AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

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Special Series:
Managing the Diabetic Patient

Case managers can make a difference in diabetes continuum of care

Goal: Teach patients to take charge of their diabetes

The purpose of the University Diabetes Treatment Center at Parkland Health & Hospital System in Dallas is to encourage self-management. The center helps patients take charge of their diabetes so they are in control of their disease rather than their disease being in control of them. Once patients are admitted to the program, they begin learning self-management skills such as blood glucose / urine ketone monitoring, record keeping, insulin preparation and administration, and meal planning. **Lori Allums**, RN**,** diabetes clinical nurse specialist there, acts as the case manager in the unit for coordination of care and discharge. She also teaches patients about the types of diabetes, prevention and treatment of acute and chronic complications, exercise and sick-day management, and some pathophysiology.

"Without self-management, complications can take over their lives down the road," says Allums. "We stress that you often don't feel sick when your sugars are high, 200 to 300 mg / dl. That's the scary part about diabetes. The disease is easy for patients to ignore because they don't think they're having a problem. We let them know that, even if they don't feel bad, their nerves and other parts of their bodies are being affected by high sugars." Parkland's

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Supplement: *Patient Education Quarterly*

News Brief

COMING IN FUTURE ISSUES

■ Measuring satisfaction: See how one facility created a unique survey instrument that asks 'How're we doing?'
■ Keeping control of CM staff competencies: Competency assessment demystified through 11 verification methods
■ Reusing medical devices — What you can do: Where does the case manager fit into this difficult issue?
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Special Series: Managing the Diabetic Patient

program gives patients information on how to take care of themselves, but learning self-management doesn't always come easy in the two to three days a patient spends in the center. Factors such as language, vision, educational level, and a person's ability to interpret numbers can make the learning process difficult.

"Since our mission is to educate, if a patient can't learn for one reason or another, he won't benefit from our unit. We are a county hospital, so we get a lot of patients who are homeless and drug-addicted," says Allums. "They forget to take their meds. We see the same people come in over and over, and they are challenging to work with because they often don't take an interest in their health."

Addressing patients' concerns about insulin

Parkland is the only inpatient diabetes unit recognized by the Alexandria, VA-based American Diabetes Association (ADA) in the Dallas / Fort Worth area. **(See article on ADA recognition in *Patient Education Quarterly* section, p. 12.)** The 10-year-old center is directed by Allums, and patients are cared for by a dedicated dietitian, 10 nurses, two nursing assistants, a medical director, three rotating attending physicians, and interns. She says they also see repeat admissions for people who were sick and thought they shouldn't take insulin. "We teach them it's true that if they take insulin and don't eat, they can get low blood sugar. But of course, the insulin has to be adjusted to their needs."

Since Parkland's unit has only 11 beds, they can't take every diabetic admitted to the hospital. With the help of the hospital case manager, a diabetes fellow assesses every diabetic patient who is admitted and sees if that patient would benefit from being on the specialized unit. A typical unit admission is a person with an unhealing abscess who has never been diagnosed with diabetes. Without specialized care, infection can set in, and an amputation could result.

"Over the years, patients were admitted to this unit who were 'walky-talky' — they were feeling fine except that they needed to be put on insulin," says Allums. "Now, with managed care, people are typically started on insulin in an outpatient setting."

James Rosenzweig, MD, the director of disease management at the Joslin Diabetes Center / Joslin Clinic in Boston, says it used to be routine for diabetic patients to be admitted and treated for several days in the hospital, but now insurance companies mandate outpatient care. The trend is to get patients out as fast as possible. Even so, he says, "it's probably better for elderly diabetic patients or those with multiple chronic illnesses or compliance issues to be kept for a few days. You don't want their problem incompletely treated, then have it exacerbate. I've seen house officers incompletely treat ketoacidosis — they bring the blood sugars down to normal, but neglect to clear the acidosis and ketones — and their patients relapse very quickly."

Allums says her Parkland unit gets the patients who have other comorbidities but need insulin as well. They get some of the sicker patients, such as those with diabetic ketoacidosis. "In another facility," says Allums, "those patients would be transferred to the ICU. Our nurses are trained to manage them with an insulin-glucose infusion protocol. They adjust their insulin requirements depending on their blood sugar." If a patient needs to be on a heart monitor or ventilator as well, he goes to the ICU at Parkland.

Spending on disease management pays off

For 15 years, Diabetes Treatment Centers of America (DTCA), a subsidiary of American Healthcorp in Nashville, TN, has provided management services to hospitals nationwide and presently provides a comprehensive plan for inpatient diabetic management to 72 customer hospitals in 29 states. Hospitals pay considerable fees for the services of DTCA, and those fees are confidential, says **Robert Stone**, MBA, executive vice president of DTCA. "But utilizing our services increases a hospital's market share by creating a reputation for the hospital as a source of experts in diabetes services," he says. Also, he explains, taking care of these patients efficiently reduces the cost of treating them, and facilities find that dollars are produced that pay the company's fee.

DTCA is involved in the management of every patient with diabetes at its client hospitals, beginning from the moment admissions notifies DTCA.

"We work with case managers throughout the inpatient stay," says Stone. "We support and enable them and the whole nursing staff to be aware of the unique needs of the diabetic population," he says. The consultants work with all departments of the hospital on systems modification so that, for example, patients aren't sent to X-ray without first getting a meal. They also work one-on-one with the attending physicians to make sure the needs of patients with unique metabolic management problems are not overlooked.

"Diabetic patients tend to stay in the hospital 30% to 40% longer than patients without diabetes with the same admitting diagnoses. Healing rates are slower and infection rates are higher."

Diabetics often have multiple complications that can prolong their surgical hospitalization. They don't do as well as nondiabetic patients following surgery because it takes longer for them to heal.

"Perioperative management is extremely important in terms of outcomes," says Stone. "It's a critical population to work with. Diabetic patients tend to stay in the hospital 30% to 40% longer than patients without diabetes with the same admitting diagnoses. Healing rates are slower and infection rates are higher. Mortality rates are closely related to metabolic management."

Rosenzweig says cardiologists in particular tend to ignore blood glucose control when patients come in for coronary artery bypass graft procedures. "It's usually when they are getting ready to discharge patients that cardiologists discover that their patients' levels are out of control and that there are a variety of other complications as well. Then they call in the endocrinologist."

It would be better if the endocrinologist managed the patient from the beginning, he says. If good glycemic control is achieved early, problems can be dealt with more easily. When it is not, infections are prolonged and more difficult

to treat, and sugar levels take longer to come under control. "The issue is that diabetes is a multisystem disease," explains Rosenzweig. "It involves many problems — cardiovascular, renal, neurological — and all tend to magnify the overall problems."

Susan Burke, RN, BSN, diabetes program manager for Blue Cross Blue Shield of the Rochester, NY, area, says she routinely helps hospital case managers with their initial contacts with diabetic patients by giving them information they may not have. "For example," says Burke, "my records show if a patient has ever had an HbA_{1c} or an eye exam. Those are the kinds of things we can advise case managers to follow up on."

> "One of the key issues we're looking at now is making sure the diabetic's primary care physician or endocrinologist knows his patient is at an ED when the patient presents there."

Blue Cross's Diabetes Disease Management Program, begun in 1997, identifies members with diabetes using claims data and hospital admissions information. Burke and her colleagues have access to the names that are downloaded monthly to the diabetes registry — people who are admitted for any related or unrelated problem. She can look at the information on a patient and see how he is being followed. "Is he getting connected to care? If he has heart disease, has a cholesterol check been done? We go through an algorithm," Burke says, "and a red flag goes up for someone who should be assigned to a follow-up phone call after discharge, or if someone should be on a list for a mailing that reminds him that he hasn't had an eye exam in two years, for example."

Burke points out that the admission of a patient with uncontrolled diabetes is a window of opportunity that shouldn't be missed. While he is in the hospital, you can get an understanding of what happened to the patient that landed him there and how it could have been prevented. She says that with proper education, many admissions for uncontrolled diabetes could be avoided.

"One of the key issues we're looking at now," says Burke, "is making sure the diabetic's primary care physician or endocrinologist knows his patient is at an ED when the patient presents there. When a person with diabetes comes into the ED, there's often no communication with his doctor. The doctor doesn't know the patient has come in, so he can't do appropriate follow-up on discharge to make sure that whatever happened to the patient doesn't happen again. That doctor needs to know his patient stopped taking insulin for 10 days, for example, or whatever else pushed him over the edge."

Education could avert diabetes admissions

Joan Totka, RN, MSN, CDE at Children's Hospital of Wisconsin Diabetes Center in Milwaukee, says case management is key across the continuum of diabetes management. "That's where people have to look when they address diabetes," Totka says. "The clinical path is an important piece, but case management is very important too."

Totka explains that pediatric diabetic ketoacidosis is different from adult diabetic ketoacidosis. "Kids can die from mismanagement if adult guidelines are followed," she says. "Case management includes the outpatient care of these children."

Totka says a diabetes clinic often has to demonstrate its value to hospital administration. "Diabetes programs are labor-intensive and are not money-makers," she notes. "They are more of a public service."

Maria Barnwell, president of E2M Health Services in Dallas, agrees: "The diabetic patient is expensive. They spend about 1.7 days longer in the hospital than the non-diabetic patient."

Totka says clinics tend to lose money, but you can capture revenue for your clinic from the lab or pharmacy. "The lab is the golden child of any hospital. They have no costs compared to the money coming in. You can point out, 'Maybe my clinic doesn't make money, but look at the revenue generated in the lab from the patients who come from my clinic.'"

Another way to demonstrate value to your administration is to point out how the clinic is affecting the community and how its influence stretches beyond hospital walls, says Totka. "Get them to look at the global perspective. They'll see they can't do without you. We do outreach programs where we distribute educational materials in schools and elsewhere. Not only do we impact the community, but diabetes management is seen as one of the facility's best programs, not because it makes money but because we are indispensable."

Peggy Gardner, PhD, director of medical education and executive director of research at Via Christi Health System in Wichita, KS, was part of a team that developed a clinical algorithm for its diabetes project called Freedom With Diabetes. "Our diabetes case managers originally came out of an area in the hospital called diabetes care," she says, "an old-style, pre-managed care inpatient education program where patients would come for five days and go through the program. Those case managers had a focus on diabetes and are valuable to the project."

Designed as an outpatient project, the Freedom With Diabetes team developed tools for use in physician offices, including a resource manual, chart stickers, and reminder sheets. Offices also received inexpensive glucometers and simple disposable devices for testing pedal neuropathy.

Physicians refer patients into project

The primary care physicians in those offices fax referrals to the project, where telephone operators use scripted materials to contact patients and answer questions. A care coordinator performs a risk assessment and enrolls appropriate patients into an education program. She also provides links between patients and specialist providers and sometimes intervenes to meet with patients and their doctors.

Gardner says the project was begun three to four years ago with the assumption that good care coordination and good communication could reduce risk in the diabetic population. "Our ultimate goal," she says, "was to get HbA_{1c}s down. Nurses, certified diabetes educators, and physicians — both endocrinologists and family doctors — worked together to develop an algorithm of care for Types 1, 2, and gestational diabetics." There are now 200 enrolled in the program. The project was not fully implemented until last February, and outcomes are not yet available, but it is thought that the project will cost $500,000.

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Study shows management boosts diabetes outcomes

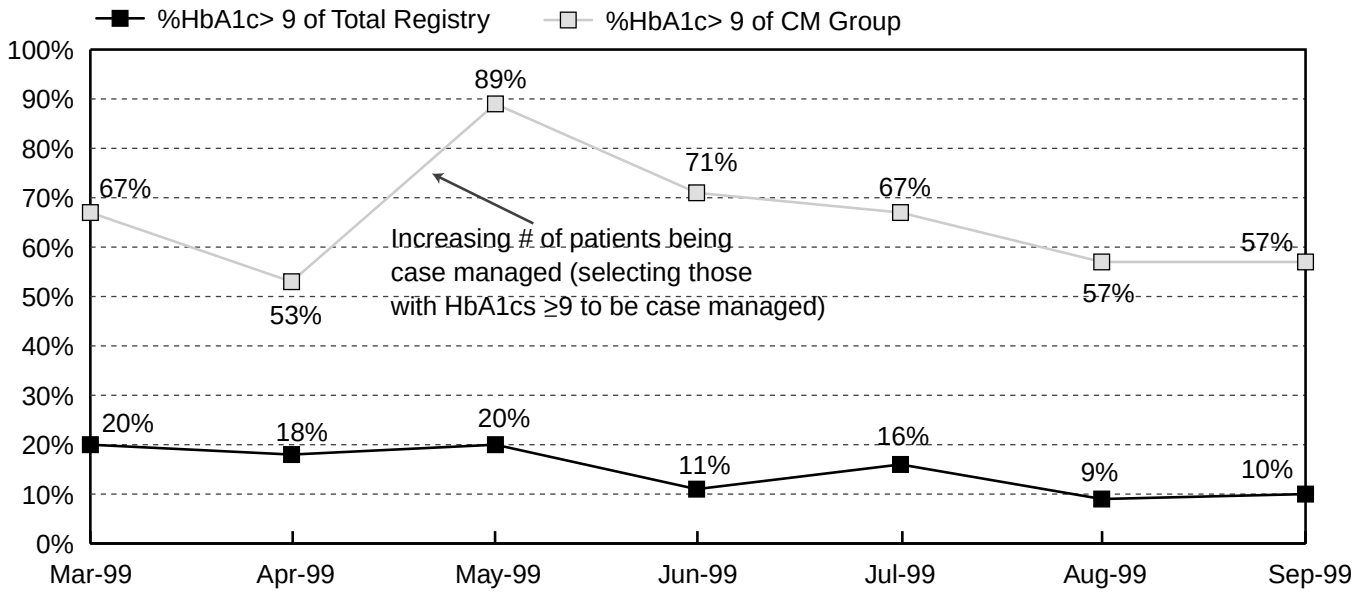
Encouraging independence and functionality helps

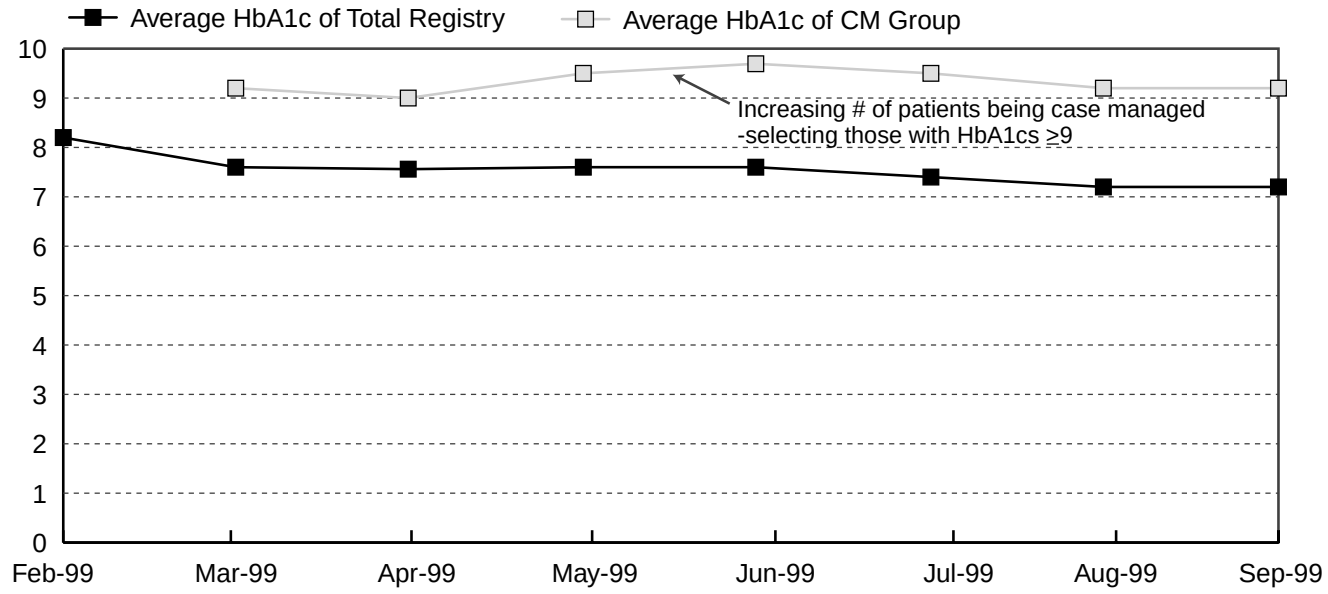
Andrea Diedrich, RN, MS, director of continuity of care at Kishwaukee Community Hospital in DeKalb, IL, led a team of colleagues who initiated a small pilot project last year to get a feel for how case managers might improve the care of their area's diabetic population. The 173-bed, nonprofit facility 75 miles west of Chicago has a small informal case management program at this time.

"The aim of the project was of course to improve care for those patients, but we mostly wanted to see the effect of a case manager on outcomes in the

(Continued on page 15)

Case-managed Diabetic Patients Show Improvement





These graphs compare the case management group of diabetes patients with the total diabetic registry at Kishwaukee Community Hospital in DeKalb, IL. Both show decreases in HbA1c levels and percent of populations with levels below 9%. Because the study team did a significant amount of work on the total registry group through the physician offices, they were studying both groups to determine what kind of decreases they would observe in HbA1c levels.

Source: Kishwaukee Community Hospital, DeKalb, IL.

CRITICAL PATH NETWORK™

Parent to Parent Program paths minimize OB complications

By **Christie Peck**
Nurse Coordinator
Parent to Parent Program
Janice Schriefer, RN, MSN, MBA
Clinical Systems Improvement Specialist
Spectrum Health
Grand Rapids, MI

The Healthier Communities Department of Spectrum Health in Grand Rapids, MI, is home to several parent support projects. One of the initiatives, the OB (obstetrics) Special Care Parent to Parent Program (PPP), is designed to offer intensive in-home care to mothers and families who have pregnancies complicated by preterm labor, diabetes, hypertension, multiple pregnancy, history of pregnancy loss, and/or hyperemesis gravidarum. In addition, the program helps families who express concerns about housing, finances, adequate nutrition, transportation, child care, domestic violence, and substance abuse.

Intervention is delivered by a team consisting of an RN, a community health advocate, and a volunteer support parent (peer mentor) in collaboration with the mother's primary care provider, medical social worker, dietitian, and other members of the health care team. Intervention begins as soon as possible in pregnancy and continues until the infant's first birthday (or 12 months corrected age). Mothers generally enroll during the second trimester of pregnancy and receive an average of 19.2 weeks of prenatal intervention. **(See chart detailing demographics of plan participants, below.)**

Education ensures healthy pregnancies

Comprehensive care of the family requires physical and psychosocial assessments as well as assessment of mother and family strengths and abilities to participate in self-care. Education surrounding issues of pregnancy, complications, understanding medications and treatment modalities, and accessing appropriate resources that enable families to be compliant with a multidisciplinary plan of care is vital to positive pregnancy outcomes. For this reason, intervention

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Demographic information on Parent to Parent Program participants

Age:	**<19**	**20-25**	**26-35**	**>36**	
	8.4%	28.9%	54.2%	8.4%	
Marital Status:	**Never married**	**Divorced**	**Married**	**Widowed**	**Separated**
	27.6%	2.3%	66.7%	1.1%	2.3%
Ethnicity:	**White/Caucasian**	**African-American**	**Hispanic**	**Other**	
	77.9%	16.3%	4.7%	1.2%	
Insurance:	**Commercial**	**Medicaid**			
	67.5%	32.5%			
Years of Education:	**<12 years**	**12 years**	**>12 years**		
	10.5%	41.9%	47.7%		

The Helen DeVos Women & Children's CENTER at Butterworth Hospital

MATERNAL SUPPORT SERVICES CLINICAL PATH PRETERM LABOR

This pathway is only a guideline. Patient care will vary on their individual needs.

Name:

NCM:

Advocate:

Physician:

Clinic:

GOALS:

1. To maintain pregnancy with the avoidance or minimization of complications.
2. To identify the early warning signs of preterm labor.
3. To access medical intervention prior to complications.
4. To promote verbalization of fears.
5. To become knowledgeable about, and thus compliant with, the treatment regime.
6. To become knowledgeable about the physiological effects of preterm labor to mother and fetus.
7. To identify need for further resources.

Please fill in dates and check all boxes that apply, write NA over boxes that do not apply.

Dates	**First trimester**			**Second Trimester**			**Third Trimester**		
	☐ Enrollment Visit	☐ Phone	☐ Phone	☐ Visit	☐ phone	☐ phone	☐ Visit	☐ Phone	☐ Phone
Consults	☐ MSW ☐ RD ☐ Maternal Fetal Medicine ☐ Referring Physician	☐ PRN	☐ per team conference	☐ Per team conference	☐ PRN	☐ PRN	☐ Per Team conference	☐ PRN	☐ Per Team conference
Assessment & Interventions	☐ Complete client profile ☐ Complete Consent Form ☐ Assess home environment ☐ Initial needs assessment ☐ Baseline vital T,P,R,B/P ☐ Begin weight graph ☐ Beck's Depression Scale, evaluate, refer to MSW as needed	☐ assess , intervene, educate, refer per Clinical Practice Model (CPM) guidelines	☐ assess, intervene, educate, refer per CPM guidelines ☐ Complete client's program evaluation	☐ Check progress toward goals ☐ Assess lifestyle risk behaviors (enrollment update? ☐ T, P, R, B/P, FHT ☐ assess/ intervene/ educate/refer per CPM guidelines	☐ assess/intervene/ educate/ refer per CPM guidelines	☐ assess/ intervene, educate, refer per CPM guidelines	☐ Assess lifestyle risk behaviors (enrollment update) ☐ T, P, R, B/P, FHT ☐ assess/intervene/ educate/ refer per CPM guidelines ☐ Repeat Beck's Depression Scale, compare and evaluate, refer to MSW as needed	☐ assess, intervene, educate, refer per CPM guidelines	☐ assess/intervene/ educate/ refer per CPM guidelines
Diet	☐ Overview of nutrition ☐ ADA diet for pregnancy ☐ _____calories ☐ 24 hour recall	☐ 24 hour recall ☐ evaluate weigth gain	☐ 24 hour recall ☐ evaluate weigth gain	☐ 24 hour recall ☐ Evaluate weight gain	☐ 24 hour recall ☐ evaluate weigth gain	☐ 24 hour recall ☐ evaluate weigth gain	☐ 24 hour recall ☐ Evaluate weight gain	☐ Review teaching as needed	☐
Activity	☐ As tolerated ? ☐ Activity limitations?	☐ As tolerated ? ☐ Activity limitations?	☐ As tolerated ? ☐ Activity limitations?	☐ Reinforce activity limits ☐ Review "What is Bedrest?" ☐ Assess compliance ☐ Muscle tone and strengthening exercises	☐ assess compliance	☐ Assess compliance	☐ Reinforce activity limits ☐ Review muscle tone and strengthening exercises ☐ assess compliance	☐ Assess compliance	☐ Assess compliance
Tests	☐ Prenatal Screen ☐	☐ MSAFP ☐ Ultrasound ☐ NST	☐	☐ GTT	☐	☐ Ultrasound? ☐ Biophysical profile? ☐ NST?	☐	☐ Amniocentesis?	☐
Medication	☐ Prenatal Vitamins ☐	☐	☐	☐	☐	☐ tocolytics? ☐ betamethasone?	☐	☐	☐

Source: Spectrum Health, Grand Rapids, MI.

Education (see Ed Record)	☐ Orientation to Parent to Parent Program ☐ Introduce education record ☐ Introduce Parent Journal	☐ Per education record	☐ Per education record	☐ Per education record	☐ Per education record	☐ Per education record	☐ Per education record	☐ Per education record	☐ Per education record
Signatures (Name/Time)									

Instructions: Please indicate any significant variances from the pathway in the boxes to the right. Write in the variance code, the date the variance occurred, comments and your initials. Your comments for improving the care for this population or the pathways format are appreciated.

CODES FOR COMMON VARIANCES:

Issue	Issue	Issue	Issue
Decreased fetal movement	Nausea	Noncompliance with activity orders	Vomiting
Hypertension	Infection	Noncompliance with diet	PROM
Inadequate diet	Vaginal Bleeding	Lack of help at home	Thrombophlebitis
Preterm labor	Hyperemesis	Anxiety	Urinary tract Infection

Pathway Variance/ Exception Code	Date	Comments	Initials

Ideas for improving care for this population:	Ideas for improving format of this pathway:

Source: Spectrum Health, Grand Rapids, MI.

(Continued from page 7)

must be specific, consistent, and high-quality. A plan was designed to measure the program outcomes based on the following six goals:

1. to reduce the adverse psychosocial effects of pregnancy complications for pregnant women;

2. to provide women with education about pregnancy and their pregnancy complications;

3. to have a mutually determined plan of care;

4. to assist in the identification of infants at risk for, or experiencing, developmental delay and provide appropriate referrals when needed;

5. to provide pregnant women with parenting education and support;

6. to provide women with services during and after their pregnancy that are helpful and meet their needs.

Outcome measures include:

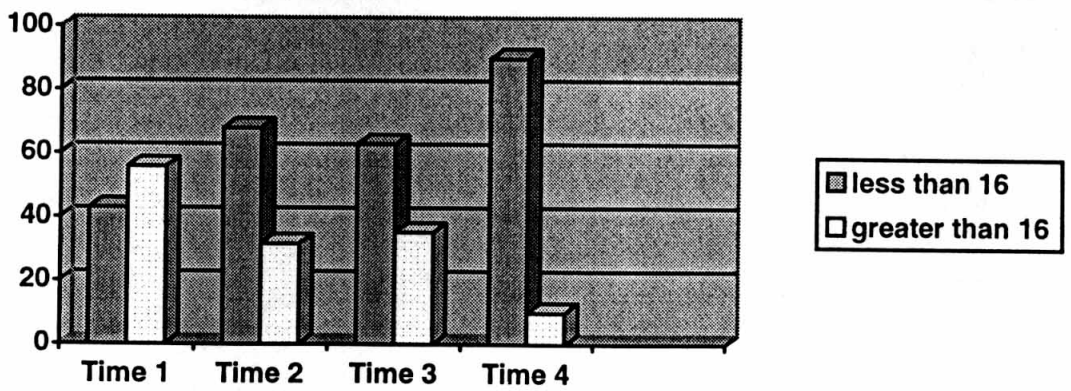
- standardized assessments of depression, perceived stress, mastery, and social support at four time points (two prenatal and two postnatal);
- documentation of ongoing progress toward educational goals on a prenatal and postnatal education record;
- completion of a needs assessment by mothers at enrollment and their inclusion in the written mutual plan of care;
- developmental assessments of all infants at 4, 8, and 12 months (corrected) of age and numbers of referrals made for developmental follow-up;
- completion of a satisfaction survey.

Results from the standardized measures of depression, perceived stress, personal mastery, and social support scales show positive progress. **For example, results from the Center for Epidemiological Studies depression scale are shown below.** Scores above 16 indicate the presence of depressive symptoms. Of note is the change from 55.8% of mothers showing depressive symptoms at enrollment to 31.7% and 35.3% at times 2 and 3, and, finally, only 10% at discharge from the program.

In order to ensure that consistent, individualized, high-quality care is given to each family, clinical paths were developed to guide the program services to mothers with the most common pregnancy complications — premature labor, diabetes (IDDM and gestational), hypertension, and multiple pregnancy. Clinical paths have become a vital part of quality because they ensure that all team members are aware of the services needed by each population. The clinical paths are used by all members of the PPP team; volunteer parents have even written a modified version for their use. The care paths address consultations with health team members, nursing assessments based on independent and interdependent guidelines for care, non-licensed assessments, intervention, and education, and provide an opportunity to document any variances in the clinical care that may affect outcomes.

The paths do not replace a mutually determined, individualized plan of care, but do provide a mechanism to help decrease cost and increase efficiency. They help us determine what variances to the path will affect outcomes. And their use frees time to focus on patients' individual needs and helps to match services to those needs at the point of care. Quality care begins with qualified caregivers working together to meet the unique needs of each individual family. ■

Depression Scores of Mothers in the Parent to Parent Program



Source: Spectrum Health, Grand Rapids, MI.

PATIENT EDUCATION
QUARTERLY

Hospitals: Diabetics must have skills before discharge

Diabetes education moving to outpatient area

About 10 years ago, nurses at York (PA) Health System would contact diabetes educators when a patient needed teaching. Today, educators have moved to the outpatient area, where they set up formal classes. This trend is common in health care today, says **Donette Lasher**, MAT, patient education coordinator for the health care system.

In the old system, when the educators left, the inpatient floor nurses were supposed to teach patients survival skills if they were admitted to the hospital for diabetes, then refer them to the outpatient program. A formal policy was written and pamphlets stocked on each unit, yet many of the nurses felt they lacked expertise or they just didn't have the time.

Inpatients fell through the cracks

"It takes about an hour to go over some of the information," explains Lasher. As a result, patients on the inpatient side weren't being referred to the outpatient area. All the referrals were coming from the endocrinologists at clinics. A committee of physicians, dietitians, diabetes educators, and nurses was formed last summer to examine the problem, and it decided someone needed to be accountable for inpatient diabetes education. It considered training nurses or hiring an inpatient diabetes educator.

Lasher called other hospitals to inquire about their inpatient education for diabetes. She also tracked the teaching history at York Health System and had the nurses ask their clinical directors for suggestions. The consensus was that an inpatient diabetes educator would be the best solution, and money was allocated to fill the position.

Many health care facilities today are reviewing their policy for inpatient diabetes education to correct problems. "The major problem is letting people fall through the cracks," says **Nancy Moline**, RN, MEd, CDE, regional diabetes care management program coordinator for Kaiser Northern California Region in Oakland. "The connection between inpatient and outpatient is really difficult sometimes. You don't necessarily catch everyone." A second problem is providing consistent information. Different health care workers sometimes give patients contradictory information, says Moline. Various health care institutions are implementing solutions to these problems in a number of ways. At Kaiser, a tool kit for diabetes teaching is stocked on each floor.

Tool kit contains all information needed

"I started by inservicing the nurses about diabetes and then decided they needed some kind of a tool kit so they would have everything they need at their fingertips," says Moline. The tool kit contains all the information needed to teach patients about Type I or Type II diabetes. The assortment is built around a starter kit produced by a drug company with the basic tools a newly diagnosed diabetic needs, such as a syringe for insulin. Additional materials, such as pamphlets and videos, were inserted to tailor the kit to the teaching policies outlined by Kaiser. A teaching sheet explains what the nurses are supposed to teach and the order in which it should be taught. For example, it lists which videos for newly diagnosed diabetics should be shown first, second, or third. The tool kit and teaching checklist provide a guideline of what survival skills are needed by newly diagnosed patients.

There is also a quick assessment tool nurses give patients. It's a simple quiz in which patients check "yes" or "no" answers for several questions. "The assessment tool gives nurses an idea of how to target the patient's education," says Moline.

Teaching is slightly different at Baptist Health System in Miami. Anyone with diabetes who is

admitted to the hospital is given an identification bracelet to wear that reads "DIABETES PRECAUTION." Diabetes patients wear the bracelet regardless of the diagnosis for which they are admitted to the hospital, explains **Lois Exelbert**, RN, MS, CDE, administrative director for the Diabetes Care Center at Baptist Hospital.

In addition to the bracelet, special posters are hung in the patient's room reminding nurses what information is important to teach the patient. A reminder for the physician to order diabetes education is placed in the chart.

Nurse, dietitian educate together

"As soon as we get an order from the physician for diabetes education, our team goes out," says Exelbert. The team consists of a nurse and dietitian from the outpatient area who are both certified in diabetes education. Because many of the patients are so sick during their hospital stay, they are simply taught survival skills that consist of giving themselves insulin when appropriate, testing for blood glucose levels, and following a basic meal plan. The teaching is ordered for newly diagnosed diabetes patients or those struggling to control their disease.

Although the program at York Health System is not yet complete, an assessment tool is in the process of being created. This tool is a combination of a tool found at another hospital and one produced by the American Diabetes Association. Focus groups consisting of patients who have been discharged from York also are being used to help design the curriculum and review materials such as videos and pamphlets. The patients are asked what their priorities were as inpatients and what they needed to know when they were discharged. A way to evaluate the effectiveness of the teaching also is being built into the program.

While an inpatient teaching plan is important to ensure that patients are taught survival skills and referred to the outpatient program, nurses must be continually reminded during inservices to make sure the teaching gets done, says Kaiser's Moline.

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Diabetes education helped by regulatory agencies

Standards shape programs, teaching, materials

Following a mock survey in preparation for the real accreditation process conducted by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations, administrators at York (PA) Health System hired a patient education coordinator one month prior to the process. The goal: To improve compliance with the standards. Before creating the new position, when the mock surveyor asked who coordinated patient education or who was the central person responsible for it, there had been no answer, explains **Donette Lasher**, MAT, who was hired as patient education coordinator at York in August 1998.

Other major changes at the health system included the formation of an interdisciplinary committee and the development of a record for documenting patient education. "We relied on the mock surveyor to let us know what [the Joint Commission] was looking for, and the record was one of the recommendations she made because [the Joint Commission] is interested in how well we work together. The more we handed off to each other, the happier they were," says Lasher. An interdisciplinary teaching record not only provides evidence of education; it provides evidence of interdisciplinary teaching, she says.

Although most health care facilities don't undergo such a dramatic transformation before a Joint Commission survey, the accreditation agency's standards do shape and mold patient education throughout the health system.

While patient education was being done at Shands Hospital at the University of Florida in Gainesville, the Joint Commission survey prompted staff to create a team to go over the standards and look for areas for improvement, says **Kathy Conner**, ARNP, MN, coordinated care manager in the department of nursing and patient services at Shands. The team saw the need to make patient education more interdisciplinary and collaborative. Therefore, they created an interdisciplinary tool for documentation so staff could easily see which disciplines had taught and built on the education.

Following the survey, the team focused on CQI efforts for education and came up with five recommendations that were approved. They included the creation of a multidisciplinary team to oversee patient and family education and developing a computerized index of patient education materials.

Specific programs receive the accreditation

Standards for other regulatory agencies don't have such a hospitalwide impact. Most affect how patients are educated within individual programs. For example, The Commission on Accreditation of Rehabilitation Facilities (CARF) in Tucson, AZ, creates standards for individual rehab programs.

"Whenever you get CARF-accredited, it is not the organization that gets accredited; it is specific programs within that organization, and there are different specialty accreditations," says **Terrie Black**, MBA, BSN, CRRN, RNC, a CARF surveyor and rehabilitation consultant at Hospital for Special Care in New Britain, CT.

There are standards for brain injury programs, spinal cord injury programs, outpatient rehab programs, and comprehensive integrated inpatient programs that include stroke patients, she explains. CARF standards are more specific for some programs than for others. A spinal cord injury program must cover a wide range of education such as pulmonary care, sexual counseling, skin care, and substance abuse. However, the standards emphasize that the education must meet an individual's needs, so it is not limited to the suggested topics.

"The program we have for spinal cord patients, Independent Living Skills, is driven by the CARF standards," says **Susan Wise**, BSN, RNC, DRRN, a rehabilitation educator at the University of Utah Hospitals and Clinics in Salt Lake City. However, many educational sessions are given in addition to the required curriculum. For example, patients are taken out to eat at a restaurant of their choice one day so they can get used to being in public.

To have a diabetes program recognized by the Alexandria, VA-based American Diabetes Association (ADA), stringent patient education standards must be met. **(For information on an ADA-approved program, see story, p. 1.)** There are 15 content areas that basic diabetes education must cover, and the teaching within these areas must be based on an assessment of patient needs, says **Betty Nalli**, ARNP, MSN, coordinated care manager in the department of nursing and patient services at Shands.

The ADA standards not only govern the topics taught, but the materials distributed as well. All patient education materials written in-house must be submitted for approval, says **Amparo Gonzalez**, RN, BSN, CDE, director of the Specialty Center for Diabetes Care at Saint Joseph's Hospital of Atlanta. One of the most challenging aspects of the standards is the requirement to collect data to prove the diabetes education is enhancing the patient's ability to self-manage the disease.

NCQA focuses on outcomes

A fourth agency, the National Committee on Quality Assurance (NCQA) in Washington, DC, sets standards for managed care plans. Health systems that wish to contract with a managed care company to educate its members must adhere to the standards by which these companies are accredited.

"You have to use recognized guidelines. We go through a lengthy research process of educational designs. In that way we can take bits and pieces, but they have to be based strongly on a recognized entity and you have to quote that entity within your model," says **Stacey Bateman**, RN, BSN, director of program development at Flagship Healthcare in Miami Lakes, FL. For example, the ADA guidelines were used to design Flagship's diabetes education program.

Also, outcomes are crucial. There must be some sort of proof that the education is effective, she says. Get a copy of HEDIS 3.0 (Health Plan Employer Data and Information Set), advises **Nancy Walch**, BSN, MPH, CDE, CHES, coordinator of the health education and wellness department at Queen's Medical Center in Honolulu.

HEDIS is a set of standardized performance measures set by NCQA to measure the performance of managed health care plans. Programs must help managed care meet these performance measures, she says.

Do all these standards fit together? "We see them complementing each other. The ADA standards reinforce where we see the Joint Commission going," says **Sharon Valley**, MS, CDE, education coordinator for the diabetes center at Shands Hospital. For example, the Joint Commission emphasizes an interdisciplinary approach for patient education, and ADA-recognized diabetes programs incorporate nurses, dietitians, physicians, and specialists in adult education. The Joint Commission also looks for education over the continuum of care. Diabetes teaching is a perfect example of this because it often begins in the hospital and is completed in an outpatient setting, and follow-up continues to make sure that the outcomes were achieved.

Inpatient nurses and certified diabetes educators from the outpatient area at Shands worked together to create an education pathway that provides guidance on what to teach in an acute setting. "In the inpatient setting, we try to focus on the essential education, and then when the patient is referred to the diabetes center, the educators can do the follow-up with more in-depth education," says Valley. The health system also created a documentation form to record inpatient education. A copy of the form is either sent or faxed to the diabetes center when the patient is discharged, says Valley.

Surveyors find common ground

Some accreditation agencies are beginning to work together. The Joint Commission and CARF now will arrange to do surveys of a health care facility at the same time. "There is a lot of collaboration going on between the two accrediting agencies that has not always existed in the past," says Black. While it takes time to make sure educational programs are in compliance with standards from outside regulatory agencies, most educators agree that becoming accredited is well worth the effort. For diabetes programs, having your program recognized by the ADA helps ensure reimbursement for patient education.

"Any time I talk to a managed care company or case manager for a third-party payer, the first thing they ask is, Are you recognized? No one wants to talk to you if you are not," says Gonzalez. The accreditation process, which ensures that standards are being met, is a catalyst for good patient education, says Lasher. "Surveys and standards are a benefit to us because every three years, on a regular cycle, they remind us of what good patient care is. They help keep us accountable and give us the priority to do it," she explains.

Following standards by a reputable agency ensures that you are implementing best-practice principles based on the latest research, says Valley. "If one wants to be associated with the cutting-edge clinical standards in a given specialty area, then one allies with that organizing body," Gonzalez says.

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Special Series: Managing the Diabetic Patient

(Continued from page 5)

hope of increasing our case management activities within the hospital," says Diedrich. Her team coordinated the diabetes registries of three participating physicians and gathered a group of about 20 diabetic patients whose HbA_{1c}s (glycosylated hemoglobin) were 9% or greater, then assigned an RN case manager with expertise in diabetes.

The pilot ran from February to September 1999. "She called the patients on a weekly basis to discuss their self-management," Diedrich says. "She offered encouragement and chatted with them about things they could be doing for themselves that they may need help on." By several months into the project, average HbA_{1c}s came down. **(See two graphs showing improvements, p. 6.)** "We felt positive about our small accomplishment," she says, "and now we're expanding upon the program. We'll soon be working with people in our registries who have HbA_{1c}s of 8%."

Diedrich says the pilot project encountered barriers, such as getting physician buy-in. "Also, it's not always easy to justify the cost of a case manager — there's a time investment, and positive outcomes are hard to measure on the short term." Keeping patients motivated was another challenge. "These patients tend to 'fall off the wagon,'" says Diedrich. "But for the most part, patients continued to participate in our project because they were happy to have the support and encouragement. They were happy to have someone to answer questions for them."

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In the beginning, the team offered an eight-week educational session to get patients interested. "We invited every patient on the three registries," says Diedrich. "Our patient base originated with the patients who took the class, as long as they had HbA1c levels equal to or greater than 9%." Others became part of the pilot too if their physicians recommended them.

What were the keys to the project's success? "For one thing, the physicians' support with their registries," she says. "Also, the case manager we hired had credibility and respect. We set up goals for her phone calls, so she knew how to direct the conversations. Also, there was good documentation, so monthly follow-up flowed smoothly."

The Institute for Healthcare Improvement in Boston invited the Kishwaukee team to present their outcomes at its Oct. 28-29, 1999, National Congress in Dallas.

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Special offer for alternative medicine nursing newsletter

American Health Consultants, publisher of *Hospital Case Management* and *Alternative Medicine Alert*, is pleased to announce the publication of a new monthly publication for nurses on alternative medicine and holistic nursing. Beginning in January 2000, each issue will contain review articles of specific alternative therapies and modalities; abstract and commentary from current medical and nursing journal articles; and columns on controversies in holistic nursing, applying therapies to clinical nursing practice, and legal and ethical issues surrounding holistic nursing and alternative medicine. Subscribers will be eligible to receive approximately 12 contact hours of nursing continuing education credits at no extra charge.

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NEWS BRIEF

Do UTI guidelines work?

A group of researchers showed recently that practice guidelines can be applied to common problems such as uncomplicated urinary tract infection (UTI) and result in substantial cost savings with no decrease in patient satisfaction or quality of care.[1]

The protocol called for telephone triage by a nurse and a standardized treatment regimen. About 1,900 patients at 22 clinics received treatment based on the guidelines, while about 250 patients at control clinics did not. Patients at the 22 clinics were less likely to receive urinalysis, urine culture, or an office visit than patients in the control group. Rates of subsequent office visits for UTI, sexually transmitted disease, or pyelonephritis did not differ significantly between the groups. And a post-treatment survey of patients revealed that 95% were satisfied with the care they received. The investigators noted that collaboration among physicians, nurses, pharmacists, and support personnel was essential to the success of the guideline implementation.

Reference

1. Saint S, et al. The effectiveness of a clinical practice guideline for the management of presumed uncomplicated urinary tract infection in women. *Am J Med* 1999; 106:636-641. ■

CE objectives

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

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■