visits and staff can be a challenge, consistency in staff assignments for dementia patients is important, says Notarstefano. "The most important part of caring for a dementia patient is establishing trust, and that is hard to do when a different clinician comes to the home each visit."

- **Pay attention to the time of day.**

"Some patients are less confused and more energetic earlier in the morning, while others might be better to see in the early afternoon," points out Notarstefano. Find out which time of day is best, and schedule visits for those times, he suggests.

- **Be aware of non-verbal cues.**

"A patient with dementia might not be able to verbalize pain or discomfort," says Notarstefano. For this reason, home health staff should look for non-verbal cues, he adds. "One patient could not tell the aide that he had to go to the bathroom, but he would play with his belt buckle when he felt the urge," says Notarstefano. "The aide knew him well enough to notice the behavior and recognize the need," he adds.

Also, most dementia patients cannot use the standard pain charts to indicate level of pain, so a nurse or aide might notice that a normally active patient doesn't want to get out of bed, says Notarstefano. Any time a patient's behavior changes suddenly, consider pain, infection, or reaction to a medication change as a cause, he suggests.

- **Simplify choices.**

Although you want patients to participate in their care as much as possible, make that participation easy, suggests Notarstefano. "Organize clothing so that the patient can easily choose what to wear, or lay out one or two choices on the bed," he recommends. ■

JOURNAL REVIEW

Study shows at-home care effective for CHF patients

Hospital-at-home care may be a practical alternative to traditional hospital inpatient care for patients with acutely suddenly worsening chronic heart failure, according to a recent report in the *Archives of Internal Medicine*.[1]

Hospitalization for chronic heart failure for older patients has increased and occurs in 2% to 3% of patients over age 85 every year, according to the authors. In the United States, worsening of chronic heart failure leads to more than 1 million hospital admissions per year and a 50% risk of subsequent hospitalization within six months of discharge. Although the hospital is the standard venue for providing acute medical care, it may be hazardous for older persons, who commonly experience complications due to treatment, functional decline, and other adverse events, according to the authors.

Researchers from the University of Torino, Italy, compared the effectiveness of a physician-led hospital-at-home service for elderly patients with acute decompensation of chronic heart failure with traditional hospital inpatient care. Patients age 75 or older with decompensation of chronic heart failure were randomly assigned to either a general medical ward (53 patients) or to the Geriatric Home Hospitalization Service (48 patients) between April 2004 and April 2005. The Geriatric Home Hospitalization Service provided diagnostic

and therapeutic treatments by hospital health care professionals in the home of the patient.

At six months, 15% of all patients had died, with no significant differences between the two groups. "The number of subsequent hospital admissions was not statistically different in the two groups, but the mean time to first additional admission was longer for the Geriatric Home Hospitalization Service patients (84.3 days vs. 69.8 days). Only the Geriatric Home Hospitalization Service patients experienced improvements in depression, nutritional status, and quality-of-life scores," the authors write.

"Recent trends in health care favor alternatives to traditional acute care in hospitals. These trends include advancement in telehealth technologies and increased demand for treatment at home," the authors conclude. "Further development of hospital-at-home care will require additional research and dedicated resources to support dissemination."

REFERENCE

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Scientists find trigger to help prevent aging

Spanish explorer Ponce de Leon may never have found the fountain of youth, but scientists at Mount Sinai School of Medicine have discovered a way to help prevent aging and disease by triggering a transcription factor, the CREB (cAMP response element binding)-binding protein (CRP), that controls the activity of genes that regulate cellular function.[1]

CRP is triggered by dietary restrictions that affect the body's glucose metabolism. There was no difference in the type of dietary restrictions imposed, low-fat vs. low-carbohydrate, as long as the total number of calories consumed was decreased.

"We discovered that CBP predicts lifespan and accounts for 80% of lifespan variation in mammals," says **Charles Mobbs**, PhD, professor of neuroscience and of geriatrics and palliative medicine at Mount Sinai School of Medicine in New York City. "Finding the right balance is key; only a 10% restriction will produce a small increase in lifespan, whereas an 80% restriction will lead to a shorter life due to starvation."

The research team found an optimal dietary restriction, estimated to be equivalent to a 30% caloric reduction in mammals, increased lifespan over 50% while slowing the development of an age-related pathology similar to Alzheimer's disease.

The second part of the study demonstrated that a higher-calorie diet that leads to diabetes inhibits the production of CBP and increases the effects of aging.

Researchers suggest that developing drugs that mimic the protective effects of CBP — those usually caused by dietary restriction — scientists may be able to extend lifespan and reduce vulnerability to age-related illnesses.

REFERENCE

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CMs can take role in fighting obesity epidemic

Education should target the entire family

Pick up any newspaper or magazine or turn on the news, and you're likely to hear somebody talking about this country's obesity epidemic.

There's a lot of emphasis these days on obesity and helping people keep their weight down and avoid chronic disease. Health care workers have always known that obesity contributes to and exacerbates chronic conditions. With today's sedentary lifestyles and dependence on fast food, obesity is become a bigger and bigger concern, says **Connie Commander,** RN-BC, BS, CCM, ABDA, CPUR, president of Commander's Premier Consulting Corp.

Consider these recent reports:

Obesity-related medical costs reached $147 billion in 2008, or about 10% of U.S. medical spending, according to a report by the Centers for Disease Control and Prevention (CDC). As of 2006, the number of obese adults had more than doubled in 25 years to 72 million people, or 35% of adults, the CDC reports.

A study released in Nov. 2009, shows that rising obesity rates will be an increasing burden on the health care system over the next decade, and if current trends continue, 43% of Americans will be obese and obesity spending will quadruple to reach $344 billion by 2018.

The study, "The Future Cost of Obesity: National and State Estimates of the Impact of Obesity on Direct Health Care Expenses," was based on research by Emory University health care economist **Ken Thorpe**, PhD, executive director of the Partnership to Fight Chronic Disease. The study was commissioned by UnitedHealth Foundation, Partnership for Prevention, and American Public Health Association.

As she worked with a hospital in California late last year, Commander drove nine miles to work each day and passed literally dozens of outpatient dialysis centers.

"There is a huge population of people with end-stage renal disease, and we know that obesity is one factor in contributing to such chronic conditions for certain individuals," she says.

"When people are overweight, they are subject to diabetes and cardiac issues, which are very expensive to treat. Obesity is the No. 1 driver of our future medical costs," says Laurie Gondek, vice president of health advocacy products, who oversees CIGNA's lifestyle coaching and disease management programs.

Society frowns on people who are overweight, and since many people reach for food when they feel uncomfortable or unhappy, it creates a vicious cycle, adds **Cathy Campbell**, BSN, MBA, CHC, FACHE, director of case management at Mesquite Specialty Hospital in Dallas.

"As a registered nurse, I know that many diseases are attributable to obesity. People's bodies are in a compromised condition when they are obese. The reality is that obesity is an illness, and people often need psychological treatment to overcome it," Campbell says.

Many obese people suffer from depression, which drives them to eat more in an attempt to feel happier, she points out.

Weight loss is important to any person in the continuum of care, whether it's a member with risk factors, someone with a chronic disease, or a relatively healthy person who has a few pounds to lose, says **Linley Thomson-Siag**, MPH, MPA, health educator in health promotion and wellness department at CDPHP, an Albany, NY-based health plan.

"Research says that if people lose just 5% to 7% of their body weight, they can prevent chronic diseases. Just that 5% can be critical to an overall health goal," she says.

Health care professionals tend to tip-toe around weight problems, even though they know that being overweight is a comorbid factor in every disease, Commander says.

"We in the health care field need to be accountable at different levels to the population we serve. Case managers need to look beyond the person right in front of their face. We have an opportunity to encourage everybody we touch to live a more healthy lifestyle," she says.

Case managers need to do their part in preventing obesity and helping people lose weight, Commander adds.

"We know that obesity leads to diabetes and potentially to other conditions such as coronary vascular disease and renal insufficiency. Obese people are likely to have higher rates of hypertension and cardiovascular disease. Chances are that an obese person is going to develop one or more of these conditions. We need to encourage people to do healthy things before they develop a chronic disease," Commander says.

Commander recommends that case managers do everything they can to help clients live a healthy lifestyle, regardless of the condition or episode of care you are helping them learn to manage.

"Weight, diet, and an exercise regimen should be included as part of the plan of care as we work with our individual clients in managing their chronic conditions and staying healthy. Even if obesity is not the primary reason someone was hospitalized or has a chronic condition, it is a comorbid factor," she says.

Build weight management, healthy eating, and exercise into the care plan for all of your patients and work with them to identify little things they can do in their daily life to stay healthy, Commander suggests.

"Hospital case managers can include tips about eating healthier or taking the stairs instead of the elevator in their education for patients, even if the hospitalization isn't related to obesity," she says.

As you work with your clients on managing their chronic conditions, include family members and caregivers in the mix, Commander says. Encourage family members to set an example and entice them to get healthier as they support the patient, she adds.

People have to want to lose weight and exercise,

and they need support to do so, she says.

"The Case Management Adherence Guidelines speak of knowledge, self-motivation, and willingness to change, and we know that people are not going to change unless we set up support for them. That's why it's always a good idea to have others in the family participate in healthy lifestyle changes," she suggests.

The guidelines developed by the Case Management Society of America (CMSA) are designed specifically to help case managers work with their patients on medication adherence and behavioral changes, Commander says.

"It's important for case managers to work with the individual patients, but they also should follow up with a program that makes sense to the family so they want to participate," she says.

For instance, if the patient needs to follow a low-fat or low-salt diet, encourage the family members to follow the diet and become healthier as well. This gives the cook in the family an opportunity to learn new methods of cooking or experiment with seasonings to provide food that tastes good and is healthy as well, she says.

"Don't just tell people they need to exercise or lose weight. Encourage them to diet or exercise in an effort to support the patient in maintaining a healthy lifestyle. Build around what the patient needs to do and include family members and friends who can support the patient," she says.

For instance, if grandfather needs to start a walking program, suggest that he walk with the grandchildren, which will get them on an exercise program.

Tell family members that their dad needs to exercise but it's hard for one person to do it himself. Suggest that they come up with a buddy system.

Mention that it's hard for one person to follow a diet when other people are eating other things.

A critical intervention is to provide resources for the family and caregiver, she says.

"Healthy eating and weight loss is part of the patient education that case managers are responsible for. Sometimes we let it slip a little because we have such busy schedules, but teaching preventive care is as important as helping people learning about their medication," Campbell says.

Approach weight loss gingerly, Campbell recommends.

"We don't want to offend anyone, but it's very important to be open and honest in letting patients know that they are endangering their lives," she says.

Campbell advocates bariatric surgery for patients who are obese as long as they receive an extensive psychological work-up and understand that the surgery isn't a cure but a tool.

"I have a gastric band and I know several people who have had gastric bypass. I have been able to reach out to people because I have been there," she says.

Campbell advocates therapeutic communication with your patients.

"One technique might be to approach someone and comment that they seem unhappy. This can elicit a conversation and provide them with an outlet. So many times, we are busy and just keep moving along," she says.

When you visit patients in the hospital, sit in a chair so you will be on their level and try to get them to talk, Campbell suggests.

"If you keep standing, they'll think you are in a hurry. Allow them to vent their feelings and frustrations and get around to what is making them unhappy, which may very well be that they don't feel good about themselves because of their weight. Just one visit may not do it, but if people know you really care, you can help them," she says.

Health plans are taking a proactive approach to helping members lose weight and stay healthier.

CDPHP's Weigh 2 Be program is a six-week classroom program offered at various locations in the community. The classes are open to any member who is interested. Topics include interactive sessions taught by experts on healthy eating, physical activity, and stress management.

The health plan is piloting the program at the offices of large physician groups.

"We've found out through the case management program that the best referrals come from physicians who know the issues of individual members," says Melissa Marcelli, health educator in the insurer's health promotion and wellness department.

In addition to the physician-centered approach, the health plan is offering the program to employer groups during lunch time.

"The unique feature is that people don't need to have to lose weight to be in the program. We focus on proper nutrition and healthy eating. Many of the people who participate just want to learn to eat healthier," adds Thomson-Siag.

For instance, the program includes a session on sodium and how reducing sodium in the diet can help people lose weight and keep blood pressure under control, Marcelli says.

Other components include sessions on how stress

can affect eating habits and weight and ways to manage it as well as exercises that people can do at home or at their desks.

CIGNA's Healthy Steps to Weight Loss weight management program offers people a non-diet approach to weight loss and long-term lifestyle changes. The program is available online and telephonically. The program has received an overall satisfaction rating of 96.3%.

In additional to helping people with weight management, the program includes a lifestyle assessment that helps individuals and disease management nurses work together to create a personalized program.

The tool takes a practical approach to weight management. For instance, if the individual reports that he doesn't like to cook for himself, the nurse suggests healthier choices for fast-food meals. If the person eats when stressed, the program offers stress management techniques.

"We look at the person holistically and assess his readiness to change. We focus on behavior, not diet. The purpose is to motivate people to make the behavioral changes they need to stay healthy," Gondek says.

The program is open to anyone who wants to enroll through employers who have purchased the suite of lifestyle management programs.

The program meets CIGNA's requirements for preparing patients for gastric surgery.

People can go to CIGNA's web site, fill out the profile information, and take a personal lifestyle assessment. They can follow the program at their own pace and receive content by e-mail depending on their personal preferences.

The telephonic program includes 12 modules that many participants complete in six weeks while working with an individual coach.

"The secret to the success of the program is meeting the person where they are. The coaches spend a lot of time listening to the people and finding what motivates them, then empowering them to set goals that they think are attainable," she says. ■

Program focuses on proactive interventions

Nurses work at sites to case-manage disease

At ProHealth Care in Waukesha, WI, community outreach is more than the hosting of an educational event from time to time.

A team of 23 nurses is strategically placed at 50 community sites, including churches, schools, low-income housing projects, homeless shelters, food pantries, and health resource centers. Their role encompasses health promotion, disease prevention, early detection, and disease management, says **Deborah Ziebarth**, RN, MSN, manager, Community Benefit for ProHealth Care, a health care system that consists of two hospitals and several clinics.

"We are a continuum of care for our health care organization," explains Ziebarth.

She says health care is not only providing treatment in clinics and hospitals. A certain percentage of the population needs assistance with accessing the health care system, using it effectively, and knowing when to access it. Also, there is the education component that helps with disease prevention and early detection.

Most of the outreach efforts are funded through the nonprofit health care organization's community benefit dollars, as well as partnerships with churches and other organizations.

For example, nurses that work with churches, as part of Parish Nursing, have 50% of their salary and benefits covered by that congregation and the other half by ProHealth Care. That is also the case with most community outreach nurses as well, although ProHealth pays 100% of the benefits and salaries of the nurses that work in eight elementary schools.

Ziebarth says the Community Benefit program includes unique partnerships. One church helps support a nurse that not only works within the congregation, but also at three homeless shelters as part of the church's mission outreach. Another church helps support a nurse at a food pantry as part of its mission outreach. Two churches have pooled their resources, each providing 25% of the salary and benefits, in order for the nurse to work at a low-income mill site providing health care access to an underserved population.

No matter how a salary is covered, each of the outreach nurses is an employee of ProHealth Care and under Ziebarth's supervision.

Nurses tailor activities to the population they serve. For example, one Parish Nurse initiated a walking program to aid in disease prevention called "Walking to Jerusalem." Participants tracked their steps and mileage along a map on the wall to determine how close they were to reaching their destination.

To promote good health, nurses may hold a class or organize a health fair that pertains to the needs of their target population. Screenings are often held for early detection, including blood pressure screenings or blood glucose screenings.

Nurses also advocate for patients. For example, a patient may have a chronic disease and need a certain type of medication that he or she cannot afford. The nurse may then intercede on behalf of the patient, asking the physician to write a prescription for a less expensive medication.

"The role of the nurse is to decrease barriers of access for the individual and to improve the health of the community we are serving," explains Ziebarth.

Assessing community needs

To help determine the needs of the population a nurse serves, members of a congregation or a community are incorporated into the program. For example, Parish Nurses will work with a health ministry group or leader at the church to gain insight into the needs of the congregation, says Ziebarth. Also, these leaders provide needed assistance at health fairs and other events. A Parish Nurse will survey the congregation as well to determine how to meet the health needs of the population.

At the Hispanic Health Resource Center, where three outreach nurses work, an advisory group meets with the nurse quarterly to give direction. The group is always given information about the outcomes of its advice, so it recognizes its ownership in what takes place for the health of the community, says Ziebarth.

In addition, respected individuals within the community who are bicultural and bilingual are trained to assist in health promotion and disease prevention. They will often do car seat training or organize walking groups, so the nurses can concentrate on specific education and case management.

Ziebarth says ProHealth Care can be very creative in how to meet the health needs of communities. For example, one nurse, whose work is funded in partnership with a church, splits time between a free clinic in downtown Waukesha and a storefront shelter for the homeless in the downtown area. Volunteers from the church assist the nurse at the storefront by doing such tasks as accessing pharmaceutical programs that help the homeless obtain medications.

"Her community is the underserved population of downtown Waukesha, and she spends some time at the free clinic, so there is a referral to and from the clinic. It is a great model," says Ziebarth.

One important element of the program is computerized client documentation that allows nurses in the program to share information. Everyone who comes in contact with the client, which may be at a homeless shelter, public school, or food pantry, knows what care and education he or she has received.

"We have complete continuum of care, for we know what others are doing in caring for this person," says Ziebarth.

In addition, the nurses might flag physicians at a clinic when there is something they should know to improve the patient's care. In this way, each patient has the best outcomes, she adds.

This record keeping helps ProHealth Care track patient outcomes. Also, nurses keep diaries on patients by writing their clients' stories in order to track outcomes, says Ziebarth.

When choosing how best to spend community dollars, Ziebarth says her department looks for an entry point to a particular population and an environment that will support a nurse and take some ownership. To reach its goals, the organization developed a strategy in 2007.

The strategy has a list of target populations that include: non-English-speaking populations; poor children and family units; frail and/or isolated elderly; indigent (uninsured) and working poor (underinsured); homeless; mentally disabled; and victims of violence.

Also identified are key areas of community health need including: access to primary care services and a medical home; dental services; effective chronic disease management and support; mental health services; and prevention and early detection.

COMING IN FUTURE MONTHS

- Improve efficiency with technology
- How to spot signs of elder abuse
- Managing outliers under new regulations
- Reaching patients across cultural boundaries

The strategies are designed to promote the development of services that do the following:

- Remove barriers to service, e.g., language, financial, lack of knowledge, and navigation skills.
- Encourage prevention and early detection of illness.
- Provide care management and advocacy services.
- Relate to local needs assessment findings and, as appropriate, state or national health plan priorities.
- Emphasize evidence-based programming/ models.
- Create partnerships that build on existing ProHealth Care service/strengths and address key areas of need.
- Create partnerships with organizations that have the same target population and complementary goals.
- Create partnerships that promote community capacity building, collaboration, achieve shared vision, and maximize leveraging of resources.

"ProHealth Community Benefit Program is a partnership with other organizations that have a shared vision. It has now been working for 15 years and keeps growing," says Ziebarth. ■

Hospital reduces ED wait with lean management

Lean management techniques helped Lahey Clinic Medical Center, North Shore, in the city of Peabody, MA, boost patient satisfaction and reduce emergency department (ED) waiting times.

Lahey is a full-service hospital featuring a 24-hour ED, the only ED in Peabody. More than 17,000 patients visit the ED annually. In October 2007, Lahey partnered with an Ottumwa, IA-based consulting firm to coach hospital staff on the application of lean management skills by revisiting their processes in the emergency department and identifying more efficiencies to improve patient care.

The first problem identified was the increased volume of ED visits, which resulted in long wait times for patients, says **Bob Schneider**, senior vice president at the hospital. With the goal of preserving patient care, Lahey began a series of rapid improvement events to help physicians, nurses, and staff see work more efficiently in their daily

CNE QUESTIONS

21. What were the two main causes of the deaths and injuries associated with Negative Pressure Wound Therapy, according to the U.S. Food and Drug Administration alert released in Nov. 2009?
    A. Bleeding and infection
    B. Lack of training and improper use of device
    C. Length of therapy and type of dressing
    D. Infection and improper dressing changes

22. Which of the following patients is not a candidate for Negative Pressure Wound Therapy?
    A. Patients on anticoagulants
    B. Patients with untreated osteomyelitis
    C. Patients with infected wounds
    D. All of the above

23. What is one step home care workers can take to reduce the risk of stress while caring for a dementia patient, according to Elizabeth Gould, MSW, director of quality care programs at the Alzheimer's Association?
    A. Keep interactions with patients formal and clinical.
    B. Insist that a family member be present at all times.
    C. Never share personal phone numbers with patients or family members.
    D. Limit number of dementia patients on personal caseload.

24. What technique can help home health workers improve a dementia patient's compliance, according to Peter Notarstefano, director of home and community-based services for the American Association of Homes and Services for the Aging in Washington, D.C.?
    A. Present all information in writing.
    B. Don't try to explain what you are doing.
    C. Send same staff members to home.
    D. Schedule visits later in the day.

Answer Key: 21. A; 22. D; 23. C; 24. C.

tasks. Schneider says the goal was to improve patient flow and reduce waiting time. Facilitators led selected members of the hospital and patients in an intensive forum where new ideas for improvement were piloted.

When Lahey decided to pursue lean management practices in the ED, the organization had a particular interest in better serving patients not deemed in critical, urgent need of assistance, Schneider explains.

Lahey developed new roles and work processes that addressed those issues and significantly reduced the wait time for all patients. First, Lahey added the role of "air traffic controller" jointly managed by the unit secretary and charge nurse with help from the triage nurses. It is now their responsibility to help monitor patient flow throughout the department and to match available physicians with patients who have been waiting long periods of time and match them up accordingly, Schneider explains. ■

CNE OBJECTIVES

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

CNE INSTRUCTIONS

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with **this** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

Hospital Home Health

the monthly update for executives and health care professionals

HHH030110TM

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at right.

Please make label address corrections here or PRINT address information to receive a certificate.

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E-mail:_____

CNE Evaluation: Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your certificate**.

CORRECT ● **INCORRECT** ⊘ ✓ ✗ ⋀⋀

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After participating in this program, I am able to:						
2. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.	○	○	○	○	○	○
3. Describe how those issues affect nurses, patients, and the home care industry in general.	○	○	○	○	○	○
4. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices.	○	○	○	○	○	○
5. The test questions were clear and appropriate.	○	○	○	○	○	○
6. I detected no commercial bias in this activity.	○	○	○	○	○	○
7. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
8. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

9. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

10. Do you have any general comments about the effectiveness of this CNE program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature**_____

Nursing license number (required for nurses licensed by the state of California) _____