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APRIL 2006
VOL. 17, NO. 4 • (pages 37-48)

Wellness programs keep employees healthy, reduce health care costs

CMs can launch a 'grass-roots effort'

As employers grapple with rising health care costs, they're starting to realize that the key to cutting costs is to keep their employees healthy, rather than waiting until there's an illness to manage, says **Connie Commander**, RN, CCM, ABDA, CPUR.

"When I meet with employer groups, they tell me that they know they have sick people and those with chronic illnesses, but they also want programs that are focused on wellness. If you can prevent someone from getting ill or prevent an exacerbation, it will save money and it's cost-effective in the long run," adds Commander, owner and president of Commander's Premier Consulting Corp., and national president-elect of the Case Management Society of America (CMSA).

Employee groups already know the positive outcomes of keeping their employees working. They have more productive hours, and they don't have to bring people in to cover for someone who is sick, she adds.

Employers know they can't prevent their employers from being in accidents or getting colds, but they do realize that they can encourage people to alter their lifestyles to stop smoking, lose weight, eat better, and exercise more and, when they do get sick, to follow their treatment plans, she adds.

"Employers are asking for the medical field to teach their employees to be more healthy. It's a quality-of-life issue that affects everybody's bottom line," Commander says.

When Commander worked with managed care organizations in the mid-1980s to 2003, some companies would reimburse people or give them a reduction in premium if they joined a health club or engaged in other healthful behavior. They referred to themselves as health maintenance organizations because they did just that, she adds.

"In the '90s, disease management was a huge initiative, and everybody was going to hit all these populations and educate them. The expectation was that once you gave people information and sent them

reminders about what they needed to do that they would be compliant," Commander explains.

The emphasis on health maintenance has come full circle from the infancy of the HMO industry, she says.

"Some companies had gotten away from the health maintenance piece, and now they're coming back around," Commander says.

Employer groups have begun to approach insurers, looking for ways to keep their employees healthier, cut down on absenteeism, and make sure the employees are well and able to perform 100% when they're on the job.

"In the face of rising health care costs, more and more companies are seeing the value of promoting healthy lifestyles at work. Our on-site programs give employees convenient access to health screenings and education right at their workplace," says **Terri Kachadurian**, MS, manager of work site health promotion for Health Alliance Plan (HAP), based in Detroit. **(For more on HAP's employee wellness programs, see related article on p. 41.)**

Employer groups are determining that, instead of cutting benefits, the best way to address rising health care costs is to keep their employees healthy in the first place, adds **Sarah Weiser**, PhD, director of employer health partnerships at Blue Cross and Blue Shield of North Carolina, based in Chapel Hill. **(For a look at their efforts, see related article on p. 39.)**

"We help them determine where to focus on wellness efforts. A lot want to do the right thing but don't know where to start," she says.

"Ask anybody in the health field, and they'll tell you that health maintenance affects the bottom line in a positive way," Commander adds.

With the emphasis today on obesity, diabetes, and rising health care costs, the time may be ripe for an emphasis on wellness activities, she says.

"It will be a huge initiative. We didn't get to this place easily. It's going to be a slow boat to turn around. We have to start somewhere. We can't just focus on people who become ill," Commander points out.

Employers still are looking for the magic wand that will help them reduce heath care costs, says **Catherine Mullahy**, RN, BS, CRRN, CCM, president of Options Unlimited, a Huntington, NY-based case management company.

"We've tried case management, disability management, disease management, and predictive modeling to see if we can find the people who are likely to be sick down the road. Now may be the time to see if we can do health and wellness programs," she says.

But employers who already are feeling the pinch of rising health care benefit costs may be reluctant to spend more money on wellness programs, Mullahy points out.

"There's not a lot of data on return on investment for health and wellness activities, and it may take a long time for the effort to pay off. Employers are spending dollars on catastrophic cases and may not have enough left over to pay for wellness programs," she says.

That's where case managers come in, adds Commander.

As they work with patients who are chronically ill or catastrophically injured, case managers

Case Management Advisor™ (ISSN# 1053-5500), is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Case Management Advisor**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (ahc.customerservice@thomson.com). Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. For approximately 18 CE nursing contact hours, $449. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

Editorial Questions

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should take the opportunity to work with them on preventive measures, she notes.

"What we need to do is go back to the grass roots and teach people to be more healthy. It's a shift back to what we knew when our grandmothers told us to eat our vegetables," Commander says.

All of the publicity about the shortages of flu vaccine and the potential for an avian flu pandemic has spurred a hand-washing phenomenon, she reports.

As she has traveled around the country, Commander has noticed the increase in the number of people who are carefully washing their hands in airports now that there is a big concern about the spread of avian flu.

"In one airport, I saw a child with a bottle of hand sanitizer washing her hands. People are trying to prevent themselves from getting sick, and it's happened because of their awareness about the flu," she says.

The same kind of educational effort on weight management, diet, exercise, and smoking cessation can make a difference, and case managers have the opportunity every day to educate the people with whom they are working and their family members, Commander adds.

"Wellness could become a grass-roots campaign. Case managers may be focusing on a disease or a specific injury or illness, but they can use that opportunity to educate not only the individual but other family members," she says.

If a case manager has a client who has had a stroke, has coronary artery disease, and smokes, that client already fits into a disease management program.

"But what about the family members? We should be doing some wellness education with them. We, as case managers, should use the opportunity talking to families and significant others to help educate them on lifestyle changes," Commander says.

Many people are not aware of the risks associated with their behavior. Case managers have a great opportunity to heighten their clients' awareness of a healthful lifestyle and to help them understand that the choices they make today can affect their health in years to come, she adds.

"Maybe they can start eating one nutritionally sound meal a week. As case managers, we can motivate people; and as we focus on adherence to treatment plans, we can also help them adhere to a wellness plan," Commander says.

A typical health plan takes claims data, sorts them by DRG, and determines the members who quality for disease management programs, Commander points out.

The health plan sends information to people eligible for the program. The health plan may refer these members to the company web site and call them to remind them it's time for a vision exam or other procedure, she adds.

"Population management gives people a lot of information, but it doesn't motivate the individual. They need this individual approach from a case manager to help them follow the treatment plan. They could be in denial. It's a huge challenge to get people to make lifestyle changes," Commander explains.

"So many people are working two jobs to put food on the table. We've got to come up with ways to motivate them," she says.

If someone doesn't have time to work out, suggest that they get up during commercials and work out. Encourage them to take a break at work and walk up and down the stairs. Maybe they'll do it once this week and twice next week.

Go one step further and focus on prevention of the chronic disease with the entire population, Commander suggests. Send out a newsletter for the rest of the family or pick an educational topic, such as walking for health, and send out information each month or each quarter.

"If a case manager is coordinating the care of a diabetic with five family members and there are two other diabetics in the family, he or she should look at the other three to see if there are ways to keep them from becoming diabetic," she says.

Reinforce the idea of a healthy lifestyle, including regular checkups, exercise, and proper diet.

"You may get more leverage because the family member has someone who is ill in front of them and they can see the effects of the disease," Commander says. ■

Tailor-made initiatives meet needs of employers

Factor employees' conditions, other issues

Recognizing that employee groups are not all the same, Blue Cross and Blue Shield of North Carolina offers customized health and wellness programs for its employer-group customers.

"We're not a one-size-fits-all employee wellness program. We go to the employee to find out their

needs and design a package for them," says **Sarah Weiser**, PhD, director of employer health partnerships.

For instance, some groups have told them that the printed materials are likely to end up in the trash because the employees don't read well. In those cases, the Chapel Hill, NC-based health insurer may set up a slide presentation on a health issue in the company's break room or bring a speaker on-site to discuss a particular condition.

In one company, where 30% of the employees speak Spanish, the company brought in Spanish-speaking staff for a presentation.

The company started its health and wellness promotions with employer groups two years ago, based on requests from some companies who wanted help in keeping their employees healthy.

"We realized a need to work more closely with employer groups to help address rising health care costs at the group level. The companies know that instead of cutting benefits, the best way to address increasing costs is to keep employees healthy in the first place," Weiser says.

When the insurer begins working with an employer group, the company conducts a two-hour interview and develops a group assessment profile that includes what has worked in the past, how they reach out to employees, any employee publications, and buy-in from senior and midlevel management.

"We have different kinds of employee populations and employers that are in different places on the continuum. Some are providing only a health fair. Others have fairly sophisticated wellness programs. When we meet with them, we look at ways we can partner with them to leverage their resources," she says.

For instance, the company ascertains whether the supervisors will let people off for wellness activities at the work site and whether they have an occupational health nurse or wellness coordinator on-site. Employer groups are interested in return on investment and often want to know what they can do that will make the biggest impact in the shortest time, Weiser says.

"We show them research that indicates wellness activities do pay off but it is over two or three years. We know that a health fair doesn't magically save costs but that incentive programs and changing behavior does make a difference, and a health fair is a good place to start," she says.

Before Weiser's team suggests a wellness strategy to an employer, it conducts an in-depth analysis of the company claims data to determine which conditions are driving the company's health care costs and compiles a list of the five top conditions affecting employees along with key opportunities for improvement.

"We look at conditions that are cost-drivers but can be impacted at the work site. If there are a lot of people with back problems, there is an opportunity to do something about that. If there are a lot of employees with asthma, we would recommend a workplace asthma initiative," she says.

Weiser suggests that the company offer incentives that encourage their employees to sign up for a program, pointing out that a $50 initiative can drive participation in a program.

The first step in the insurer's employer health and wellness initiatives is to suggest programs that already exist but that the employees may not be using.

"We want to leverage existing Blue Cross programs and work on ways to increase employee participation in the programs," Weiser says.

For instance, if diabetes is a significant issue, the company mines its data to determine what percentage of employees already are in the diabetes disease management program.

"We advise the employer about the program and work with them on educating the employees about the program at the work site. If the situation with the employer group is appropriate, we will bring a presentation to the site," Weiser explains.

The health plan often brings a display of materials about a particular program and sets it up outside the company cafeteria, supplementing the company's materials with information from sources such as the American Diabetes Association.

In other cases, the company's case managers and diabetes educators have presented a 30-minute program on diabetes for employees, handing out free glucometers or, in some cases, pedometers to emphasize the importance of exercise in keeping diabetes under control.

"We can put together a whole campaign on diabetes, including an information session by a clinical person, information about our disease management program, newsletter articles, posters, fliers, and tools for a Diabetes Awareness Day," she says.

The efforts begin with resources already being offered by Blue Cross and Blue Shield of North Carolina and are supplemented by other resources, such as information provided by a pharmaceutical company, or community resources, such as smoking cessation courses provided by the American Lung Association.

The programs are tailored to the individual

needs of the companies.

For instance, when claims at a textile company showed that migraine headaches were a big problem, the company sent a representative to the break rooms at five plants to talk about the BCBSNC migraine disease management program and help people enroll.

When appropriate, the company reaches out to the family members of employees.

For instance, as part of the men's health program, Blue Cross and Blue Shield of North Carolina sends information home addressed to "Someone Who Loves . . . John Doe."

"We know that women tend to drive health care decisions more than men. We use these techniques in a couple of groups so that the women will encourage their spouse to participate," Weiser says.

The on-site programs represent a good opportunity to educate employees on disease management and case management programs for which they may qualify, she notes.

"Many people are either not aware of the program or they don't understand how helpful it can be. We offer members with chronic diseases the opportunity to work one-on-one with case managers on a personalized plan," Weiser says.

Many times, the employees don't understand disease management or case management and suspect that they'll have to pay for the program.

"These on-site presentations are a very effective way in getting employees engaged. We allay their anxieties and reinforce the ways their health plan can benefit them," she says.

Bearing in mind that family members of the employees also may be big consumers of health care costs, Blue Cross and Blue Shield of North Carolina encourages employers to invite family members to health fairs and presentations.

"When we do a health fair or mini-booth on specific topics, we make it clear that family members are eligible for the program. The employers recognize that family members do drive some of the costs. Most start with their own employees and move on to the family members," she says. ■

On-site wellness programs are popular with employers

Companies see effort as a value-added service

The first year that Health Alliance Plan (HAP) offered on-site wellness programs for employer groups, the Detroit-based health plan implemented programs at 20 companies.

Four years later, in 2005, the company set up about 400 employee wellness programs at 194 companies.

"Our employers come to us, looking for ways to keep people healthy and reduce health care costs. Employee morale, recruitment, and retention are all factors that companies consider when they launch a wellness program," says **Terri Kachadurian**, MS, manager of work site health promotion.

HAP expects to host work site health promotion for even more companies in 2006, she adds.

Companies are looking at absenteeism and productivity, as well as presenteeism, which means an employee is at work but not working at full capacity because of an illness or a condition such as a migraine headache, she says.

HAP offers a wide spectrum of wellness activities, in some cases just filling in the gaps in the programs the company already has. For other firms, HAP develops comprehensive wellness programs.

"We try to understand the company and what their resources are so we can get a better handle on their needs," she says.

The programs run the gamut from on-site health screenings to educational lectures on health and wellness topics.

Many of the on-site services are provided by vendors, local hospitals, or visiting nurses which HAP contracts, but in some cases, the insurer's nurse case managers will talk to the employee groups about managing their conditions.

HAP provides reports to the employers that include aggregate health screening data, such as how many employers were screened for hypertension along with the number with high-, medium-, and low-risk factors. All of the personal information about employees is kept confidential. HAP doesn't give the company any individual health information, Kachadurian reports.

"When we have enough participation in any given employer group, we can report aggregate data to them. Often we don't go back to the same group of employees and do the same service, which makes it difficult to provide employers definite outcomes data on the effectiveness of the program," she says.

Often, an on-site health screening will prompt the employer to sign on for more wellness activities, Kachadurian points out.

"If we find a high level of any risk factors, we encourage the employer to provide additional

programs," she says.

Some of the companies invite family members to attend the on-site wellness programs.

"Reaching out to all our members is important. An employee has a spouse and children, and we want to reach all of them," she says.

HAP often offers a small incentive to members who participate in wellness programs and encourage employers to offer bigger incentives.

"We find it really boosts participation when we offer an incentive. As an HMO, regulations limit us to providing a token gift. Employers can give rewards with a higher dollar value, which motivates even more people," she says.

In addition to on-site services, HAP encourages its employer groups to promote iStrive for Better Health, a customized on-line health improvement program offered directly to members.

HAP promotes iStrive to the members through its publications, on the web site, and through employer groups. Swin Cash, captain of the Detroit Shock, the Women's National Basketball Association team, is the plan's celebrity spokeswoman for the iStrive program.

Participants fill out an on-line health risk assessment and receive immediate feedback on how to adopt healthier habits. They are offered the opportunity to sign up for one of six lifestyle behavioral change programs — weight management, smoking cessation, nutrition improvement, stress management, chronic disease management, and back pain.

When members sign up for a lifestyle program, they fill out a detailed assessment of lifestyle and behavior relating to that particular program. The questions are designed to determine motivation to change, barriers to change, and other factors needed to create a personalized plan of action to address the issue. "No two health improvement plans are alike. The member receives a newsletter tailored to the individual and e-mails to remind them of healthy behavior," she says.

The recommendations reflect potential barriers to achieving health goals, such as motivation to change, lifestyle factors, and emotional obstacles to changing health behavior.

Members receive a $5 gift card to a chain restaurant offering healthful food for completing the online health risk assessment and a $25 gift certificate to sporting goods or grocery stores for completing at least one of the follow-up programs.

"We believe in prevention and think it's important for our members to get appropriate preventative services and be as healthy as they can be," Kachadurian says. ■

GUEST COLUMN

Certification unifies CMs in diverse field of practice

Multiple credentials can complement each other

By **Kim Schuetze**, ACSW, CCM
Chair-Elect, Commission for Case Manager Certification (CCMC)
Rolling Meadows, IL

Case managers come from a variety of professional backgrounds and practice in a number of specialized areas. They may work in hospitals, outpatient environments, insurance, third-party providers, or home health, or may specialize in nursing, behavioral health, social work, vocational rehabilitation, physical therapy, or occupational therapy. With this rich professional diversity, case management provides an important cohesive element.

My own professional background is social work and for the past several years as a hospital social worker. My responsibilities and duties include working with families — particularly parents of ill and injured children — to assess their needs and provide access to resources. In addition, I am part of a multidisciplinary team that also includes physicians, nurses, and other care providers. I am proud of my background as a social worker and my credential from the Academy of Certified Social Workers (ACSW). Recognizing my role as a patient advocate and a steward of care resources, I also became a Certified Case Manager (CCM).

With these two credentials, it may appear that I am wearing "two hats." In truth and practice, however, I see them as completely complementary, one enhancing the other. Moreover, I believe that as a CCM, I have effectively leveled the proverbial playing field with nurses and other caregivers, finding more common ground between their practice areas and mine.

More importantly, I know that *both* professional credentials — as an ACSW and CCM — hold me accountable to higher standards. My decisions and actions must be weighed against professional standards and codes of ethics (including the Code of Professional Conduct for Case Managers, adopted by the Commission for Case Manager Certification).

As any case manager who has other licenses or credentials, I am always cognizant of the standards of my field — as well as the professional criteria and ethical practices of being a CCM. At all times I am aware of the legal, ethical, and moral consequences of what I do — including how and with whom I communicate.

For example, in a hospital environment, there is the potential for confidential information about a patient, family situation, or aspects of a case to be discussed and communicated. Often, this sharing of information is necessary as a multidisciplinary team addresses the needs of the patient and/or family. Unnecessary or frivolous sharing of information, however, is strictly forbidden and against ethical practice. If I were only a social worker — not licensed or certified — then I could face dismissal from my job should I violate the standards or code of ethics of my place of employment. Certified as a social worker and a case manager, however, I face the more serious consequences of the loss of my license and my certification.

These consequences are neither punitive nor limiting of my ability to perform my job, to be a strong advocate empowering patients and their families or to help facilitate communication between the various parties on the treatment team. Rather, I see these ethical and professional standards as elevating what I do, reminding me of the importance of every decision and action I take and commanding the respect of other professionals with whom I work. I view licensure and certification as a source of pride.

In social work and in case management, we deal with a very vulnerable population. There can be subtle violations of ethic standards: an off-handed comment, information that is shared indiscriminately with a colleague. Through certification, I am constantly reminded that my role is to protect the consumer and the public. There is no doubt where my priorities lie.

For all of us in the case management field, the certification and licenses that we bring to the table unify us. We appreciate the fact that we come from variety backgrounds; that we practice differently with specialties that enhance the way we carry out our responsibilities. As certified case managers, we are bound by common professional standards that bring ethics to the forefront of all our practice actions.

*(Editor's note: **Kim Schuetze**, ACSW, CCM, is the Chair-Elect of the Commission for Case Manager Certification (CCMC). Schuetze, who has spent more than 10 years in health care and hospital social work, currently is a hospital social worker at Kosair Children's Hospital in Louisville, KY.)* ■

Reduce hospitalization rates with these tips

Top performers share best practices in national study

As performance improvement programs and the ability to track data and trends from outcomes-based quality improvement reports have become more sophisticated, home health agencies report improvements in all categories, except hospital readmission rates.

That lag was the primary reason hospital reduction was chosen as the topic for a national home health study conducted by the Briggs Corp. and cosponsored by the National Association for Home Care & Hospice and Fazzi Associates Inc.

"The national average for hospitalization from the home health care setting is 28%," points out **Robert Fazzi**, Ed.D, president and CEO of Fazzi Associates, a benchmarking and consulting company in Northampton, MA. While the average has not changed significantly in a negative direction, it also has not improved over the years, he adds. "We wanted to identify the best performers, the agencies that were in the top 10% of this category, and document what strategies they were using to reduce their hospitalization rates," he explains.

After identifying and contacting slightly more than 700 agencies that are in the top 10% of agencies with the lowest hospitalization rates, more than 200 agencies were resurveyed in the final stage of the study, which focused on specific strategies used to reduce hospitalization.

"While 333 agencies responded to the first contact with descriptions of strategies they used, we went back to the final 205 because they were intentionally using these strategies in an effort to reduce hospitalization," he explains. "We did find that the most successful agencies used multiple strategies rather than only one," he adds.

The most prevalent strategies used to prevent hospitalization by study participants were:

- **Fall prevention.**

The elderly population cared for by home health makes fall prevention a high priority for many agencies, Fazzi points out. A total of 66% of survey

respondents use environmental assessment of the home, evaluation of medications that can cause dizziness, and identification of balance difficulties as key efforts to prevent injuries from falls, he adds.

• Front loading.

The most unexpected strategy to make the top of the list was front loading, a method used by 64% of agencies in the study, says Fazzi. "These agencies identify patients at risk for hospitalization and adjust their visit schedule to see the patient more frequently in the first few weeks after admission," he explains.

The staff at Washoe Home Care in Reno, NV, attribute their agency's hospitalization rate of 17% to front loading. "We work closely with the hospital discharge planner to identify high-risk patients and we meet with the patients before their discharge," reports **Martina Petersen**, RN, interim director of the agency. "If home care is appropriate for the patient but we think the patient and the caregiver will need extra support, we schedule extra visits in the first two weeks to provide extra care and education," she explains.

• Management culture and support.

Sixty-one percent of agencies in the study identified their organization's culture as a key factor in reducing hospitalization, Fazzi says. "All staff members are involved and no person puts a 2 p.m. crisis on hold. Everyone addresses a patient's problem as soon as possible so that the patient doesn't feel like he or she needs to go to the hospital for care," he explains.

"All of our staff members know that outcomes matter," says **Patricia Fleming**, RN, chief clinical officer for VNA of Rhode Island in Lincoln. "Outcome data are presented every two months to our board members, every quarter to our quality council and every month at our supervisors' meeting," she says. Supervisors share information with their staff members and outcome data are posted on bulletin boards, she adds.

Before you can share outcome information, you should ensure that someone is reviewing and evaluating the data on a regular basis, Fleming points out. While she is the point person for reviewing the data, all staff members become involved in identifying areas that need improvement and tactics to improve outcomes.

• 24-hour availability.

Answering services, nurses on call, and triage teams are used by 59% of the study participants to keep patients at home, reports Fazzi. "Some agencies even offer a guarantee of a returned call within one half-hour," he says.

"We are fortunate that our hospital has an RN-staffed answering service for patient calls after hours," says **Eileen Sube**, manager of regulatory compliance for Conemaugh Home Health in Johnstown, PA. "The nurses use standardized protocols developed for our patients to triage the patient," she says. The protocols include questions to help identify the cause of the patient's symptom and offer suggestions on what the patient should do, she adds. "If the nurse believes that the patient needs attention beyond the protocol, home health nurses are on call to make phone contact or visits to patients."

• Medication management.

Because medication can affect a patient's risk for falls and different medications can interact with each other to create unanticipated complications, 59% of agencies in the study focus on accurate lists of medications that patients are using and regularly review this information, Fazzi says.

"Our patients may be on as many as 20 different medications, so we check medications every time we visit the patient," Fleming says. Nurses and therapists are instructed to go through medications at each visit, update lists in the chart, and check for contraindications with software on their laptops, she explains. "We tell patients to place all of their medications on the kitchen table so we can be sure to see everything," Fleming adds. "The only way we can avoid complications from medications is to check the medications every time and make sure patients understand what they are taking and how they should take it," she says.

• Case management.

Fifty-two percent of study participants use case management to manage patient care, says Fazzi. Having one person who oversees a patient's care, no matter how many disciplines are involved, increases the likelihood that a change in condition or symptoms that indicates a decline will be noticed, he adds.

While her agency doesn't use case managers, Sube points out that the use of a primary nurse for each patient also is effective. "Our nurses are responsible for between 10 and 25 patients that they visit," she reports. "The nurses are also responsible for receiving communications about the patient from other staff members, such as therapists, who visit the patient."

Because the primary nurse knows the patient well, she can identify changes or symptoms that might indicate a problem that could lead to hospitalization, she says.

• Patient and caregiver education.

"We revised the teaching handouts that we have always used for patients and have found that improved education reduces trips to the emergency room and the hospital," Sube says. A total of 48% of the participants in the hospital reduction study reported that patient and caregiver education was crucial in their efforts to reduce hospitalization.

"We've always used written handouts for patients and their caregivers, but two years ago we rewrote the handouts to use lay language rather than medical language," explains Sube. "We also increased the size of the type to 14 points and we used bullet points and short sentences," she adds. The one-page handouts that are designed for different conditions clearly spell out signs and symptoms for which patients should be looking.

"By explaining the disease and by clearly and simply describing early warning signs of trouble, we are able to better educate the patient and caregiver," she continues. Patients say that they refer to these handouts more often because they are easy to read, she adds, and nurses reinforce the information in the handouts by using them as teaching tools during visits.

Best strategies are low cost

"It is interesting that the top strategies don't cost a lot of money," Fazzi points out. "These strategies don't involve investment in technology or additional staff, but they do require development of policies and staff education," he says.

Other strategies such as telemonitoring did not show up as top strategies but that doesn't mean they aren't effective, Fazzi adds. Only 8% of study participants used telemonitoring as a hospital reduction strategy. That parallels the fact that only 5% to 10% of all agencies in the country use the technology, he says. When more agencies are using telemonitoring for their patients, it might become a more frequently reported strategy, Fazzi predicts.

"We have used telemonitoring for any of our patients with chronic conditions that may require extra monitoring," says Fleming. By using a telemonitor to capture and transmit information, such as blood pressure, weight gain, and oxygen levels, nurses are able to intervene before the patient reaches a crisis point, she explains.

Home health managers are fortunate that so many data on outcomes are collected and available in a benchmark format, but it is important to use the information to initiate improvement, suggests Fazzi. "Home health managers need to look at Home Health Compare, see where they rank in relation to other agencies, choose a quality improvement project, and set specific targets to reach. Studies that share best practices can help agencies identify ways to reach their goals," he says. ■

Balance EOL care between customized processes

Tools are key part of a successful approach

Quality professionals and the organizations that evaluate them place a great emphasis today on standards — core measures, evidence-based practices, and consistent processes. A dynamic seemingly at odds with this emphasis is the fact that patients are individuals, with unique needs and desires about their care.

Nowhere is this individuality more of an issue than in end-of-life (EOL) care, as evidenced in a recent study published in the *Journal of the American Geriatrics Society*[1], which examined different ethnic attitudes. For example, the study found, many Arab Americans would prefer not to go to a nursing home as they near the end of their lives, while many African Americans are comfortable with nursing homes and hospitals. Many Hispanic people are strongly concerned about dying with dignity. And many white people don't want their families to take care of them, but they — like members of other racial and ethnic groups — want their families nearby as they live out their last days.

"One of the most important findings in our study is that there are so many different points of view, it is important for health care providers to treat everyone as an individual," says lead author **Sonia A. Duffy**, PhD, RN, research investigator with the Center for Practice Management and Outcomes Research at the Veterans Affairs Ann Arbor (MI) Healthcare System, and with the departments of Otolaryngology and Psychiatry at the University of Michigan Medical School, also in Ann Arbor.

Individual patient concerns can affect their attitude on anything from pain management to theology, adds **Annette Carron**, DO, director of palliative care services at William Beaumont Hospital in Royal Oak, MI. "Certainly there are all kinds of fears about addiction and side effects from pain medication," she notes. "Some families

have barriers and are even uncomfortable with morphine."

"As far as standardization, truthfully, we've tried to look at standardizing EOL [end-of-life] care, and it's not as easy to do because everyone is unique," says **Dawn Snyder**, RN, MSN, clinical nurse specialist in palliative medicine at Geisinger Medical Center in Danville, PA. "Each individual at the end of life may have different symptoms, and everyone has a unique way of dying."

Still, observers agree, there are some common approaches — and even tools — that can be promulgated in an effort to provide the highest quality of care for EOL patients. These include patient survey tools, pain management, and a common approach to all patients — honesty.

"One of the reasons we did focus groups [as part of our study] was for tool development," notes Duffy. "We came up with 40 concepts from the literature, asked about them, and looked at new concepts that emerged from the study."

What were some of the concepts? "What I try to learn in any given moment is what the patients are wanting in terms of heroic measures," she says. "That can be very specific — many may not want a respirator, but they *do* want antibiotics."

The goal of the tool is to home in on key attitudes — a "culturally transparent" survey, says Duffy. So, for example, a typical question might be: "If you had only six months to live, would you be in favor of having life-extending care or going home and being with your family?"

"We will always ask, 'In your situation, what goals are important, and how can we help you accomplish them?'" Carron points out. "Some patients want to spend as much time as possible at home with their family and have hospice come in; others want to spend Christmas with them, and we can try and have Christmas early, if need be."

Staff ask patients to write down six short- and long-term goals. "We ask them what's important," she explains. "For example, who do you want to be with? Yesterday, an elderly woman said she really enjoyed crossword puzzles, but that her vision was now blurred. Something as simple as an ophthalmologist consult and some eye drops solved the problem." Carron adds that the goals are revisited periodically, as the patient's condition changes.

Duffy agrees that it's important to revisit patient goals. "In EOL care, things are very dynamic, always changing," she notes. "A lot of times, people get better when they are not expected to, or perhaps a cancer has spread to the brain. Then it's time to talk again."

It's a big issue if the patient's goals of care are not defined, Carron emphasizes. "They may unfortunately go through testing, CPR, intubation processes they never wanted, and that's significant from a safety issue as well," she says. "We try to make it easier to process, so at least if they have an advance directive we get it on the chart and the physician looks at it. That then translates into an order."

No need for pain

One area of EOL care in which there is clear standardization is pain management, says Snyder. "There is standardization as far as assessing pain on a regular basis, treating and reevaluating it; these are JCAHO requirements," she notes.

Beyond that, Snyder ventures into an area that is gaining ever-greater credence in palliative care circles. "There's really no reason for patients to have pain," she asserts. "If people are fearful [of opiates], it indicates a lack of knowledge. "Residents and attendings are fearful, and they don't need to be. Once you have the knowledge and experience, you see that opiates are safer to use than Tylenol."

"Undertreatment of pain is a real quality issue," Carron asserts. "Most of the time, it is a myth that patients will have shortness of breath. Absolutely, patients can be kept pain-free; a lot more education is needed in terms of pain management, as well as in equi-analgesic dosing, like converting Tylenol or Vicodin to morphine." (Guidelines, she says, are available from the American Academy of Hospice and Palliative Medicine at www.aahpm.org/sites/.)

"The key is giving the right dose for the first dose," notes **Judith A. Dobson**, MSN, CHPN, a hospice/palliative care consultant in Danville, PA. "The way you start out on opioids is, you just don't pick a number based on how sick the patient is or what they tell you their pain number is. If they've never had morphine before, start with a very small dose; in IV, that's 2 mg, orally, five to 10. Then you sit with the patient, and in 15 to 20 minutes, you see how much their pain is relieved by that dose. Then, perhaps, you add another one. If you picked a number out of the air and gave 90 mg the first shot, yes, it will depress respiration. If you give it the right way, the body becomes very used to it quickly."

One of the biggest challenges, she continues, is the fear that whatever patients are given could cause addiction. Patients have this fear, says Dobson, and "doctors and nurses do not have the right education and still believe if they

give OxyContin or morphine, the patients will become addicted. It's just not true; there are genetic, psychological, socioeconomic, and environmental reasons people become addicted. Yet, most people fear prescribing for those reasons, and patients fear taking those medications."

One way to overcome these fears is with a key approach recommended by Dobson and others: honesty. "The best thing is to let people prepare," she says. "For example, when a person gets lung cancer, it's generally not curable. All the treatment that's given extends life, gives more quality of life, and gives time. Still, the first time you see a doctor and he has bad news for you, whatever it is, it's important the patient is given the truth in that they are told they have a life-limiting disease."

In other words, Dobson suggests, tell the patient you are pulling out all the stops, but you want them to know the condition will take their life sooner than they may have thought. "People don't give up hope when they hear honesty," she insists. "They can look long-range and decide, for example, how to prepare their kids. They may, for instance, want to make a video for every coming birthday, or plan for college."

Other changes can be made to improve the quality of EOL care, says Dobson, For example, she offers, "We need to get more palliative care units into hospitals, because that's where people die the worst deaths." One of the major obstacles, she notes, is financial. "We need legislation that gives us an award like an ICD-9 code for quality end-of-life care," she suggests. "We do not get rewarded for a good death."

Still, there are significant efforts being made. "We started 3½ years ago with an inpatient consulting service," says Carron. "Now, we are in the process of hiring a full-time nurse practitioner and some dedicated chaplains and social workers."

The inpatient consulting service involves a team of palliative care physicians. "You have to ask for a consult from them," she notes. "But even now we address physical, spiritual, and emotional needs, advance care planning, and any family or financial and placement issues. We have full pastoral care, so we bring in people with similar backgrounds, or social workers who know the patient's culture. We also have interpreters available."

Qualified individuals are critical, Snyder notes. "If you are working with a palliative care department, find someone certified in the field — there are board certifications now — to ensure quality of care," she recommends. "They will have more state-of-the-art knowledge."

From a hospital quality standpoint, adds Carron, palliative medicine is best served in the whole service line of care — outpatient, inpatient, nursing, home care settings. "You need good communication of goals of care across the setting," she says. "The whole continuum of care needs to be addressed."

To help ensure patients' wishes are fulfilled, "Get the advance directives on the first [computer] screen — right with their insurance number and emergency phone number," Dobson recommends. "You also need more than one surrogate. Have a form that asks, if your surrogate can't do the job, or is out of the country, please name a 'number two.' Also, indicate where the patient wants to die."

Finally says Dobson, begin your preparations early in the care process. "Referrals to hospice are coming late because people did not start to have discussions with patients early enough," she says. "You're supposed to have six months' [lead

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 **June** 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. ■

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time], and we're getting about 27 days."

How can this problem be addressed? "Docs need to learn how to say the tough things with kindness and compassion and say them up front," Dobson says.

She recalls with appreciation the physician who treated her mother. "He said to her: 'Mrs. Brennan, you have a life-limiting disease because of this [breast] cancer, but there are many things we can do to help you. You can have chemotherapy, and surgery; we will stay with you, take care of the symptoms you have, and when I realize there is not any more we can offer you and you are getting close to the end of your life, we call that comfort care only. I will tell you when that is.' Five years later, he says, 'Do you remember when I told you that?' Even though she had dementia, she said she remembered, and he said, 'Now is that time.' And she said, 'I understand.'"

This type of advance preparation eases transfers to hospice. How can you tell when "that time" has come? "There are clinical guidelines you can use that indicate when someone has about six months to live,"[2] says Dobson. "When that time comes, it's only fair to the patient and their family that they should know."

References

1. Duffy SA, Jackson FC, Schim SM, et al. Racial/ethnic preferences, sex preferences, and perceived discrimination related to end-of-life care. *J Am Geriatr Soc* 2006; 54:150-157.
2. Medical guidelines for determining prognosis in selected non-cancer diseases (second edition); published by the National Hospice and Palliative Care Organization. Web site: www.nhpco.org/templates/1/homepage.cfm. ■

CE*questions*

13. According to Sarah Weiss, PhD, research indicates that wellness activities pay off for employers over what period of time?
    A. Immediately
    B. Over two to three years
    C. Over four to five years
    D. Never

14. Health Alliance Plan members who complete an on-line health risk assessment receive what incentive?
    A. $50 cash
    B. $25 gift certificate to a sporting goods store
    C. $5 gift card to a health chain restaurant
    D. No incentive is given

15. What was the most unexpected strategy to make the top six strategies used by home health agencies to reduce hospitalization in the National Home Health Hospitalization Reduction Study, according to Robert Fazzi, Ed.D?
    A. Patient education
    B. Front loading visits
    C. Use of community resources other than home health
    D. Fall prevention programs

16. According to Annette Carron, DO, from a hospital quality standpoint, palliative medicine is best served in what care setting?
    A. Outpatient
    B. Inpatient
    C. Nursing home care
    D. In the entire service line of care

Answers: 13. B; 14. C; 15. B; 16. D.

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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. ■