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Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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HIV-AIDS can affect treatment for chronic, catastrophic diseases

Work closely with a specialist for optimum outcomes

If you're managing the care of a patient who has a comorbidity of HIV or AIDS, keep in mind that the patient is likely to have issues that other patients with the same condition do not.

"AIDS puts a different spin on how to manage most comorbidities. It is a disease that overshadows other illnesses, and it takes a lot of maneuvering to manage it effectively," says **Donna Stidham**, chief of managed care for the AIDS Healthcare Foundation, with headquarters in Los Angeles.

Patients with HIV-AIDS who have chronic comorbid conditions or catastrophic illnesses are set up for developing opportunistic infections, says **Morris Harper**, MD, chief medical officer of HIV-AIDS & Hepatitis Associates in Waynesburg, PA.

For instance, a patient with congestive heart failure who experiences a buildup of fluid in his or her lungs is at risk for developing pneumonia. A patient with a spinal cord injury and HIV-AIDS is at high risk for pressure ulcers.

"If patients have comorbidities, along with HIV-AIDS, they need to be especially careful to take their medicines," says Harper, suggesting that case managers come up with ways to help them remember, such as pillboxes.

Stidham suggests connecting patients who have AIDS with providers who understand the disease and the toll it takes on the body's systems. For instance, if the patient has diabetes, he or she will get the best care from an endocrinologist who has some experience with HIV.

"The way a disease presents is complicated by HIV. If a physician has had some experience with HIV, he or she is better equipped to diagnose and treat patients," she says.

Harper recommends that patients with HIV-AIDS be followed medically by a clinical specialist certified by the American Academy of HIV Medicine.

"An HIV-positive patient needs to be followed closely and should

have an excellent rapport with the primary care physician. Caring and sensitive mental health professionals definitely need to be involved in the patient's care," he says.

Case managers should develop a good relationship with the patient's primary care physician or the HIV-AIDS clinical specialist and alert them if they have any concerns about the patient, Harper suggests.

"If the patient seems to be acting a little different, the case manager should communicate these differences in attitude and/or behavior to the physician. HIV-positive patients oftentimes have financial, social, mental, and housing-associated issues and problems. These accompanying problems can cause some patients to miss taking their medications. When this happens, it does not take much for them to get into trouble. It is better to err on the side of being cautious," he says.

It is essential that case managers build their base of knowledge about AIDS so they can work closely with the patients. It's especially important for case managers who work with patients in rural areas to be familiar with the disease so they can help educate the physicians, Stidham says.

"In rural areas, physicians are likely to have only one or two patients with AIDS and may not be managing those patients according to best practice standards. It's not that they're bad physicians, but they usually don't have access to the latest updates, and the case manager can be invaluable in helping the physician access information on the Internet. Case managers can be a helpful link between the patient and the provider if they know what the resources are," she says.

The cornerstone of good management of a patient with HIV-AIDS is developing a plan of care and helping the patient stay adherent to the prescribed medication regime, Stidham says.

With the advent of new drugs, adherence is easier than it used to be when it was necessary for patients to take as many as 40 pills a day, but it's still imperative that patients are compliant, Harper says.

"We now have 21 different drugs to treat HIV-positive patients. Some patients can take medication only once or twice daily," he adds.

The drugs used to treat AIDS are so complicated, the regime is so sensitive to resistance, and the drugs have so many interactions with other drugs that someone with expertise needs to be managing these patients, " Stidham says.

Case managers should make sure the patient is adherent to the treatment plan and be aware of what medications the patient is taking.

"People with AIDS need someone who is good at coaching them to be adherent. The drugs aren't easy to take, and the patients may get ill on them, especially when they are first starting. The toughest part is to keep taking something that makes you feel terrible," she says.

Medications for people who are HIV-positive will work if the diagnosis is made early and the patient stays on his or her medication, Harper says.

"We have known for some time that if patients miss taking 10% of their medications, they began to develop resistance, and if the appropriate medications are not changed, the resistance will continue to grow. We now believe that if patients

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Editorial Questions

Questions or comments? Call **Mary Booth Thomas** at (770) 934-1440.

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Editor: **Mary Booth Thomas**, (770) 934-1440, (marybootht@aol.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@thomson.com).
Senior Production Editor: **Nancy McCreary**.

miss 5% of their medications, they can develop a low-grade resistance," he says.

Patients who have HIV-AIDS may have adverse drug interactions, Harper points out.

Get a pharmacist involved in managing the patient's care to ensure that the drugs the patient is taking for the disease or condition you are managing are not contraindicated for his or her HIV-AIDS medication, he suggests.

This becomes even more critical for the HIV-positive patient on a salvage or deep salvage regimen (a treatment regimen for people who have few or limited anti-HIV drug options) and at the same time is being treated for multiple comorbidities and/or opportunistic infections," Harper adds.

It's important for patients with HIV-AIDS to feel as though someone cares about them, Harper says.

"So much of the outcome of HIV care revolves around the patient feeling good about himself or herself and feeling like someone cares if he or she lives or dies," he says.

That's where a case manager can make a lot of difference, particularly with patients who don't have a support system at home.

Monitor your patient's lab reports to make sure their immune system and other factors are within a normal range, suggests **Gene Bundrock**, MS, RN, CCM, statewide director for AIDS Healthcare Foundation's Positive Healthcare Florida disease management program.

"Lab data are a very good gauge. As the immune system weakens and the CD4 comes down to 350, people with AIDS need to be on antiviral therapy," Bundrock says.

CD4 levels, or T-Cell counts also are important to monitor. A person with AIDS can develop a serious opportunistic infection once the count drops below 50.

Resources

- AIDS Healthcare Foundation: www.aidshealthcare.org.
- Positive Healthcare: www.positivehealthcare.org.
- Centers for Disease Control and Prevention: www.cdc.gov/hiv/.
- American Academy of HIV Medicine: http://aahivm.org/.
- Association of Nurses in AIDS Care: http://www.anacnet.org/.
- National Institutes of Health: www.aidsinfo.nih.gov/
- Johns Hopkins AIDS Guidelines: http://hopkins-aids.edu/guidelines/guidelines.html.
- The Body: The Complete HIV/AIDS Resource: http://www.thebody.com. ■

DM program keeps AIDS patients out of hospital

One-on-one education is the key to success

An intensive one-on-one case management program helps people with AIDS stay adherent to their medication regime, avoid hospitalizations and emergency department visits, and learn to self-manage their disease.

Positive Healthcare Florida, the disease management program of the AIDS Healthcare Foundation, is the only NCQA-accredited disease management program for HIV-AIDS in the country. The program received a score of 98.4% out of a possible 100% during the survey.

RN care managers with extensive HIV-AIDS expertise oversee the care of 10,000 Medicaid patients with AIDS across the state of Florida.

"We've been successful because of the intense one-on-one and face-to-face work with the patients. The nurses follow them closely and develop a wonderful rapport. The core of our program is education and one-on-one coaching to improve the patients' quality of life and to keep them out of the emergency department and out of the hospital," says **Gene Bundrock**, MS, RN, CCM, statewide director for AIDS Healthcare Foundation's Positive Healthcare Florida.

The field-based care managers work out of their homes and manage the care of patients in the counties in which they live. They work closely with the patients' physicians, often accompanying patients for their office visits and working with them to coordinate care.

"Positive Healthcare takes a different approach to disease management. We do a lot of face-to-face assessments. The care managers get to know the provider and work closely with them. They meet with social service agencies in the community and incorporate them in the plan of care," says **Donna Stidham**, chief of managed care for the AIDS Healthcare Foundation.

Publicly supported patients with AIDS present a challenge to providers. They are poor. Many don't have telephones. They often live with relatives and move around a lot, Bundrock says.

The program uses representatives from the community who help find patients and call the care manager. The representative makes an appointment for the patient with the care manager, who sees him or her within three days.

"Our care managers will meet with them anywhere — the home, the doctor's office, in a restaurant, or even under a bridge. We'll go anywhere the patient feels comfortable and where their confidentiality won't be breached," Stidham says.

When new patients are identified for the program, the nurse contacts them and makes an appointment to see them, preferably at their home.

"It helps the nurses manage the care if they can see their patients in the home environment and become aware of their living conditions. Some don't have electricity. Others may not have a refrigerator or cooking facilities. It helps us tailor a care plan when we can see firsthand what the patient is facing," Bundrock says.

Patient assessments

The care managers conduct an extensive assessment that categorizes patients by severity level and acts as a guideline for the number of interventions the patient received. They determine the patients' needs and barriers to care, such as transportation, and get a consent form allowing them to go into the physician's office and examine the patient's medical record.

"These patients are not good historians on previous hospitalizations. They may know they had a cough but not whether it was pneumonia. Our nurses examine the medical record to find out what we need to know to manage the disease," Bundrock says.

The care managers zero in on patients with a high acuity level who are frequently hospitalized, not adherent to their medication regime, and are substance abusers.

"Once the nurse has seen the patient in person, some of the work can be done telephonically. She might not need to see patients every month if they are doing OK, the lab work looks good, and she knows they are being adherent with their medications," Bundrock reports.

The disease management nurses remind patients if they have physician appointments, check to see that the appointment has taken place, and visit the physician office to review the chart. They give the patient a pillbox to help them organize their medications and stress the importance of taking the medication until the physician discontinues it.

Because confidentiality is an issue with AIDS patients, Positive Healthcare mails AIDS-related educational materials only to patients who have given their permission. Otherwise, introductory and follow-up letters are very generic.

The care managers know their community well, often serving on local health planning councils. They know the practitioners in the community and know how to guide their patients through the complex medical system to get help.

The care manager can mine the database for claims data and talk to the physician if a patient is making frequent trips to the emergency department.

"These patients have a lot of mental health issues as well. Depression is a huge problem, and many are on psychiatric medication. Physicians can't get the patients interested in caring for themselves until their mental status is stable," Bundrock says.

Dental care is another problem for AIDS patients on Medicaid.

"The state doesn't pay for dental work of any kind, but Medicaid patients still get toothaches. We try to get them access to dental care so they won't go to the emergency department or hospital with an infection that's the result of a dental problem," he says.

A team of nurses and an LPN care partner manage the care of the population in each area. The LPN takes care of telephone calls and other reminders for patients who are on severity level 1, allowing the care manager to concentrate on the more complex patients who are in and out of the emergency department, helping them avoid admissions.

For instance, AIDS medications often cause adverse reactions until the patient gets used to them, causing trips to the emergency department for pain and nausea. The care managers encourage them to try alternatives.

Working with physicians

"Now instead of going to the emergency department when they start a new medication and have cramps, they call the care manager who helps them understand that it might be a side effect of the medication. They suggest that they use an over-the-counter medication rather than going to the emergency department," Bundrock explains.

The care managers work closely with the physicians and nurses in physician offices to make sure that the patients are getting the recommended care. They refer any problems they spot to Bundrock or the medical director, who contacts the physician and educates him or her about evidence-based guidelines for the treatment of HIV-AIDS.

Positive Healthcare holds six educational programs a year in each region, informing physicians about the latest information from the scientific community.

"We stay up on new treatment regimes and make sure the physicians know about them. A bad regime can have a bad outcome, which in turn can cost hundreds of thousands of dollars," Bundrock says.

Physicians in the AIDS Healthcare Foundation's disease management programs work with the physicians who care for the patient.

"They don't want to interrupt the physician-patient relationship but they do want to enhance the physician's access to knowledge about the condition," Stidham says.

In California, the AIDS Healthcare Foundation began operating one of the first Medicaid managed care programs specially designed for people with AIDS in California in 1995. The foundation has recently received approval to operate a Medicare Advantage plan, allowing the patients to get their drugs through Medicare Part D.

The Medicaid program covers the sickest of the sick, only people with AIDS. HIV-positive patients are not eligible.

The state of California compares the foundation's costs to the fee-for-service Medicaid program and splits the savings with the foundation on a 50-50 basis.

"Our patients have always had better outcomes, shorter lengths of stay, and less cost that the fee-for-service patients," Stidham says.

Patients in both the Medicare and Medicaid programs are assigned an RN case manager who has HIV expertise. All of the primary care physicians and specialists in the network have experience working with people with AIDS, and the formulary is designed with people with AIDS in mind. ■

Program helps HIV-AIDS members over obstacles

Disease takes precedence in CM programs

When the state of New Jersey mandated that health plans establish a case management program for their publicly insured members with HIV-AIDS, Horizon-NJ health plan went a step further and put a nurse who is experienced in HIV case management in the position.

"It's not just a matter of putting a nurse in a seat when you develop a program of this caliber and scope. You need to have the right professional in charge, someone with expertise in managing the care of people with infectious diseases. We felt that to increase quality of care for these members, we needed someone with more expertise," says **Pamela Persichilli**, RNC, director of clinical operations for the Trenton-based health plan.

The plan provides case management for approximately 1,300 members, about 60% of whom are HIV-positive, while the rest have AIDS.

Patricia Havercamp, RN, BSN, senior case management consultant, coordinates the care of all members with HIV-AIDS, even if they are eligible for another disease management program.

"If a member has comorbidities, the HIV program takes precedence. They may get the diabetes education piece from the diabetes program, but their care is coordinated by the HIV-AIDS case manager," says **Cathy Kelly**, RN, BA, CMCN, CPUM, manager of utilization management.

When one of the HIV members becomes pregnant, her care is coordinated by the high-risk obstetrics case manager, who works very closely with the HIV case manager.

"We have a very robust multidisciplinary team that meets every two weeks to discuss the patients with comorbidities," Persichilli says.

The purpose of the care management program is to educate the members about their disease, to identify any barriers to care, and to encourage the members to be compliant with their medication regime so they will avoid emergency department visits and hospital admissions, she explains.

"The whole mission and philosophy of our organization is to expand our partnerships with community organizations in order to inform our members and overcome obstacles to care. A population that is publicly insured has so many obstacles that they don't know where to get help," Persichilli says.

Horizon-NJ health plan does everything it can to ensure that its members with HIV-AIDS get the care they need, including allowing an infectious disease specialist to serve as the primary care physician for this population.

The reason is twofold: AIDS is such a complicated disease that patients really need a specialist to provide their care. In addition, the patients are more likely to go to the infectious disease clinic than to another provider.

"In the case of these members, the specialist becomes the primary care provider. They get

their flu shots and other care at the infectious disease clinic. This is not a population that will go to multiple places to receive care," Kelly says.

Havercamp collaborates with the infectious disease physicians, social workers, and case managers in the infectious disease clinic, working with them to develop a treatment plan and reinforcing what the patients hear at the clinic.

"Trying to manage HIV-AIDS without a connection to an infectious disease specialist is almost impossible. It has to be a partnership, and you have to make an effort to build a close relationship with the specialist," Kelly says.

When new members with HIV or AIDS are identified, the case manager gets in touch with the member by telephone, educates him or her about the disease and treatment options, and encourages the member to see an infectious disease specialist.

The program is part of Horizon NJ Healthcare's longitudinal case management program, which stratifies members into categories based on the disease process.

Havercamp uses an assessment tool and utilization data and stratifies members based on their needs.

For instance, someone who is in and out of the hospital frequently would be a high-risk patient and would receive intensive case management, while someone who is compliant might get an occasional telephone call.

A newly diagnosed AIDS patient is stratified to a higher level until the case manager feels the member understands the disease and the treatment regime.

As a general rule, the case manager talks to members monthly, but members who are in the most severe level may receive a phone call once a week or even every day.

The case manager works with the infectious disease clinic on a treatment plan that both of them reinforce. The most important component is encouraging the members to be compliant with their medication regimes, Kelly adds.

"The clinics really like having our case manager reinforce what they are saying to these patients. I just got a letter from the HIV care manager at an infectious disease office saying that we are making the physician's job easier by helping our members learn to navigate the system," Persichilli says.

The clinics reciprocate, helping the case manager get in touch with the members and encouraging their patients to work with the case manager.

"Sometimes members don't want to talk to us, particularly when they are newly diagnosed. We see the infectious disease clinics as our go-between because it's one place that the members do go," Kelly says.

The health plan is promoting education of people who may be infected and not know it.

"The biggest increase in the AIDS population is among heterosexual females. We've had several healthy young women who ended up in the hospital in critical condition because they didn't realize they had HIV and got an opportunistic infection," she says. ■

Customer service key to patient satisfaction

Respond to complaints, utilize survey trends

Anyone who works in retail knows that customer satisfaction is the key to repeat business, leading to a more successful financial future.

Customer satisfaction also is just as important to a home health agency's successful future, according to home health managers who have focused on improving their own agencies' patient satisfaction programs.

A continuous staff education awareness program, inservices to better prepare staff members to handle complaints from patients, and hiring the right staff members for the job all contributed to the Press Ganey Compass Award won by Mercy Homecare in Cadillac, MI, for a significant improvement in patient satisfaction scores, says **Maureen Hayes**, RN, professional service manager of the agency.

"All staff members worked together to make customer service a part of our agency's culture," explains Hayes. "Customer service became a part of every meeting's agenda, all new employee orientations, and inservices that were designed to help employees address patient's individual concerns," she says.

Because staff morale affects the level of customer service you can provide, some processes and staff positions were restructured to better use staff members' talents, says Hayes. "We focused on hiring the right people for each job, whether it was a case manager or a physical therapist," she says. "By making sure the employee is handling a job for which he or she is best prepared, we improved everyone's enthusiasm because no one felt like

Courtesy and smiles project good image

Effective telephone etiquette necessary

People who choose home health care as their profession are caring, people-oriented professionals, but home health managers should not assume that being caring and friendly always results in the best customer service, say experts.

The patient's perception of the quality of care begins with the first telephone contact, points out **Karen Marshall Thompson**, RN, MS, administrator of Southern Ohio Medical Center Home Health Services in Portsmouth. "We train all of our employees on telephone customer service and we teach everyone to answer the phone with a smile," she says. Even though the caller cannot see the smile, there is a difference in the tone of your "hello" when you are smiling, she points out.

"We do provide some scripts for employees to follow when answering questions and we teach key words to use in telephone conversations that show the caller that we are listening to them and we want to help them," says Thompson. The most effective thing staff members learn in telephone etiquette training is to close every call by asking, "Is there anything else I can help you with today?" she says.

"Patients are often surprised by this question because it shows that we are not trying to rush them so we can move on to something else and that we are willing to spend time with them to handle their question," Thompson points out. "It is a great way to end a telephone call because the patient feels good when the call ends," she adds.

When employees do receive complaints, it is important that they know how to handle them, points out **Maureen Hayes**, RN, professional service manager of Mercy Homecare in Cadillac, MI. "We teach everyone that a concern or complaint from a patient is an opportunity for us to improve, not a reason for us to become defensive," she says. "It is important that every patient concern or complaint be reported to a supervisor or manager so that we can identify trends and find ways to address complaints," she says.

Employees need to feel comfortable reporting complaints and that means they have to know that there are no repercussions for reports, says Hayes. Even if a complaint appears to be directed at an employee, such as a nurse arriving late for a visit, there may be factors beyond the nurse's control, such as traffic at that time of day, which can be addressed by a revision of the schedule, she points out.

"We remind nurses that many of our patients are anxiously awaiting the visit as a social experience, as well as a health care visit," points out Thompson. "Our nurses call the evening before the visit to confirm a time so that the patient knows when we plan to be at their home," she says. "If a nurse does have a visit run longer than normal or if the nurse is running ahead of schedule, he or she will call patients to let them know of the change in schedule," she says.

The telephone calls demonstrate that nurses do respect their patients' time, says Thompson. "If the nurse is late and the patient has heard nothing, the patient assumes that his or her visit has been forgotten," she says. "Once a nurse realizes that he or she is going to be late, it just takes a few minutes to call patients to reassure them that they are not forgotten." ■

they were overwhelmed or forced to cover for someone else," she says.

After reviewing patient concerns on satisfactions surveys, Hayes' agency discovered a trend in dissatisfaction with physical therapist availability. "We added physical therapists to our staff to better meet patients' needs and satisfaction scores for that service increased," she says.

While patient satisfaction scores and comments are discussed at all staff meetings, and posted for all staff members to read, Mercy Homecare emphasizes the importance of customer service by developing customer service competencies that must be met for each position.

Along with spelling out what customer service activities each person must demonstrate in their job, inservices that teach each staff member how to handle complaints were also developed, says Hayes. "We teach everyone how to accept the complaint and listen carefully, then we tell him

or her how to refer the complaint for resolution," she adds.

Mercy Homecare's process spells out the staff members' responsibility to report a complaint to a supervisor, case manager or other appropriate staff member to make sure the complaint is not ignored or lost in a shuffle of paperwork, says Hayes. "We make it clear that reporting a complaint is an important part of providing care to that patient," she adds. "We don't make it a punitive process, we make it a learning process," she says.

High return rate means accurate data

When reviewing your patients' satisfaction with your service, the real challenge is to make sure you get a good return rate on your surveys, says **Karen Marshall Thompson**, RN, MS, administrator of Southern Ohio Medical Center Home Health Services in Portsmouth. "You need at least a 25% return rate to ensure reliable data," she says. "We increased our return rate by addressing the survey to a specific person," she explains. While it does take a little extra effort to personalize each letter with a survey, return rates do go up because patients like the personal touch and it doesn't make them feel like they are just part of a mass mailing, she explains.

Another simple way to increase survey return rates is to make sure that you have the patient's correct address, Thompson points out. "We often get their primary address for insurance purposes, but sometimes a patient might stay with family members during the home health episode or they might move during or immediately after we provide care," she explains. "All of our nurses know to communicate with the business office so that surveys will be mailed to the correct location."

"Keep your survey short," suggests Thompson. "We have a one-page survey that is succinct and easy to complete, and we include a postage-paid return envelope," she says. By keeping it simple, you further increase the chances the survey will be returned, she explains.

Once you get the surveys back in your office, look for trends in order to prioritize areas you need to improve, recommends Thompson. "People are generally satisfied with home health care but we are always looking for ways to improve because we are in a very competitive market," she says.

"Our patients think that their ability to reach us 24 hours each day is very important and when we noticed some ratings in this area that were not as high as we wanted, we looked at how we handled evenings and weekends," says Thompson. "We had always used an outside answering service for on-call and we tried a number of different services but we always had problems with missed calls or delays in getting messages to nurses," she says.

Thompson found the answer to her on-call answering service dilemma with her hospital's switchboard. "We analyzed the number of calls we actually received on weekends and evenings and we showed that the extra number of calls for the home health nurses would not result in a need for more switchboard operators and would not affect the operators' ability to handle hospital calls," she says. "Our home health phone line now rolls over to the hospital switchboard operator after-hours, and the operator will take messages and page nurses," she explains.

"We discovered that the hospital switchboard operators were perfect for this task because they are trained for customer service, they are accustomed to anxious callers, they know how to stay calm, and they are used to paging people," explains Thompson. "Our patients and our nurses are very happy with this change, which did improve our ability to respond to patients 24 hours a day," she adds.

At Mercy Homecare, patient satisfaction has improved because customer service has become an integral part of the agency's culture, says Hayes. The change didn't happen overnight but it can be accomplished, she says. "Just keep talking about customer service — don't make it a once-a-year topic for a meeting — make customer service a standing agenda item for every meeting that occurs in the agency." ■

AAOHN platform to focus on safety, wellness, career

Hazard preparedness, workplace violence addressed

In creating the public policy platform that will guide its efforts through 2006, the American Association of Occupational Health Nurses (AAOHN) includes priorities that reflect the changing role of occupational and environmental health nurses and the changing world in which they work.

This year's public policy platform carries over the major policy priorities identified in 2005 —

working conditions for health care workers, workplace violence, and health promotion and wellness — and adds emphasis to the evolving role of those in occupational and environmental health nursing.

The topics included in the policy platform this year are:

• **All hazard preparedness.** Occupational and environmental health nurses play a critical role in helping employees, businesses, and communities plan for and respond to a variety of threats that could have a potential impact on the health and safety of employees, businesses, and the community at large.

Because occupational health nurses are trained in emergency response planning, injury prevention, loss control, and other skills needed in times of disaster, AAOHN supports policy that includes the workplace as a primary delivery system in responding to and mitigating human, natural, and technological work and community threats.

• **Confidentiality of health information.** As health care providers, occupational and environmental health nurses have access to personal and work-related client health information, and with the privacy requirements of the Health Insurance Portability and Accountability Act are faced with an increased responsibility to protect the privacy of personal health information.

In its policy platform, AAOHN lends its support to the pursuit of federal legislation that would provide universal security standards and safeguards for protecting the confidentiality of personal health information without hindering employers' ability to fulfill their administrative obligations under the Americans with Disabilities Act, Family Medical Leave Act, and workers' compensation regulations.

• **Health promotion, wellness, and disease prevention.** Always the backbone of occupational health nursing, work site health promotion and disease prevention remains a central priority for AAOHN. In its policy platform for this year, it cites a Department of Health and Human Services survey of select employers offering work site health promotion and disease prevention programs, in which employers realized a median savings of $3.14 in total health care costs for every $1 invested in employee health promotion.

• **Nurse licensure compact.** Occupational health nurses, as well as nurses in other fields, are finding it more and more necessary to practice in more than one state, either because of the nature of their work or because they serve employers with sites in more than one state.

In response, many states have adopted the nurse licensure compact (NLC); states that enter the compact agree to recognize nursing licenses from other states in the compact. This allows nurses residing in compact states to practice in person or electronically in more than one state without applying for multiple licenses.

AAOHN supports the NLC because of the career flexibility it affords nurses, and for the opportunity for shared information among participating compact states.

• **Quality of work environments for nurses.** Health and safety risks to nurses are key factors in the severe nursing shortage threatening the U.S. health care system. AAOHN supports initiatives that focus on strategies to foster safe and healthy work environments for all health care professionals.

• **Workplace violence prevention.** Workplace violence accounted for 16% of all work-related fatal occupational injuries, the Bureau of Labor Statistics reported. As with job safety issues, prevention is the key, according to AAOHN's policy platform, and to that end, AAOHN supports legislative and regulatory initiatives that provide prevention techniques to businesses, communities, and health care professionals.

For more information on AAOHN's 2006 public policy platform, go to www.aaohn.org. ■

'Hospitals of excellence' outshine others in mortality

'Quality chasm' continues to grow, says report

When it comes to quality improvement, it seems that the best keep getting better, based on the findings of the latest Hospital Quality and Clinical Excellence study from Golden, CO-based HealthGrades Inc. This is the organization's fourth annual study, analyzing nearly 39 million hospitalizations over the years 2002-2004 at all 5,122 of the nation's nonfederal hospitals.

The study shows the hospitals in the top 5% (HealthGrades calls them "Distinguished Hospitals for Clinical Excellence") achieved 36% more improvement in in-hospital mortality and 40% more improvement in postoperative complications compared with all other hospitals over the years 2002-2004. Here is a closer look at the study's key findings:

• According to the study, during 2002-2004, patients at Distinguished Hospitals for Clinical Excellence experienced a "27% lower risk of mortality and 36% more improvement in in-hospital mortality" associated with several conditions.

These include cardiac surgery, angioplasty and stent, heart attack, heart failure, atrial fibrillation, chronic obstructive pulmonary disease, community-acquired pneumonia, stroke, abdominal aortic aneurysm repair, bowel obstruction, gastrointestinal bleed, pancreatitis, diabetic acidosis and coma, pulmonary embolism, and sepsis.

• According to a public release announcing the study, "Medicare patients had, on average, a 14% lower risk of postoperative complications at a Distinguished Hospital for Clinical Excellence for diagnoses and procedures that include orthopedic and neurosurgery, vascular surgery, prostate surgery, and gallbladder surgery.

"For those same procedures and diagnoses, Distinguished Hospitals improved their postoperative complication rates at a 40% faster rate than all other hospitals over the years 2002, 2003, and 2004."

The study also found that "if all patients with any of the 26 conditions studied were treated at Distinguished Hospitals during 2002 to 2004, 152,966 lives could have been saved, and 21,896 complications may have avoided a major postoperative complication."

"In qualitative terms, there is definitely a gap," says **Samantha Collier**, MD, vice president of medical affairs at HealthGrades and the report's author. "Everyone's improving — that's the good news — but the top hospitals improve at a faster rate, so that accounts for the gap. It's not closing because the best are doing a better job of getting closer to perfection."

Not surprisingly, Collier says strong leadership was a common element among top performers. "I'm inside hospitals all the time; and in terms of what predicts quality, one of the things I've personally seen is strong leadership. There are senior members [of management] who are present at all high-level quality committee meetings," she notes. "For example, if you have a cardiac quality committee made up of physicians, the CEO is present at those meetings. They want to show their staff they are as committed as if it were a financial or strategy meeting."

The boards at those hospitals actually spend a lot of time talking about quality, she continues. "Here's a simple test: In terms of minutes, how much time is spent on quality at board meetings? It should be at least 50%, or your hospital will not be a top performer."

Collier says quality managers often tell her they are having a hard time getting the information "upstairs" and creating a sense of urgency — which is another predictor of excellence. "If you work with consultants, they may make the presentation for you," she suggests, noting that consultants might actually get the board to listen to them more readily. "The quality manager should go to the consultant and ask them to talk to the CEO or ask them to make a presentation," she suggests. "Ask them to include the information you feel is most important, and to make the recommendation that quality reports need to be a part of every board meeting."

At one of the "Distinguished Hospitals for Clinical Excellence" — Baylor University Medical Center in Dallas — a "top-down" approach also is seen as a key to success, says **Irving Prengler**, MD, MBA, vice president of medical staff affairs. "Basically, our hospital — as well as our system — places great emphasis on quality and health care improvement," he declares.

But when it comes to actual improvement on the ground, including the key areas of lowering mortality rates and reducing complications, "I attribute our success to looking at many disease processes with a multidisciplined approach," says Prengler. This includes not only physicians and nurses but therapists or "whoever is involved in the type of care we are targeting," he explains. "We have also developed a culture in which people are listening to each other."

At present, the disease processes his facility is focusing on include pneumonia, myocardial infarction, congestive heart failure, as well as preventing surgical infections. "We are very active in [the Boston-based] IHI [Institute for Healthcare Improvement] initiatives such as the 100,000 Lives campaign," Prengler says.

"There is a surgical infection prevention program that people are following nationwide, which asks questions like, are you using the right antibiotics for prophylaxis? Are you giving them within an hour of incision? Are you stopping antibiotics within 24 hours to help reduce resistance?" he says. "Other measures we will be taking on include controlling blood sugars. This is easy to measure, but at the same time we have a protocol for intensive IV insulin therapy, as well as subcutaneous insulin, to try to improve outcomes."

The facility has been involved with the IHI's "rapid response team" program for several months "and it's been a very exciting initiative; it's become part of the hospital culture, and we

know it's making a difference," Prengler observes.

"They can tell you that you either need to act immediately, or perhaps you need to change the treatment plan," he explains. Prengler relates this personal experience: "I'm a hospitalist, and one day I was on the surgery floor and could see there was an emergency. I volunteered my services, but the nurse said, 'Thanks, but the rapid response team is on the way and we've taken care of it.' This showed me it was becoming part of our culture."

The facility also is dedicated to continuous quality improvement. For example, several years ago, when the core measure for giving antibiotics quickly was eight hours, Baylor's rate was in the mid-90s. "And if you look at our mortality rate for pneumonia, for example, it earned a five-star rating from HealthGrades, and we were well above the state average," notes Prengler.

Now, however, core measures ask for antibiotics to be given within four hours. "This is a little more difficult to do," he says. "Last month — our best recent month — we were at about 84%-85%, but we're still not satisfied."

Another facility recognized by HealthGrades, Delray (FL) Medical Center, has sought improvement in key quality areas through a number of strategies — including the pursuit of JCAHO certification as a primary stroke center. "Over 50% of our patient admissions have associated stroke risk factors, so we knew the community needed it," recalls **Karen Bibbo**, RN, MBA, chief nursing officer at the 407-bed acute care hospital and level II trauma center, adding that the facility received its certification last December. (The facility also received Solucient's 100 Top Hospitals Award in 2001, 2002, 2003, and 2004.)

One key part of the certification process involved the administration of the clot-busting drug tissue plasminogen activator (tPA). "We had protocols in place for at least a decade, as well as an established ED stroke call panel," notes Bibbo, "but this stroke protocol and the things that go along with it are relatively new."

What needed to be done differently? "Protocols were established to quickly identify and expedite care for these patients," says Bibbo. "There has to be seamless, standardized care, and everyone has to do it 100% of the time."

To help ensure standardization, the facility developed a "Tool Kit" that includes:

- **Clinical pathway for stroke.** This is included in the patient's chart.
- **Daily rounds by a stroke coordinator.** This includes review and analysis of stroke PI indicators and a concurrent review of each in-house stroke facilitating patient care.
- **Micromedex.** An on-line resource system for nursing that includes information about stroke, stroke care notes, and educational materials.
- Stroke discharge instructions. These are standardized but patient-specific.

Before the facility sought certification, Bibbo notes, every physician practiced the way he or she wanted to practice; nothing was set in stone. "Going for stroke certification required us to put a protocol in place for every aspect of that patient's care; we established and standardized our clinical pathways, documentation tools, testing, and treatment," she shares.

The hospital also designated a neurological intensive care unit. "Nurses got specialized training, and we round specifically when there is a stroke patient to be sure all elements of the protocol are in place and to ensure we are not deviating from standardized care," says Bibbo.

When patients present in the ED with signs and symptoms, the ED doc puts a call out to the tPA panel, says Bibbo. "We actually have a rehab

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. ■

COMING IN FUTURE MONTHS

- Opportunities in geriatric case management
- How remote monitoring of DM patients pays off
- How one health plan improved care for its SSI population
- Providing care for members with multiple comorbidities

hospital — Pinecrest — connected to us, and they can deliver care all the way through to rehab," Bibbo adds. "So we can provide a seamless transition." Pinecrest recently achieved its CARF — certified associated rehab facility — designation, she adds. "After we got ours, they went on and applied for theirs," Bibbo explains.

Delray Medical also uses the rapid response team model. This includes a hospital-based nurse practitioner, the critical care shift manager, and a respiratory therapist. "They quickly and competently respond to unfavorable changes to our inpatients," says Bibbo. The facility also is a participant in the 100,000 Lives campaign.

"We never stand still; we always want to make ourselves better," Bibbo asserts. "We monitor our data, compare it to previous months and years, to other Tenet (South Florida) hospitals, and facilities in the community. We use so many benchmarks — and most important of all, we look at our own numbers and benchmark against ourselves. This is a consistent approach we have that has helped us achieve these kind of awards and designations."

Quality managers who wish to monitor their progress toward excellence can start by asking themselves a few key questions, says Collier. "As a litmus test of where you are with regards to QI, ask yourself if all your teams are multidisciplinary," she recommends. "Are cardiovascular problems, for example, viewed as a physician issue or a system issue? If you 'silo' with people who all think alike, you will not get the best solutions."

(Editor's note: The HealthGrades ratings and Distinguished Hospitals for Clinical Excellence designations are available free of charge at www.healthgrades.com.) ■

CE questions

17. According to Morris Harper, MD, HIV-positive patients may develop a low-grade resistance if they miss taking what percentage of their medications?
    A. 8%
    B. 7%
    C. 5%
    D. 3%

18. At Positive Healthcare Florida, once a patient has an appointment with a care manager, the care manager sees the patient within what length of time?
    A. The same day
    B. Three days
    C. Five days
    D. One week

19. At Horizon-NJ health plan, Patricia Havercamp, RN, BSN, coordinates the care of all members with HIV-AIDS, even if they are eligible for another disease management program.
    A. True
    B. False

20. How does Maureen Hayes, RN, emphasize the importance of good customer service for all employees?
    A. Customer service is a standing item for all meeting agendas.
    B. Job competencies related to customer service are in place for all employees.
    C. Patient satisfaction survey results are reported to all staff members.
    D. All of the above

Answers: 17. C; 18. B; 19. A; 20. D.

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. ■