AMERICAN HEALTH CONSULTANTS®

# HOSPITAL CASE MANAGEMENT™

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

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# You need relationship to deal effectively with managed care managers

*Build network with MCO counterparts*

As if hospital-based case managers didn't have enough responsibilities to handle, many are increasingly having to take the lead in dealing with managed care companies. And how well you relate to your managed care colleagues could spell the difference between a cooperative or antagonistic relationship between your hospital and the managed care companies with which it contracts.

"While they were normally doing straightforward discharge planning, hospital-based case managers now have the added responsibility of having to keep in mind, for each of the HMOs they are dealing with, which of the home health agencies, which of the skilled nursing facilities, and so on, are in their network," says **Paul Reich**, MD, chief medical officer and consultant with the Scheur Management Group in Newton, MA.

Reich says the worst thing hospital case managers could do as far as the managed care company is concerned is to send the patient to a place where the MCO doesn't have a contract, because then the patient would have to pay full charges. "That has created problems for hospital-based case managers," Reich says.

He notes that managed care companies increasingly are setting up case management programs, particularly in Medicare, to manage their high-risk, high-cost patients through the whole continuum of care — while they're in the hospital, when they

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## COMING IN FUTURE ISSUES

■ Bioterrorism: Just when you thought you were finished with the Y2K bug, there are other real bugs to worry about now

■ Read what your colleagues have to say about Karen Zander's article on social work and case management

■ Why don't nurses and physicians follow clinical practice guidelines? Lack of awareness, lack of familiarity, lack of agreement, lack of outcome expectancy all figure in

■ Read what your colleagues have to say about the new rapid *Streptococcus pneumoniae* bedside test

■ Every month, critical pathways you can use and adapt. Coming up: Bed sores, congestive heart failure, and more

come home, if they go to a skilled nursing facility, and even as outpatients.

Because the managed care case managers want to manage over the whole continuum of care, they want to work with their hospital counterparts. "But hospital case managers might perceive their efforts as the managed care case managers wanting to take over the case," says Reich, who has experience setting up case management programs for MCOs "On one hand, having someone share in the work relieves the work load, but on the other hand, it can be seen as a move to take one's job away." He says that interface has to be managed very carefully.

### *Bridging the divide*

His advice: "Get to know managed care case managers personally. Visit with them so they are not just voices on the other end of the telephone. Let them know you are there for them when they need advice on a particularly troublesome problem." He says both types of case managers have to realize they are in the same business of trying to do the best thing for the patient.

**Toni Cesta**, PhD, RN, director of case management at Saint Vincents Hospital and Medical Center in New York City, would go one step further: "One of the ways we build bridges with our managed care case managers is having offices for them on-site in our hospital. That way, they interact with the hospital case managers on a daily basis and work proactively with them. We make them a part of our team." Cesta says by having those on-site offices, case managers have been able to manage and reduce the number of insurance denials they receive from on-site reviewers.

"Some opponents of this system think that if these people are on-site, they'll be looking in the charts and find more things to deny," says Cesta. "We've found the opposite. They see how sick some patients really are, so it works to our advantage."

**Lawrence F. Strassner**, MS, RN, of Ernst and Young in Philadelphia, adds, "Often there is some skepticism by hospital providers — physicians and case managers — regarding the overall focus of the managed care case managers. Typically, they have been viewed as focused only on UR [utilization review] and less on clinical care coordination. [The managed care case manager] has also been seen as the person who

is recommending a denial day or denial of a planned service." Strassner says managed care case managers are often generalist-focused rather than disease specialists, and that has led to some skepticism on the part of the hospital providers.

"As managed care companies are taking a more active role in managing and coordinating care, traditional UR must become less the focus, with more of an integrated approach to care coordination that includes utilization management," Strassner explains. "The focus of the managed care case manager — particularly with risk patients — is more on care coordination across the continuum." So the hospital case manager is just one piece of the continuum, but often the most costly piece of care. Strassner says it is essential that the managed care case manager and hospital case manager work together with providers to establish the plan of care as well as the discharge plan, taking into consideration the patient's benefit plans and community resources.

"To work effectively and efficiently, hospital and managed care case managers must both be on the same page, understand the value each brings to coordination of patient care, and keep the patient as the center of focus," Strassner concludes. "It is imperative that the managed care case manager and the hospital-based case manager have a strong collaborative working relationship."

**(For more information on cooperating with managed care case managers, see *Hospital Case Management*, February 1999, p. 21.)**

### Recommended Reading

Bodenheimer T, Casalino L. Executives with white coats: The work and world view of managed care medical directors. *N Engl J Med* 1999; 341:1,945-1,948, 2,029-2,032.

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# Will case managers survive in integrated systems?

*How new law dried up revenue stream*

By **Donna Zazworsky**, RN, MS, CCM
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As the volatile health care market in Tucson, AZ, grew to stage four managed care, in which capitation predominates and the focus on integration is essential, an integrated delivery network approach to cost containment and quality care was imperative. This meant expanding the primary care medical group and adding a management service organization to provide support services such as service authorization and claims adjudication. What happened next at Carondelet Health Network in Tucson is a story that has repeated itself in many other health care organizations and raises the questions: Can integrated delivery networks survive? And how does case management survive as part of an integrated delivery network?

Carondelet initiated its community nurse case management program in the early 1980s. This model consisted of bachelor's-, master's-, and doctoral-prepared nurses working with high-risk populations to reduce hospital admissions and readmissions, all the while demonstrating a positive impact on patient satisfaction and clinical outcomes. The success of Carondelet's model paved the way for other organizations throughout the country to reconsider a proactive approach to case management.

In the early 1990s, Carondelet's community case management program entered into a capitated contract with the first commercial and Medicare HMO in Tucson to provide case management and home care services for the HMO's senior enrollees. This experience provided an opportunity for nurse case managers to actually manage the care of a targeted population. While they learned the challenges of managing services for a high-risk population, the information led to the development of guidelines for service referral and the establishment of the community nurse case management mantra: Match the patient with

the right service, at the right time, with the right provider, and for the right cost.

At the same time that Carondelet's case management activities grew in the local managed care market, the organization was selected by the Health Care Financing Administration to be a Medicare Demonstration site for its Community Nursing Organization Project. The project randomly selected study and control groups — 2,000 and 1,000 patients respectively — of Medicare seniors who were not already enrolled in a Medicare HMO. The low- and moderate-risk seniors were assigned to a nurse partner, and those at high risk were partnered with a community case manager. All study group members were reassessed every six months.

The Community Nursing Organization covered Part B services, such as home health nursing, therapy, outpatient services, and durable medical supplies, as well as an extensive array of health screenings and health education services. The nurse partners and case managers initiated and provided oversight of these services.

As the organization continued to manage the care of the Medicare senior group, Carondelet began to assume more global risk contracts with many of the local HMOs. In these contracts, as part of the capitation fee, the community nurse case managers were delegated to provide case management for the plans' high-risk patients. In other words, the plan or management service organization could refer its patients to the community nurse case managers to manage patient care and help the patients get the services that were most appropriate. In this way, the community case managers became an integral part of the network. They worked closely with Carondelet Medical Group to manage the high-risk HMO patients and with all physicians and hospitals that were involved with their community nursing organization patients.

Meanwhile, the case managers implemented a disease management program and began a networkwide focus on specific targets such as congestive heart failure and diabetes. Their congestive heart failure pilot utilizing community case managers demonstrated a dramatic decrease in hospital readmissions. As a result of the pilot, an acute care and community model was implemented early last year.

Unfortunately, due in part to the changes brought on by the Balanced Budget Act of 1997, Carondelet was no longer able to sustain its capitated contracts with the local HMOs. All parties worked together to build agreements that would preserve patient care; as a result, Carondelet reverted to a fee-for-service model with the HMOs. That meant the delegated services were all taken back, including community nurse case management. The internal revenue stream for case management was gone.

Some of the local HMOs hired a few of Carondelet's most highly skilled community case managers so that service to the existing case managed patients was not interrupted. Carondelet also redesigned its acute care hospital case management program from a utilization management model to a more extensive case management model. Many of the community case managers accepted the acute care roles; others went on to start their own case management businesses. The Community Nursing Organization received another two-year extension from Medicare, and some of the case managers stayed with the project.

It is critical to establish mutually agreed-upon outcomes that benefit the patient from both the payers' and the providers' points of view.

Although Carondelet experienced some difficult decisions, there was no question that the need to preserve the core business of acute care came first. With repositioning and reseeding staff and programs, Carondelet could move forward. The following lessons were learned:

- It is critical to establish mutually agreed-upon outcomes that benefit the patient from both the payers' and the providers' points of view. In other words, we not only must strive for patient satisfaction and clinical outcomes, but also for fiscal outcomes that all parties buy into.
- Every program must have a mixture of financial arrangements — fee-for-service, capitation, special carve-outs — so that if a contract is dropped or must be renegotiated, the whole department is not jeopardized.
- Document outcomes and report them regularly to all parties. Have payers and providers be a part of case management's success and improvements.

*(Editor's note: Zazworsky has partnered with Gerri Lamb, PhD, RN, associate dean, University*

*of Arizona College of Nursing, Tucson, and Toni Cesta, PhD, RN, director of case management, Saint Vincents Hospital and Medical Center, New York City, to create Case Manager Solutions, a consulting and education service for universities and health care organizations. Zazworsky also is a member of Consultant's Consortium, an international organization of nurse consultants.)*

### Recommended Reading

Todd WE, Nash D. *Disease Management: A Systems Approach to Improving Patient Outcomes.* Chicago: American Hospital Association; 1998.

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# Surgical fast-tracking: When is it beneficial?

*Rapid recovery could save $7.39 per case*

To speed up the recovery process of surgery patients and decrease staffing costs, many hospitals have embraced fast-tracking — keeping patients in a lightly anesthetized state so they regain consciousness sooner than they would under heavier anesthesia. But is fast-tracking patients a good idea under all circumstances?

Researchers led by **Franklin Dexter**, PhD, MD, at the University of Iowa College of Medicine in Iowa City, studied the economic benefits of fast-tracking patients in hospitals. The researchers found variable results; depending on how staff are paid, the strategy may or may not save an institution money. They also concluded that results depend on how many operating rooms (ORs) routinely run concurrently and on how many patients undergo general anesthesia.[1]

Before hospitals were forced to become thrifty, patients usually spent days in the hospital following surgery. Now, many walk out an hour or two after waking up. The sped-up process is enabled by fast-tracking. Patients wake up more quickly, leave the OR sooner, and may not have to stay in the recovery room as long as if they were heavily sedated. Fast-tracking is embraced as a way to decrease an institution's costs while maintaining quality care because less staffing time is required.

Dexter, associate professor of anesthesia at University of Iowa College of Medicine, used computer simulation to address two questions:

- What is the decrease in an OR staff if the time from which surgery is completed to the time the patient leaves the OR is decreased?
- What is the decrease in post-anesthesia care unit (PACU) nursing staffing if patients proceed from the OR directly to the phase II PACU, bypassing phase I PACU (where the length of stay may be 30 minutes to an hour)?

Dexter and his colleagues found that whether fast-tracking allows a hospital to reduce staffing costs depends upon the institution's labor payment structure. If a hospital pays its staff an hourly rate and the fast-tracking reduces substantial overtime, the decrease in labor costs can be significant. But if a hospital pays a set salary, the time savings may not translate into financial savings. Their results showed potential decreases in a center's labor costs to be $7.39 per case.

"Characteristically, the cost of care in the surgical suite is charged and/or apportioned proportional to the time that a patient is in the OR or PACU," says Dexter. "However, this does not mean decreasing the time in the OR or PACU will decrease costs proportionately. Generally, it does not."

Dexter wrote that what his team really found is that there is no one, single answer. "The economic impact is going to vary among institutions depending on how people are paid," Dexter wrote. "Many hospitals and ambulatory surgery centers are considering the adoption of new medicines and monitors so that their patients can leave within an hour or two after surgery. These institutions can use our analysis to better predict the financial impact of this fast-tracking."

Some new anesthetic agents permit more rapid anesthetic recovery after general anesthesia. "For example," says Dexter, "patients recover more rapidly with the newer volatile anesthetic desflurane than with the older agent isoflurane."

Dexter's study was funded in part by Aspect Medical Systems in Natick, MA, which has developed technology to measure a patient's level of consciousness during surgery. The company's BIS (Bispectral Index) monitor helps anesthesia staff titrate the dose of the anesthetic agent precisely so patients are given just enough medication to keep them unconscious during surgery, but in a

***Commentary***

# Don't rush to use surgical fast-tracking

*An outcomes data analyst comments*

By **Richard E. Gilder**, RN, BSN, CNOR
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Fast-tracking really is a function of anesthesia technique. The rapidly dispersed volatile anesthetic agents such as sevoflurane and desflurane have such low solubilities in blood so as to rival nitrous oxide. Agents such as propofol also have a rapid onset of action and an exceedingly short serum half-life. The net effect is that the patient goes out like a light and comes back equally fast.

Fast-tracking is also finding its way into cardiac bypass procedures, resulting in decreased length of stay by virtue of faster recovery time. It is not uncommon for patients to be discharged the next day.

I agree that there is no one simple answer. What works for one department or facility could be a disaster when tried in another, but one thing is clear: The use of rapid anesthesia agents and their new technology is expensive. Desflurane is almost worth its weight in gold. Propofol is very costly in a primary agent-to-agent comparison with either halothane or isoflurane. When propofol is used for maintenance, the recovery time is only a few minutes shorter than that of all the other inhalational anesthetics.

The question about the magnitude of the savings needs to be asked as well. How much savings? Who is the beneficiary of the savings? The added cost of yet another anesthesia monitor may be just enough to ensure that the whole process results in a greater cost, which would mean a lower profit, no matter what salary structure is in place at the facility.

On the other hand, if a new monitor has the potential to show the kind of all-around magnitude of benefit to the patient, the practitioner, and the facility that was demonstrated by pulse oximetry in reducing complications of anesthesia, then it would be worth it no matter what the direct or indirect cost would be. The question remains to be answered and needs to be aggressively investigated.

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state from which they can awaken soon after the procedure.

According to Dexter, there is no other such product on the market that measures the patient's depth of anesthesia. "Many clinical studies have been performed showing [the BIS monitor's] clinical efficacy," he says.[2] The U.S. Food and Drug Administration approved Aspect Medical Systems' single-use, disposable BIS Sensor Plus on Feb. 23.

Dexter suggests that if OR managers are considering an investment in a new technology to decrease labor costs, such as a BIS monitor, they should contact a consultant to run a financial analysis of their fast-tracking plans. The analysis would include the use of a computer simulation that incorporates institution-specific figures.

*Hospital Case Management* asked Dexter if any harmful effects have been documented regarding the use of the newer volatile anesthetics. "I am not aware of any harmful effects from having patients recover more quickly from general anesthesia," he answers. "Most research focuses on determining the magnitude of the benefit of having patients recover more quickly. We do not fully understand how to balance . . . the benefits of more rapid recovery from general anesthesia vs. the increased cost from using the newer pharmaceutical products and the BIS monitor itself."

Is there a danger of a patient waking on the surgery table? "There is no data suggesting that the use of monitors and agents that permit more rapid awakening of patients after the end of surgery increases the risk of awakening during surgery," he says.

Despite the varied financial implications, Dexter says he thinks fast-tracking is here to stay. "From the patient's point of view, it's an advantage because it gets them out of the hospital quicker so they can be at home, be with their

*(Continued on page 63)*

# CRITICAL PATH NETWORK™

## Care planning algorithm for lower-extremity amputation

The algorithm on the next page is a snapshot — an interdisciplinary planning guide, says **Sandra Sperry**, RN, MPA, senior vice president of clinical resources at Sisters of Charity Health Care System in Staten Island, NY. The algorithm goes in the front of the progress notes, to which everyone on the interdisciplinary team contributes and has access. "Whether you are a nurse or a house officer," she explains, "you can quickly get a sense of certain basic guidelines on the care of the patient with an amputation."

On the two pages following the algorithm are sections from Sisters of Charity's interdisciplinary pathway. "That is a day-to-day documentation tool and planning guide where staffers chart specific interventions and variations," explains Sperry. "The algorithm is used in conjunction with the pathway."

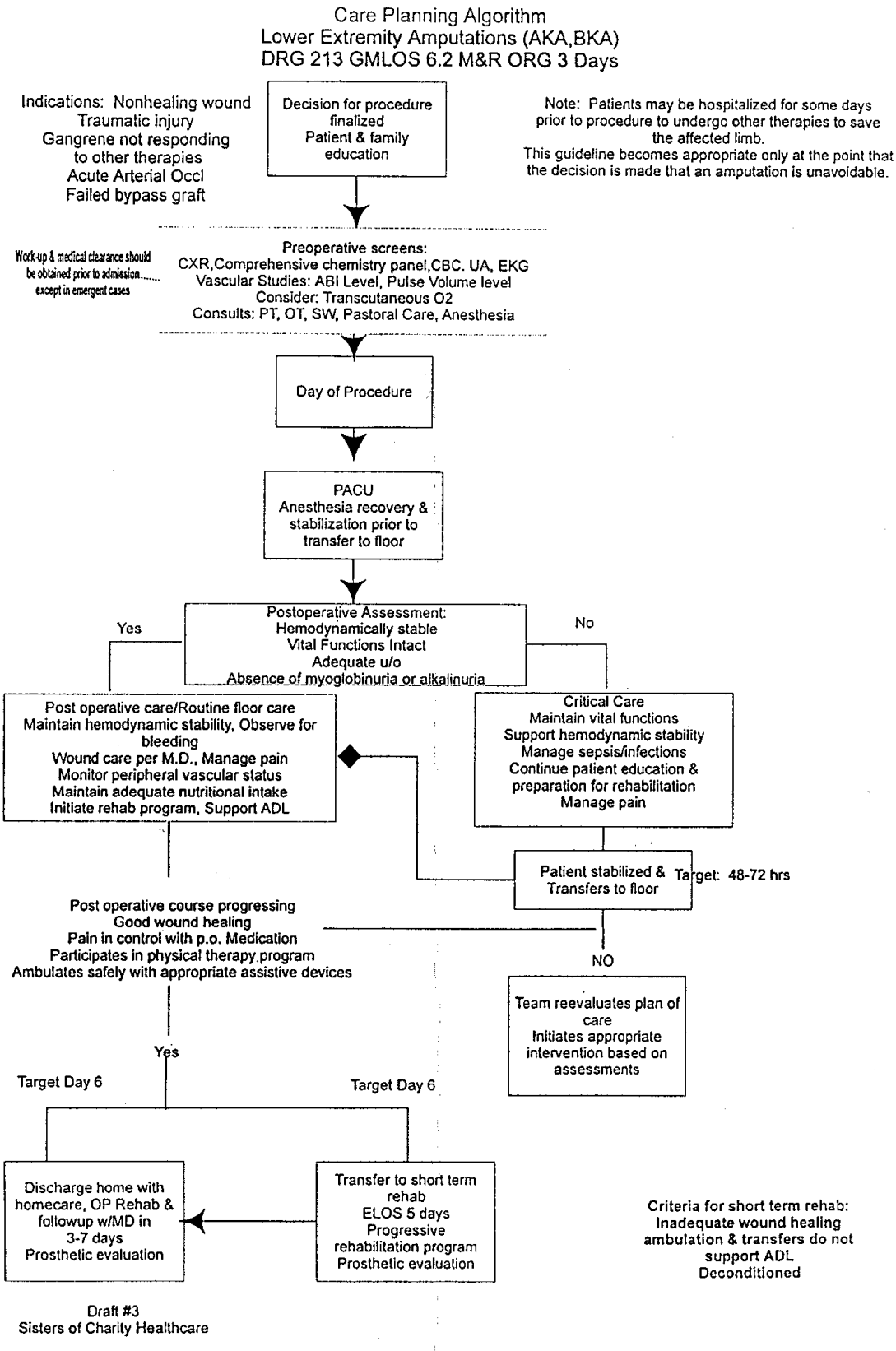
She says amputation patients at Sisters of Charity are down to an average five-day stay. "They go home with home care or ambulatory rehabilitation, depending on the patient's functionability." She explains that people who have amputations are typically sick with diabetes, peripheral vascular disease, or some other condition that led up to the amputation. "Although for this particular hospitalization, the amputation is the issue, they have some kind of chronic problem that brings them to this point. That three-day Milliman & Robertson Optimal Recovery Guideline [see algorithm] is unrealistic, unless what is being amputated is a toe." ■

## 'My feet are killing me'

For some diabetics, the statement above is unfortunately true. The mortality rate of lower-limb amputees is high. Amputations occur as a result of these complications arising in the lower limb:

- neurological changes as a result of diminished nutrition
- macro- and microvascular changes — diminished blood flow to the extremities due to hardening of arteries
- dermatological changes due to nutritional changes
- muscle and bone changes due to neurological changes
- gait disturbances due to bone/muscle/neurological changes
- excessive pressure loading due to gait changes
- excessive pressure and inappropriate shoewear leading to ulceration
- vascular changes leading to poor healing prognosis
- poor healing leading to exacerbation of condition
- gangrene
- amputation of one limb leading to excessive pressures on remaining limb plus further gait changes
- all of the above leading to amputation of the second limb

*Source:* Lesley Saunders. Presented at the 5th National Rural Health Conference. Adelaide, South Australia: March 1999.




AKA = above knee
BKA = below knee
GMLOS = geometric mean length of stay based on national standards, acuity-adjusted. The arithmetic mean does not take acuity into account.
M&R ORG = Milliman & Robertson Optimal Recovery Guideline

*Source:* Sisters of Charity Health Care System, Staten Island, NY.

Sisters of Charity Medical Center
☐ SV Campus ☐ BS campus
Multi-Disciplinary Care Action Plan
Primary Dx: Amputation: AKA or BKA
DRG 213 ELOS 6 Days M&R ORG 3 Days
**This Care Action Plan is a guideline and does not replace physician orders.**

| Patient Focused Actions: | Operative Day (Day 1 of 5)<br>Focus: Intra-operative safety, anesthesia , recovery.<br>*Pain Management.* | Notify MD and document any changes to plan |
|---|---|---|
| Assessment: | PREOP:<br>Vital signs, neuro, peripheral vascular, skin, emotional status, patient understanding of procedure<br>POSTOP:<br>Vital signs per anesthesia recovery protocol, neuro vascular checks q4h.<br>Signs of bleeding/swelling. Note drainage.<br>Response to pain medication.<br>Skin integrity | |
| Diagnostic tools: | Post-op CBC, EKG | |
| Consults: | | |
| Interventions/ Treatments | Cough and deep breathe.<br>*Pain medication PRN, per order. Consider PCA pump, patch.*<br>IV antibiotics, IV hydration to maintain u/o > 30cc/hr.<br>Foley to straight drainage.<br>Stump elevation/pillow, bed trapeze in place, Isometric exercises at bedside.<br>Anti-embolic device to unaffected limb.<br>Consider: Iron, MOM prn, vitamins A, C, E, and Zinc. | |
| Patient and Family education: | Post-op meeting of surgeon and family.<br>Pain management regimen.<br>Importance of cough and deep breathe, use of incentive spirometer.<br>Trapeze & pressure relief measures.<br>Reinforce isometric exercises. | |
| Expected outcomes: | Hemodynamically stable, afebrile, effective respiration, pain controlled. | |
| Triggers: | Any signs or symptoms of bleeding, hemodynamic instability, poor pain control, fever, and u/o <30cc/hr, compromise of vital functions | |
| Name & Title<br>Date & Time | | |
| Name & Title<br>Date & Time | | |
| Name & Title<br>Date & Time | | |

DRAFT # 3 6/14/99

*Source:* Sisters of Charity Health Care System, Staten Island, NY.

Sisters of Charity Medical Center
☐ SV Campus ☐ BS campus
Multi-Disciplinary Care Action Plan
Primary Dx: Amputation AKA or BKA
DRG 213 ELOS 6 Days M&R ORG 3 Days

**This Care Action Plan is a guideline and does not replace physician orders.**

| Patient Focused Actions: | Post Op (Day 5 of 5)<br>Focus: *Increase activity*, participates in ADL, pain management, functional assessment. | Notify MD and document any changes to plan |
|---|---|---|
| Assessment: | Vital signs per routine.<br>Respiratory status & neuro vascular checks q shift.<br>Wound healing.<br>Positive response to pain medication.<br>Skin– include unaffected limb.<br>Safety/progressive capability in ambulation with assistive device. | |
| Diagnostic tools: | | |
| Consults: | | |
| Interventions/ treatments | Consider discontinuation of antibiotics in closed wound.<br>Dressing change per attending plan.<br>*Progressive gait training with assistive device within weight bearing status.*<br>Pain medication PO PRN.<br>Iron, MOM PRN, vitamins A, C, E, Zinc<br>*Finalize plan for discharge to home with rehab, short-term rehab.* | |
| Patient and Family education: | Reinforce safety precautions for transfer, ambulation.<br>Reinforce use of assistive device for ADL.<br>Review medication plan, potential for food/drug interaction..<br>Reinforce discharge plan. | |
| Expected outcomes: | Adequate coping skills. ADL managed with assistive device when needed.<br>Pain is managed.<br>*Progressive, safe ambulation with assistive device.*<br>Patient/Family verbalize agreement and comfort with discharge plan. | |
| Triggers: | Inability to discharge patient.<br>Any signs/symptoms of post op complication, unmanaged pain, negative wound healing or anxiety/concern related to discharge plan. | |
| Name & Title<br>Date & Time | | |
| Name & Title<br>Date & Time | | |
| Name & Title<br>Date & Time | | |

DRAFT # 3 6/14/99

*Source:* Sisters of Charity Health Care System, Staten Island, NY.

PATIENT EDUCATION
QUARTERLY

# Teach patients to imagine better health; it happens

*Imagery and visualization can improve outcomes*

The mind can be a powerful tool for reducing stress and anxiety, which can result in decreases in pain, side effects, and even length of stay, according to experts in imagery and visualization. To harness the mind's power, people must learn to draw upon the resources of the right-hand side of the brain, says **Susan Ezra**, RN, HNC, co-director of Beyond Ordinary Nursing, a Foster City, CA-based certificate program in imagery for nurses.

"We go to a physician or practitioner to receive some intervention, which is good, but we can also tap into our inner resources. We can tap into the power of the mind and the body's natural intelligence in healing," says Ezra. For example, the body already knows how to repair a bone or heal a wound.

Imagery and visualization are based on the idea that people often have a lot of the answers to their health problems, but they don't relax and become quiet enough to go inside and find the information. Sometimes they don't know they have the information. The right side of the brain is the bridge between the conscious and subconscious mind and holds the key to bringing this buried information to bear on the illness. **(To learn more about training in imagery visualization techniques, see Editor's note at the end of this article.)**

There are two types of imagery. Guided imagery is the therapeutic process that harnesses the imagination to improve mental attitude and achieve positive outcomes and innate healing within the body. The process is scripted and can be directed by either a practitioner or an audio tape.

Integrative imagery takes this therapeutic process to a deeper level by eliciting and working with a person's own images, both positive and negative. A trained practitioner guides this process in order to help the person bring to mind an image that symbolizes something such as healing. The practitioner directly engages the image, often in dialogue. For example, if the image symbolizes healing, it may reveal what is needed for the body to heal while the discussion is taking place with the practitioner.

Imagery and visualization can be used in many ways in a health care setting. They're useful in moving people past barriers that block a successful recovery, says **Fran London**, MS, RN, health education specialist at Phoenix Children's Hospital. Often, goals are difficult to achieve because people can't even imagine success.

For instance, a patient who cannot imagine walking again after hip surgery will have trouble getting out of bed. If this patient imagines walking, the images are filled with pain and falling, thoughts that become a barrier to success. "Patients need to know they must visualize only positive images and that visualization is most effective when done in great detail, involving as many senses as possible," says London.

The steps begin with identifying the goal, deep breathing for relaxation, and imagining success in detail. It's not a one-time activity, but something that should be done once or twice a day until success is achieved.

Because patients can take guided imagery audiotapes home with them and listen to them frequently at their convenience, tapes are good tools to help people relax and develop a positive state of mind before surgery or a procedure, says **Diane L. Tusek**, RN, founder of Guided Imagery, Inc., in Willoughby Hills, OH. Tapes help patients who struggle with chronic disease such as diabetes as well as patients who face life-threatening diagnoses such as cancer.

"I don't believe in using guided imagery tapes that are disease-specific, because I don't want to focus on the disease. I focus on grasping the adversity we have in life and becoming a better

person, then actually moving forward," says Tusek. For full benefit of the process, patients are encouraged to listen to the tapes one to two times each day. **(For information on guided imagery tapes, see resource list at right.)**

When used as a relaxation technique before a procedure, guided imagery can be a single event. Patients going to the lab for an electrophysiology study (EPS) at Deborah Heart and Lung Center in Browns Mills, NJ, are given their choice of medication to relax or guided imagery. "The mind is such a wonderful instrument. You can relieve your pain and anxiety just by focusing on other things and putting other images in your mind," says **Patricia Stanford**, RN, BSN, manager of the EPS department at Deborah.

> "The more we can empower patients to tap into their inner resources, the more we will maximize their ability to either get well or stay well, and imagery is one modality to do that."

To prepare a patient for guided imagery, she describes what the lab room will be like in order to lessen the chance of distraction. She also teaches the patient how to breathe, which helps in the relaxation process. It helps to take them through a relaxation and imagery exercise before they go to the lab because it is easier for them to get into the process when they have done it before, says Stanford.

Imagery and visualization have many benefits, says Ezra, including an increased ability to cope and an enhanced sense of well-being. These techniques are particularly timely in the current health care climate that focuses on patient empowerment. "The more we can empower patients to tap into their inner resources, the more we will maximize their ability to either get well or stay well, and imagery is one modality to do that," says Ezra.

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*(Editor's note: Beyond Ordinary Nursing is a 110-hour certificate program that provides in-depth, hands-on training in therapeutic imagery for nurses. The fee is $150. Courses are offered throughout the year on the East and West Coasts and in the Midwest. Contact Beyond Ordinary Nursing for a brochure and calendar.*

*Also, Diane Tusek offers staff training in guided imagery and consulting on how to initiate a guided imagery program. Guided imagery tapes and CDs are also available. Two adult tapes or the CD cost $16.99 plus $4 shipping and handling. The children and adolescent tape is $11.99, and the CD is $16.99 plus $4 shipping and handling.)* ■

# Mark your calendar for these conferences

Conferences offer networking opportunities, ideas to improve programs, and learning about newly released research outcomes. Following is a list of conferences that may be beneficial to patient education managers. Because some were in the planning stages when this issue went to press, the details are not always complete, so please contact the organization directly for further information.

• **Cancer, Culture and Literacy: Future Directions for Health Education & Promotion** — May 4-6, Clearwater Beach, FL. Cost: $225; if application is postmarked after April 10, $325. Sponsor: H. Lee Moffit Cancer Center and Research Institute Education Program, Tampa, FL. For more information, contact: Susan Easter, Moffit Cancer Center Education Program. Telephone: (813) 632-1775. Fax: (813) 979-3874. E-mail: seaster@.usf.edu. Web site: www.moffitt.usf.edu / Promotions / ccl.

• **Health Education by the Sea** — Oct. 5-6, Otter Rock, OR. Cost: $135. For more information, contact: Loretta Glaze, North Lincoln Hospital, 3042 N.E. 28th St., Lincoln City, OR 97367. Telephone: (541) 996-7113. Fax: (541) 996-7219. E-mail: glazlo@nlhospital.org.

• **Health Care Educators Conference** — Oct. 20-22, New Orleans. Cost: $385 for HCEA members; $475 for nonmembers. Sponsor: Health Care Education Association, Philadelphia. For more information, contact: Beth Miller, HCEA, 1211 Locust St., Philadelphia, PA 19107. Telephone: (888) 298-3861. ■

# Kids learn to 'do the right thing'

*Emergency training not too difficult for kids*

Knowing how to react in an emergency can mean the difference between life and death for the victim. Therefore, many community outreach programs target adults, giving them such skills as CPR training and first-aid techniques. However, adults are not always present during crisis situations. That's why community outreach classes at Valley Children's Hospital in Madera, CA, have been designed to give children the skills they need in emergency situations.

For example, CPR for Kids is a class taught to children ages 6 through 11, and Home Alone provides information on everything from choking to fire safety for children ages 7 to 12.

The Home Alone courses are aimed at latchkey kids, children who arrive home from school to an empty house because both parents are at work, says **Casey Eckert-Luker**, community education/health coordinator at the hospital.

The CPR for Kids class came about after Eckert-Luker saw a television show that re-enacted a near drowning and the attempts to save the victim by a young teen when no adults were present. "The teen on television started doing all kinds of things to save the child's life that were not correct. After seeing that show, I went to the CPR instructor and asked if children were too young to learn CPR," explains Eckert-Luker.

To tailor CPR to children, the CPR instructor and Eckert-Luker went through the literature to make the language appropriate for children. They did not want to dilute the meaning of any of the words used, such as resuscitation. Rather than replace such words, the instructors defined the words for the children.

Part of the instruction helps children recognize the warning signs of cardiopulmonary emergencies for adults and children. CPR often is thought of as something used on an adult, so the instructor discusses some of the situations that might occur that would cause a child to stop breathing, such as a blow to the head or near-drowning.

Children learn CPR techniques for infants, children, and adults, and they practice on mannequins. The children also learn how to do the Heimlich maneuver.

During both the CPR and Home Alone classes, children are trained to talk to a 911 dispatcher. Children need to know what dispatchers will say and what kinds of questions will be asked so they don't panic during the call, explains Eckert-Luker.

While CPR instruction is discussed during the Home Alone course, hands-on teaching is not included. Much of the class focuses on the discussion of "what would you do if" scenarios. These scenarios include the following:

• What would you do if you got a phone call that made you feel uncomfortable?

• What would you do if you came home from school and the door was open and you knew mom and dad weren't home?

• What would you do if someone came to the door and you didn't recognize that person?

• What would you do if you put something in the microwave to heat and burned yourself?

The scenarios are taken from a book that Eckert-Luker found at a commercial bookstore, titled *What Would You Do?* Children are given a copy of the book to take home and encouraged to go through at least one scenario each night with their parents.

The classes are offered quarterly. The Home Alone course costs $20 for the first child and $10 for each additional child, and parents are required to attend. The CPR class is $15 per child. A fee is charged to cover the cost of the instructor and class materials, but Eckert-Luker is trying to find ways to offer the classes in community settings free of charge.

*For more information, contact Casey Eckert-Luker, Community Education/Health Coordinator, Valley Children's Hospital, Madera, CA. Contact: (559) 353-7230; Fax: (559) 353-7160; caseyluker@valleychildrens.org.* ■

# Overcoming an adverse teaching environment

*Apnea management skills blocked by many barriers*

Each year, about 400 infants are discharged from Phoenix Children's Hospital on an apnea monitor. To ensure the safety of the baby who has this life-threatening condition, parents are required to attend two classes to learn how to respond to the alarm.

The timing of events is not always conducive to teaching, says **Jane Diaz**, RN, MSN, manager of the Apnea Management Program at the children's hospital. Parents are often exhausted, having spent many hours at the hospital with their baby. Others have a lot of anxiety caused by the baby's diagnosis. "If we feel there is a high level of anxiety, we will teach the family in private. Otherwise, we teach in a group," she says. Classes are held Monday through Friday at 1 p.m. and 3 p.m.

"About 99% of the time, all babies need is a touch and they are absolutely fine."

The first class session provides instruction on how to respond to the apnea monitor alarm, and the second class teaches parents how to perform infant CPR. The emphasis in the alarm response class is on learning to follow a step-by-step process that keeps the parent calm. "Every time the monitor alarms, we don't want families to dive into the room waking up the baby, putting them on the floor, and beginning CPR. About 99% of the time, all babies need is a touch and they are absolutely fine," explains Diaz.

Parents are taught to walk to the baby's room when the alarm goes off, counting the beeps from the alarm. The alarm indicates that the baby has stopped breathing or has had a drop in heart rate. Each beep is one second, and by counting, they can determine how long the episode is lasting.

In the child's room, they check the baby's color to determine if CPR is needed immediately. If the color is normal, they check to see if the baby is breathing. This can be done by looking for movement in the baby's chest or licking their fingers and putting them in front of the baby's nose and mouth to feel air. The next step is to gently stimulate the baby. If there is no response, they pick the baby up, place him or her on their shoulder, pat the baby's back firmly, flick the fingers, flick the toes, and slap the bottom of the baby's feet. If there is still no response, they begin CPR.

It's important that parents do not rush into the room and immediately perform CPR or turn off the alarm, says Diaz. The monitor is computerized and helps the management team track the severity of each episode to determine how the baby is progressing.

A member of the apnea management team calls parents within one week following discharge. During the phone call, the team member assesses parents' knowledge of the information taught in the classes. "If we recognize that they retained very little, we review in depth what we taught. Sometimes we encourage them to come back and take the class again," says Diaz.

There are many reasons why parents might not remember all they were taught. Anxiety and exhaustion play a factor. Also, parents might have been given the diagnosis before being asked to attend the class and could be in a state of denial.

To help reinforce the teaching, parents are given a packet of detailed information. They receive a poster that covers the steps for infant CPR that they can hang in the baby's room. They also receive a flowchart that covers the steps for responding to the alarm on the apnea monitor.

A list of indicators, such as an increased number of alarms or a color change in the baby, accompanied by the name and phone number of a contact person, helps parents respond appropriately to problems. For example, one set of indicators would trigger a call to the apnea management program; another group would initiate a call to the baby's physician; and another set would generate a call to paramedics.

Parents are told to call the apnea management program any time, day or night. However, follow-up calls by the apnea management team are made on a case-by-case basis as long as the baby is on a monitor.

*For more information, contact Jane Diaz, RN, MSN, Manager, Apnea Management Program, Phoenix (AZ) Children's Hospital. Telephone: (602) 239-4740. Fax: (602) 239-3556. E-mail: apnea@phxchildrens.com.* ■

(Continued from page 54)

families," Dexter says. "From a hospital's point of view, even if large decreases in costs cannot be expected, fast-tracking will increase the productivity of the work force so staff members can do other things with their time. It may not cut costs, but rest assured that it is going to increase productivity."

As an example, according to **Wendy O'Dea**, spokeswoman for Aspect Medical Systems, 71% of the cases at Community Hospitals in Indianapolis are fast-tracked (4,380 cases out of 6,128 per year).

*For more information, contact Franklin Dexter, PhD, MD, department of anesthesia, University of Iowa College of Medicine, Iowa City. Telephone: (319) 356-1616. E-mail: franklin-dexter@uiowa.edu.*



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# NEWS BRIEFS

## Pension funds work toward direct contracting

Californians are searching for new ways to provide health care — and may do away with HMOs in the process. Two pension funds that together represent 1.5 million people, the California Public Employees Retirement System (CalPERS) and the California State Teachers Retirement System (CalSTRS), may provide an answer.

CalPERS is considering eliminating its HMO contracts for more than a million members in favor of contracting directly with physicians and hospitals for its patients. In December, a CalSTRS task force also recommended direct contracting. Proponents of both arrangements say that by eliminating HMOs' share of about one-fifth of the premium dollar, direct contracting could decrease premiums and may even increase reimbursements for doctors and hospitals. A direct contracting system has been tried on a large scale only in a few places, notably Minnesota. Opponents warn it could bring new administrative headaches. ▼

## Customers will have more clout

Customer service will be an important factor surrounding success in managed care of the future, according to **Stewart W. Hall**, president of Boston-based S.W. Hall & Associates, at a recent conference in Nashville, TN, sponsored by the American Association of Health Plans. "When your costs, networks, quality indicators, and benefit packages become more like your competition's, the only way for your organization to stand out will be with service," he said.

Health care consumers may not always understand quality, but they do understand service. While customer service requires a minimal amount of investment, it can help an organization with accreditation and compliance issues. And good customer service can significantly boost an organization's bottom line by helping decrease disenrollment rates. In the past, he said, customer service was viewed as the "fix-it department"; now it is more of a "member advocate" department.

*For more information, contact Stewart W. Hall, S.W. Hall & Associates, Boston. Telephone: (617) 934-9454. World Wide Web: www.swhall.com.* ■



## 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. ■