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Assigning ownership to measures helps plan improve its scores

Staff are responsible for quality-of-care measures

An initiative that assigns "ownership" of HEDIS®* measures to various staff members has resulted in improved HEDIS scores and national acclaim for Keystone Health Plan Central, a wholly owned subsidiary of Capital BlueCross, independent licensees of the Blue Cross Blue Shield Association.

Management-level staff are assigned responsibility for each HEDIS Effectiveness of Care measure and are responsible for constantly monitoring the measure and creating quality improvement activities.

As a result of the initiative, HEDIS scores improved, and the plan's HMO, Keystone Health Plan Central, was recognized by the National Committee for Quality Assurance (NCQA) as one of the top five best-performing commercial health plans in effectiveness of care in the Middle Atlantic region.

Effectiveness of Care measures indicate how well a health plan performs in making sure members are receiving necessary care for conditions that relate to significant health issues such as cancer, heart disease, smoking, asthma, and diabetes.

The health plan began its initiative to improve HEDIS scores several years ago, according to **Elizabeth Barnett**, BSN, JD, vice president for clinical management.

"When we got back our scores, we identified opportunities for improvement. We looked at both those far-ranging opportunities without losing track of the measures on which we were doing well," she says.

The health plan's HEDIS scores have improved every year since the initiative began, Barnett reports.

"In some cases, we're already into the 90% range, leaving a small margin for improvement. Each year, we target areas of opportunity and continue to work on all of the measures," she says.

The management team decided that the quality improvement goals were too far-reaching to be the responsibility of just two or three people. Instead, management-level staff were assigned responsibility for

each HEDIS measure.

It was obvious who would be responsible for some of the measures, Barnett says.

For instance, the manager of disease management "owns" the measures related to diabetes. She and her team keep up with the latest clinical practice guidelines, pull data from the health plan's database to see what is going on with patients, study the interventions the plan makes with members, and work with physicians to better manage care for members with diabetes.

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Editorial Questions

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The medical director with pediatric expertise was in charge of the pediatric immunization measures. The tobacco cessation educator was responsible for the tobacco cessation programs.

In the case of measures where the health plan didn't have programs to improve those measures, the management team identified staff who might be able to develop programs.

"In some cases, we didn't have people with the necessary skill sets, but we did have an organization need," Barnett says.

The first step in a quality improvement program is making sure that there is ownership of the measure because ownership is a year-round activity, Barnett says.

The responsibilities are twofold for people who own the measures. They make sure that the HEDIS measures are not adversely affected when the health plan makes changes from an organizational perspective.

They also are responsible for making recommendations for the program about how the process can be improved. They monitor what other health plans are doing and identify changes that would benefit their members.

The health plan has task forces that concentrate on preventive health, conditions and disease management, and service. The owners of the measures sit on the task force. When the HEDIS scores are calculated, each task force analyzes the data and looks at areas where the plan should focus during the next year.

"We look at our population, determining if the demographics have changed, if the primary disease conditions have changed, if the preventive measure rates have changed. We look at anything from our population that can affect our scores or indicate that an area should be a priority," Barnett says.

One initiative concentrated on obtaining laboratory values from the providers, rather than having to collect the information from the members' individual charts.

"We want to know not just that the laboratory tests were performed but what the values were. Because we had a unique relationship with these providers, we were able to negotiate a way to capture that information and feed it into our care management process," Barnett explains.

Now, the laboratory data from the vendor are incorporated into the care management system, giving the nurse case managers access in real time to the lab values.

"It really helps our nurses manage and helps the HEDIS data overall," Barnett says.

Another project was aimed at improving rates of retinal examinations for diabetics.

"These rates are relatively low across the industry and represented a big area of opportunity," Barnett says.

The team determined that the requirement for a referral sometimes is an obstacle for members who need the examination and that some members avoid the exams because of the copay requirements.

The team designed an educational flyer that is sent to all members with diabetes, allowing them to have an examination without a referral and authorizing the provider to conduct the examination without collecting a copay from the member.

Rather than rotating the measures over time as NCQA allows, Capital BlueCross measures each element every year.

"This allows us to track improvements over time and to understand how we are managing these patients," Barnett says.

Disease management programs

When the NCQA announces new HEDIS measures, Capital BlueCross starts assigning staff for those measures and starts thinking about how to improve them even before they are part of the HEDIS scores.

The plan finetunes its HEDIS data to eliminate members who don't meet HEDIS criteria and to capture data from all members who do.

"We work to really understand who are the members who fit into HEDIS criteria and who doesn't," Barnett says.

For instance, a member may have been prescribed an inhaler for a one-time incidence of exercise-induced asthma but does not, in fact, have asthma. This member would be eliminated from the HEDIS data.

"As the disease managers interact with the members, they identify whether they are appropriate to be included in the HEDIS measures. We work with providers to determine which members may appear to be appropriate but who are not," Barnett explains.

For instance, a member who had a bilateral mastectomy may not be appropriate for a mammogram.

The health plan's quality nurses go into the field and capture data from patient records at physician offices. The quality nurses are assigned regionally to a group of physicians and hospitals to work on credentialing and quality improvement measures, as well as HEDIS data collection.

If the administrative data do not show that an eligible member received the services that are included in HEDIS measures, the quality nurse goes to the physician office and reviews the chart.

The nurse talks with the physician staff to find out if there is another way the member might have received the service — for instance, from the OB/GYN instead of the primary care physician.

"Some plans have the doctor fax back the information or work with a data collection vendor. We have found it more effective to go on site," Barnett says.

For instance, if the information isn't in the chart, the nurse already has an established relationship with the provider and the office staff who are willing to work with someone they know to track down the information.

Disease management programs represent Capital BlueCross's best opportunities to improve quality of care and to create programs that make the plan attractive to employer groups, Barnett points out.

"Our broad range of disease management programs set us apart from other carriers because we manage the care for the high-end, high-cost members but also have preventive health programs targeted to the healthy and at-risk members," she says.

The health plan stratifies its population into healthy and at-risk categories as well as chronic and catastrophic categories so they can target the messages to the members.

With the healthy and at-risk populations, the plan concentrates on preventive health management.

The chronically ill are invited to participate in a wide range of disease management programs aimed at improving their quality of life and educating them to better manage their conditions, resulting in improved medical costs.

Case managers coordinate the care for the catastrophically ill or injured patients.

"People with chronic illnesses have higher medical costs than other members. Because employer groups are looking to cut medical costs, they appreciate the mechanisms we have in place to control overall costs and increase quality of care," Barnett says.

**HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).* ■

Web-based consults save money, boost satisfaction

Members, docs communicate on nonurgent matters

When Blue Shield of California conducted a pilot project paying physicians for Internet-based consultations for nonurgent conditions, the San Francisco-based health plan found the initiative reduced office visit claims by $1.92 per member per month and total health care costs by $3.69 per member per month.

An independent study conducted by researchers at Stanford University and the University of California at Berkeley of several health plans that use the web-based communications system from RelayHealth found that physician satisfaction ratings exceeded 90% among regular users, that more than half of physicians surveyed preferred an internet-based consultation to an in-office visit for nonurgent medical issues, and more than 70% of patients gave the service high ratings for convenience and ease.

Participants included Blue Shield of California, Blue Shield of California Foundation, self-insured employers within the Silicon Valley Employers Forum, a subsidiary and affiliate of Pacific Business Group on Health, and ConnectiCare, a Farmington, CT health plan.

The system, called webVisit®, allows patients to access a secure web site and consult with their physician's offices for prescription refills, to get laboratory and test results, to set appointments, and to ask questions about nonurgent health conditions.

"Patient-physician communication over the Internet for nonurgent matters is a convenient way for members to get quick answers to their health care questions. There is the potential for savings. When members monitor their health and take care of problems earlier, they can stay healthier and avoid health care costs in the future," says **Sejal Hingrajia**, project manager, network management for Blue Shield of California.

Blue Shield of California started its first pilot project at a time when on-line communication between physicians and members was a hot topic of conversation throughout the health care industry, Hingrajia says.

The health plan was the first in California to offer the service.

"We wanted to see what the response to an opportunity to communicate via Internet would be from physicians and patients. We conducted the pilot project to determine the type of adoption rate we could expect and whether patients and physicians would be satisfied with such a system," she says.

After the initial pilot project with members in its PPO market, Blue Shield of California expanded its on-line communications services in a second pilot project involving 750 physicians from nine medical groups and 11,000 members in its HMO market.

"For the second pilot, we wanted to expand our scope and get more of a diverse population and treatment group spread throughout California. For this pilot, we chose physicians in our HMO market," Hingrajia says.

The web-based communication is a win-win situation for all parties involved, points out **Robert Forster**, MD, chief medical information officer and vice president for Blue Cross and Blue Shield of Florida, which started reimbursing physicians for web-based consultations in January, also using the webVisit system from RelayHealth, based in Emeryville, CA.

"The webVisit system improves access for patients and pays physicians for on-line visits. Overall, it doesn't cost more on the premium side. It's the best of all worlds," Forster says.

Communication over the Internet about minor issues avoids the telephone calls back and forth between the patient and the physician or a nurse. It takes care of routine requests, such as prescription refills without tying up the time of a staff member and keeps working people from having to spend a lot of time off work for an office visit for a nonurgent condition, he says.

"We know how difficult it is in parts of Florida for working moms and dads to take time away from work for an office visit for minor problems. This system helps patients get help with their low complex types of health problems effectively and efficiently," Forster says.

The system is helpful to physicians as well because they can answer the questions at a convenient time and avoid a lengthy office visit for a minor complaint, he says.

"We looked closely at the time element. The average patient inquiry takes about 6.5 minutes for the physician to review the complaint and the information questionnaire gathered. The reimbursement comes out to be more, based on the time it takes, than an office visit," Forester adds.

The system has far-reaching potential for other areas of the health care arena, points out **Eric Zimmerman**, senior vice president of marketing for RelayHealth.

"In addition to physicians, the system could work for case managers, nurse educators, disease management specialists, and others working in the medical environment. It allows patients to consult practitioners about a variety of issues related to management of disease, lifestyle changes, dietary questions, and monitoring health status," he adds.

Higher satisfaction

Medical practices and independent research studies have reported a significant reduction in telephone calls and higher patient satisfaction when they communicate with patients over the Internet, Zimmerman says.

"When I talk to doctors, they tell me that the people with chronic conditions who are stable are the biggest users and those who benefit the most. They can send over their glucose level, weight, and blood pressure logs to the doctor and ask questions about their conditions in a way that the doctor can easily see what is going on. It's a very convenient way to deal with situations that are important but not urgent," he reports.

About 75% of the physicians who use the system are primary care physicians.

About half of the webVisits involve chronic condition management, including medication issues and side effects, he says.

Some of the top reasons for webVisit consultations include: colds and flu, sore throat, sinus pain or pressure, urinary symptoms, coughing, abdominal pain, back pain, cholesterol, headache, rash, allergic symptoms, depression, foot and ankle injury, hypertension, muscle aches and pains, chronic pain, eye infection, and anxiety.

Only patients who were previously seen in person by the provider are eligible to use the RelayHealth service.

Here's how the service works: When health plan members log onto their secure web page to consult their physician using a webVisit, the service checks the member's eligibility for reimbursement, informs the member of the doctor's response time, and presents a menu of choices regarding the health issue. The service offers members options to request or cancel an appointment, request a lab test or result, request medication refills, request a referral, or send a brief note to the doctor or the doctor's office.

"These convenient services are free to the member and save the practice time when handled securely on-line," Zimmerman says.

When a member selects the webVisit option, the service presents an online interview that asks a series of symptom- or need-specific questions that gather information the physician needs for a response. The physician may pull the patient's chart or access it on-line through RelayHealth's integration with the electronic medical record.

The RelayHealth clinical development team has written more than 140 evidence-based, clinically structured interviews that have been reviewed by a team of physicians.

The questions use branching logic, similar to the questions a health care provider might ask when interviewing a patient about a particular problem.

Each webVisit interview is accompanied by the patient's RelayHealth Personal Health Record, which is updated by the patient as part of the web visit and includes demographics, allergies, medical history, and medications that patient is taking.

"In many cases, it's the first time the primary care physician gets to see the full list of medicine a patient may be taking because so many of them are seeing multiple physicians," Forster says.

The service notifies health care providers when a member is waiting for a response to webVisit, either by e-mail or fax or via a monitor available on the provider's own secure RelayHealth home page. The webVisit message from the member is presented as a concise clinical note for the doctor that includes current complaint, history of present illness, pertinent health history, and comments.

"The information is prepared for the physician so that when he or she logs on to answer the question, everything they need to know is at hand," Forster says.

When a patient logs onto the system for an Internet visit with a physician, the system automatically runs an eligibility review and determines if there is a copay obligation.

Once the doctor responds, the member's credit card is charged for the copay.

The preliminary questioning is thorough, and the on-screen instructions are carefully structured to remind patients never to use the service in an emergency situation, Zimmerman says.

"If a patient logs on with a complaint that doesn't qualify as nonurgent, the system instructs the patient to take appropriate action and not use the service," he adds. With webVisits, the

responsibility to determine that the patient's problem is not urgent is with the physician, just as if the patient had contacted the physician over the telephone, Hingrajia points out.

"The doctor reviews the information from the member and has the option to say that the member needs to be seen in person," she says.

On average, physicians respond to patients using the Internet-based service within four to eight business hours, Zimmerman says.

For physicians in Blue Shield of California's HMO programs, the payment for the visit already is included in their capitated payment. They do receive the member's copay, however.

The copay is equal to the member's standard office visit copay but is capped at $10. For instance, if a member's standard office visit copay is $15, the member pays just $10 for the webVisit. The PPO physicians receive the copay and an additional payment, bringing the total for the web-based visit to $25.

When Blue Shield of California began its Internet-based patient-physician communication initiative, the health plan worked with its network managers to define a target list of medical groups, taking into account location, size, culture, and their level of proficiency in technology, Hingrajia says.

"We introduced the program to medical groups, and Relay Health worked directly with the interested groups to sign the contract. Each medical group takes a different approach to rolling out the program to their physicians," she says.

When a physician enrolls with the RelayHealth services, Blue Shield of California notifies members via a postcard that their primary care physician is available for visits on-line. Registered physicians also are listed in the provider search functionality on the Blue Shield of California web site.

The program also is publicized at the doctors' offices with brochures and posters.

Blue Cross and Blue Shield of Florida linked its webVisit program to its pay-for-performance program, which rewards physicians based on several criteria including patient satisfaction, clinical quality and efficiency, and administrative efficiency. **(For details, see *Case Management Advisor*, January 2005, p. 4.)**

"These two programs link very well together. It allows us to get more revenue to the primary care physicians and provides incentives for physicians to see patients for minor problems," he says.

The program started with 300 primary care physicians statewide and continues to grow.

Blue Cross and Blue Shield of Florida started signing up physicians for the Internet visits in January and notifying the members that their physician is available on-line. When members agree to communicate with their physicians via computer, the physicians have to sign off on allowing the member to participate.

"We felt that there may be some patients that a doctor might feel wouldn't be good candidates for communicating on-line. We wanted to make sure the doctors were comfortable with communicating with their patients," he says.

Blue Cross and Blue Shield of Florida is the first health plan in the state to offer web-based physician services for its members.

"We felt that by being the health plan that brought this innovation to Florida, we could differentiate ourselves from the competition by offering something that has been proven to help facilitate relationships between physicians and patients," he says.

Forster had been watching the results of the Internet-based physician services for several years.

"The privacy issue is paramount. Once the technology had improved to the point that we could ensure privacy, we went forward," he says.

The idea is particularly appealing to young people who grew up with computers and who regularly use other on-line services such as banking and shopping, Forster points out.

"We know there is a national deficit of physicians and a growing population. This system can be particularly beneficial to the primary care physicians who administer 80% of the care," he says. ■

Escorts, training, duress signals improve staff safety

High-risk area visits require awareness and support

Actual scenarios: A nurse goes to check on a pediatric patient, and the mother punches her with no provocation.

An estranged husband comes into the house while the home health nurse is teaching the patient's mother how to do enteral therapy — as he begins physically abusing the mother, he looks at the nurse and says, "You're next."

A schizophrenic man who is not taking his

Four tips to protect your agency's employees

Protecting employees as they travel throughout the area and into many different types of situations often means giving them trainings and tools that can help them avoid, or escape, a dangerous situation. Conversations with home health nurses and aides, as well as review of incidents that have occurred, help you discover what issues need to be addressed, explains **Carrie Krueger**, RN, BSN, clinical director of home care services at Cincinnati Children's Hospital Medical Center. Some of the changes or enhancements to her agency's protocol for visits include:

1. Use a duress signal.

A code word or phrase that is known by all staff members is used when a nurse believes he or she may be in a potentially dangerous situation. "The nurse tells the family that a page must be returned, then he or she calls the office," says Krueger. "The staff person who answers the call and hears the duress signal calls the police," she explains. It is important that the nurse give the location by saying, "I'm at [patient's name] home on [street name]" so the office staff member answering the phone knows the exact location. "It is also important that the office staff member taking the call stay on the phone with the nurse until the police arrive," she points out. If it is not possible to stay on the phone, the nurse should leave the cell phone on and in his or her pocket so others can hear what is going on, Krueger continues.

2. Communicate location.

"A nurse should make sure that someone knows where she or he is going at all times," Krueger points out. "During the weekday, it is easy because we have staff in the office and it is easy to check in with each other," she says. "Nurses who go out in the evenings and on weekends need to make sure a family member knows where they are going and how long it should be until they return," Krueger suggests. "Family members should also have a list of contact numbers for managers and supervisors in the agency if the nurse doesn't return on time and can't be reached," she adds.

3. Establish good relationship with police.

Although the nurses no longer rely upon police escorts for visits into high-risk areas, agency schedulers regularly check in with police in the different districts when a new patient with an address that is in an area that might be high risk is referred to the agency. By talking with a specific, designated contact, the scheduler is able to determine if the location is considered high risk and requires that the nurse have an escort from the protective services group at the hospital, says Krueger.

4. Don't schedule some visits in evening.

"If the patient is located in a known high-risk area, we don't schedule night visits," Krueger says. If the patient needs care at 11 p.m., have them go to the emergency department, she adds. ■

medication makes advances toward the nurse as she cares for his child.

No home health manager wants his or her employees in any of the situations described above, but they are real incidents that have happened to the employees of Cincinnati Children's Hospital Medical Center's Home Care Services. The good news for home care employees in this organization: A comprehensive employee safety program is in place that gives employees the backup they need in these situations.

"Five years ago, we had a nurse punched in the face by a mother with no warning and no provocation," says **Carrie Krueger**, RN, BSN, clinical director of home care services. That incident prompted a partnership between the hospital's protective services department and the home care agency that not only is preparing employees to avoid dangerous situations, but also gives them options to use to escape dangerous situations, she explains.

An employee safety program that relied on the use of off-duty police escorts or a two-nurse team for visits to areas or homes that were considered risky had worked to some extent, but it was not always possible to have an off-duty police officer and the two-nurse teams were costly, Krueger adds. "Luckily, we have an excellent in-house protective services staff, and after our nurse was assaulted, we teamed up to provide escorts from protective services for the nurses," she says.

The protective services escorts do not wear uniforms while escorting home care nurses because their hospital uniforms resemble the uniforms of Cincinnati police and would cause confusion or even escalate a situation, says **Ron Morris**, MA, CPP, CPHA, senior director of protective services at the hospital. "The escorts wear business casual clothing so that they are not confused with the police. The escort car is not marked with any logos or signs that it belongs to the hospital so that people in the neighborhood don't think that it may contain drugs or needles," he adds.

Because home health nurses' priority is to take care of their patients, they tend to accept some dangerous situations as necessary to provide care, Krueger notes. "When we started working

with protective services, we talked with nurses about situations they encountered so that we could provide training and education they needed," she explains.

The conversations uncovered situations in which nurses have gone into homes with family members cleaning guns during the visit or male family members wearing T-shirts and nothing else during the visit, Krueger says. When asked why they had not reported these incidents, nurses stated that they didn't think anything could be done, and they didn't want to abandon their patients, she adds.

One of the first steps Krueger's agency took was to reassure nurses that they were not abandoning their patients if they did not want to walk into a dangerous situation, she adds. "We emphasized that there are other ways to find care for the child, even if it means rehospitalization. Our first priority is the safety of our employees."

Nurses can leave dangerous settings

Krueger's nurses are told they can leave a patient's home or choose not to enter the home if they believe they are in danger. "Even if they have begun an infusion treatment, they can leave," she points out. "We remind our nurses that our goal is to teach the family how to care for the child so they should know how to complete the treatment anyway," Krueger continues.

"When the nurse calls to let us know about the situation, we call the family and explain the situation," she says.

The agency then notifies the referring physician if the patient cannot be seen by home health, and arrangements to provide care are made at outpatient clinics or physician offices, Krueger notes. "We make sure the child receives the care and that the parents receive the teaching they need to provide care for the child, but we also make sure that teaching and care happen in a place that is safe for home health employees," she adds.

"We want nurses to trust their instincts," Morris points out. "Our classes teach them that if they don't think a behavior is natural, they need to be cautious," he says. Topics in the employee safety classes that are offered on a regular basis include how to deal with difficult people and how to de-escalate a tense or potentially dangerous situation by redirecting the person's anger or calming them, Morris says. "We also talk about specific situations and examples of what might work for different people," he explains.

While safety classes that include self-defense techniques such as the use of pepper spray and a kubotan (a small baton that can be used as a weapon) give home health employees an extra sense of confidence that they can protect themselves, the agency also makes sure other steps are taken to provide support to employees.

"A cell phone is the simplest safety device for everyone to have, and there is no danger of it being used against you, which can be the case with [pepper spray]," Krueger notes. "We tell employees that they must keep the cell phone on their person," she says. "We don't want the cell phone left in the car to charge the battery during a visit, and we don't want it left in a briefcase."

That advice came in handy for one nurse who was in the home when the estranged husband came in and starting assaulting the mother of the agency's patient.

"The husband threatened the nurse, saying that she was next," Krueger adds. When the nurse discovered that the backdoor to which she had run was locked and she couldn't unlock it, she crawled into a closet to hide and called 911 on her cell phone that was in her pocket. The police arrived quickly and arrested the husband, Krueger continues. "We then contacted the physician and made arrangements for the child to be seen in an outpatient clinic as opposed to home care."

Another tool developed for home care nurses to use is a "duress phrase," Morris explains. "We came up with a code word that a nurse could use in a telephone conversation with someone in the office to indicate that there was a problem," he says. Within weeks of implementing the code word and educating staff members, a nurse used it, Morris notes.

"The nurse was in the home providing care to the child when the male parent started acting strangely," he explains. The nurse asked to use the phone to return a page and called the office, Morris continues. "When the office staff answered, the nurse stated that she was returning the page and that 'Lisa' needed her medication," he adds. "Lisa" is the name of the agency director and is the code word to indicate a problem.

"The nurse told the office her location when she called so we knew where to send the police," Morris says. The advantage of a code word is the nurse can call for help without angering the person in the home and escalating the situation, he adds.

Another important part of the employee safety program is a debriefing whenever an incident does occur, Morris says. "By talking with the employees, we not only reassure them that we

care about what happened to them, but also that we want as much information as possible so we can better prepare ourselves and other staff members to avoid that situation in the future," he explains.

Because employee safety courses always include information on the latest trends in safety, it's important that your safety program constantly evolve, Krueger adds. "When we first started, we didn't teach nurses how to recognize signs of meth labs or how to prevent carjackings, but crimes in our high-risk areas have changed, so our preparation has to change as well. The key is to make sure employees feel prepared and protected," she notes. ■

Nursing home patients can benefit from hospice care

Expert offers ways to improve hospice access

As increasing numbers of older Americans spend their last days in a nursing home, it's important for nursing home staff, as well as hospice providers, to identify nursing home patients who might qualify for a hospice placement, an end-of-life care expert says. Hospices often cite examples of how nursing home patients are referred to hospice care too late in their dying process to receive the most benefit from what hospice and palliative care can offer.

"The issue is how well are we caring for individuals dying in nursing homes," says **Edward Vandenberg**, MD, CMD, an assistant professor of geriatrics at the University of Nebraska Medical Center in Omaha. Vandenberg spoke about identifying terminal patients among the nursing home population at the Living a Good Life at the End of Life conference, held in Lincoln, NE, in March. The conference was sponsored by the Nebraska Hospice and Palliative Care Association and other health care organizations.

"It becomes very important when so many people may plan their last few days there to know how to improve that quality of care," he says.

Quality improvement studies in nursing homes have identified various ways to enhance care, but one item that stands out is teaching staff how to identify the patient who is going to die despite the best curative efforts, Vandenberg notes. "Those individuals sometimes have experienced undue suffering from repetitive curative attempts," he explains. "An example is the person who has end-stage Alzheimer's disease who gets repetitive pneumonia, going to the hospital to receive all treatments," Vandenberg says. "Then in another month, the person goes through the same sequence again."

One of the ways quality of life could be improved for this individual is for someone to identify this person as someone who would benefit more from a palliative approach than from aggressive curative care, he adds.

Seek opinions of experienced staff

A first step toward identifying patients for whom it's time for a hospice referral or a shift to palliative care is to solicit the gut feelings of experienced staff, Vandenberg suggests. "Never expect the newly trained individual to tackle this, but the experienced nursing home employee will have this gut feeling from a collection of tangible and objectified elements and intangible, nonobjectified elements."

For instance, experienced staff can be assisted in trusting their intuition about patients by suggesting they ask themselves this question: "Will I be surprised if this person dies during the next six months?" Vandenberg says. "And if I wouldn't be surprised, then the next question is, 'Am I doing everything I can to keep this person comfortable, or is that comfort being pushed aside in favor of more painful curative treatment that wouldn't work anyway?'" he adds.

The next step is to examine goals and care plans at quarterly care conferences with patients and their families, Vandenberg says.

If a patient is repeatedly hospitalized, this might be a time to discuss a change in care with the family. Also, staff might wish to discuss family members' comments or impressions about the patient, because often a first clue that a nursing home patient is dying will come from a family member who asks, "Do you think he's dying?" he suggests.

"Some things an experienced staff person might notice is if a person is going back and forth to the hospital with repetitive aspiration pneumonia, and each time the person is coming back worse," Vandenberg says. "Or maybe the person has pressure ulcers you can't heal despite your best attempts, or maybe the person is losing weight or has lost the ability to do activities of daily living."

A third step is for a physician to use a terminal prognosis tool to confirm staff and physician impressions about a patient's prognosis, he says.

There are good prognosis tools available that were developed based on evidence-based procedure studies, including tools for predicting prognosis in chronic obstructive pulmonary disease patients, cancer patients, and dementia patients, Vandenberg says.

"If nursing home staff feel a patient is reaching that point of futility, but they need affirmation of their hunch, then they can use these tools, looking at a variety of parameters that the tool asks them to check and see if their hunch is right," he says. "There may be a few staff members at the care planning meeting who say, 'I wonder if we're doing anything good for old Bill and his dementia,' and then they can use the tool."

Most important, health care providers need to be alert to changes that might be a sign that a nursing home patient has reached the stage where a hospice referral or a switch to palliative care is needed, instead of aggressive curative care, Vandenberg says. "The goal is to improve the quality of their end-of-life care in these facilities," he adds. ■

Insurance costs may rise as soft market hits bottom

Prices in the commercial insurance industry, which declined steadily in 2004 in the first yearlong soft market since 1998, may be showing signs of a rebound, according to a new survey. The information comes from the Risk and Insurance Management Society (RIMS) in New York City. The group's RIMS Benchmark Survey is the industry's only comprehensive survey of current policy renewal prices as reported by corporate risk managers.

In late 2004, RIMS predicted that underlying economic conditions should ensure that insurance capacity remains at levels that would discourage a pricing freefall. Prices in General Liability and Commercial Property lines appear to be fulfilling those forecasts.

Prices in both lines showed signs of firming during the first quarter of 2005 compared to the decreases experienced over the previous several quarters. Property lines saw prices continue to decline at a rate of 3.5%, but that was in sharp contrast to a nearly 10% decline reported in the fourth quarter of 2004. General Liability actually experienced a slight increase in pricing of 1.1%, potentially presaging a return to a period of rising premiums for that line, reports **Daniel H. Kugler**, RIMS vice president of membership.

"We have consistently predicted that this soft market would probably be short-lived and relatively shallow, especially compared to the extremely deep and prolonged soft market of the 1990s," he says. "We'll wait to see if we return to the go-go pricing of the last hard market, which we doubt right now, but for the time being, pricing seems to be showing signs of stabilization."

Directors and officers (D&O) liability prices seem to offer a microcosm of a market potentially in transition, he says. The initial reports show that prices declined significantly for the first quarter, down 8.1%. But anecdotal indications from the market suggest that larger programs, such as programs for Fortune 500 companies, have seen D&O prices either flatten or even increase.

David Bradford, editor-in-chief at Advisen, the New York survey company that conducted the research for RIMS, says most of the major lines seem to be showing some sign of rebounding. "We have to wonder, however, if this is the bottom, the beginning of the bottom or a brief respite ahead of another round of large decreases," he says. "We doubt it is the latter. Premiums may go a bit lower yet, but it feels like the market is testing its lower bounds." ■

Survey: Patients struggle with drug compliance

One in three (33%) U.S. adults who have been prescribed drugs to take on a regular basis reported that they often or very often are noncompliant with the treatment regimen, according to a recent Harris Interactive on-line survey. In addition, nearly half (45%) of the respondents said they have failed to take their medications because of concerns they had about the drugs

themselves, and 43% reported having not complied with their regimens because they felt the drug was unnecessary.

The survey of 2,507 U.S. adults was conducted between March 16 and 18, 2005, for *The Wall Street Journal Online's* Health Industry Edition.

Of the 63% of adults who have had prescription drugs prescribed to them in the last year — drugs that should be taken regularly — nearly two-thirds (64%) reported that they have simply forgotten to take their medication. Eleven percent said this has happened "often" or "very often." Other top reasons respondents cited for noncompliance with their treatment regimens include:

- I had no symptoms or the symptoms went away (36%).
- I wanted to save money (35%).
- I didn't believe the drugs were effective (33%).
- I didn't think I needed to take them (31%).
- I had painful or frightening side effects (28%).
- The drugs prevented me from doing other things I wanted to do (25%).

"These barriers leading to noncompliance present significant challenges to physicians and the U.S. health care system as a whole that will be difficult to address," says **Katherine Binns**, senior vice president of health care research at Harris Interactive. ▼

Telehealth can affect staff retention, job satisfaction

A three-year study conducted by the Pennsylvania Homecare Association in Lemoyne and Penn State University was designed to evaluate how telehealth affects not only patient care but also home health's ability to continue providing care during the nursing shortage. In addition to looking at agency workloads, this study assessed home health nurses' attitudes toward their jobs and their response to telehealth. A total of 1,241 surveys were distributed to home health agencies participating in the study, with a total of 629 surveys returned. Respondents were asked to score their responses on a scale of 1 (low) to 5 (high). Results include:

- Job satisfaction was high, with an average score of 4.18.
- Nurses' involvement in telehealth activities is low, with an average score of 1.9. The majority of nurses report they perform telehealth activities less than once per week. This can be attributed to the fact that many agencies use a small core group of nurses to perform telehealth activities.
- The average score for perceived usefulness of telehealth is 3.57. The longer the home health agency has been using telehealth, the more useful the nurses perceive it to be.
- Overall, nurses indicate organizational support for telehealth is in the midrange, with an average score of 3.76.

Study coordinators also looked at the relationship between telehealth and nurse retention rates. A measurement of the annual turnover rate for each of the 34 participating home health agencies was taken. Data show the following:

- Voluntary turnover rates for RNs in this sample of home health decreased from 17% in the first year of the study to 13.4% in the second year.
- The lowest turnover rates were found in home health agencies that have implemented telehealth, estimated at 11%, as compared to 19% for agencies without telehealth. ▼

AMA updates (P4P) principles and guidelines

The American Medical Association (AMA) has updated its principles and guidelines for pay-for-performance (P4P) programs. Among the updates are changes that cite the need to pilot test before implementing pay-for-performance programs so as not to penalize physicians based on factors outside the physician's control.

"The primary goal of any pay-for-performance program must be to promote quality patient care," said AMA secretary **John Armstrong**, MD,

COMING IN FUTURE MONTHS

- Legal issues that could affect your job
- Ensuring that case management continues throughout the continuum
- Ways you can work efficiently and effectively
- Disease management techniques that work

on announcing the updates. "Some so-called pay-for-performance programs are a lose-lose proposition for patients and their physicians, with the only benefits accruing to health insurers. We believe that pay-for-performance programs done properly have the potential to improve patient care, but if done improperly they can harm patients."

At its annual policy-making meeting, the AMA also adopted a policy recognizing the shortage of physicians and said it will work to bring more physicians into the work force and shortage areas, and to create medical school and residency positions in or near areas with shortages of physicians and/or specialists. ■

CE instructions

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

CE questions

5. At Keystone Health Plan Central, the manager of disease management "owns" the quality measures related to what area or areas?
   A. pediatric immunization
   B. tobacco cessation
   C. diabetes
   D. all of the above

6. Approximately what percentage of the physicians using Blue Shield of California's Internet-based consultation system are primary care physicians?
   A. 25%
   B. 50%
   C. 75%
   D. 100%

7. What is a key safety item for every home care nurse, according to Carrie Krueger RN, BSN, clinical director of home care services at Cincinnati Children's Hospital Medical Center?
   A. laptop that requires a password
   B. pepper spray
   C. police escort
   D. cell phone

8. When making a call with the "duress signal," what should a home care nurse NOT do, according to tips from Cincinnati Children's Hospital Medical Center's employee safety program?
   A. Hang up the phone before the police arrive.
   B. Give location.
   C. Stay calm.
   D. Give patient's name.

Answers: 5. C; 6. C; 7. D; 8. A.

CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■