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Creative approaches help members keep asthma under control

Costs of disease top $11.6 billion a year

Health plans across the country are coming up with innovative ways to tackle asthma, a disease that costs $11.6 billion a year in direct health care costs, according to the American Lung Association.

Strategies run the gamut from working with local agencies to improve air quality in the community to visiting patients in the intensive care unit following an asthma attack.

More than 20 million Americans suffer from asthma, according to the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics.

Asthma was the primary cause for 12.7 million physician office visits, 1.2 million hospital outpatient department visits, 1.9 million emergency department visits, 484,000 hospital visits, and 4,261 deaths in 2002, the latest year from which statistics are available, according to the CDC.

The condition accounts for 12.8 million lost school days and 24.5 million lost workdays every year, according to the CDC's statistics.

In this issue of *Case Management Advisor,* we'll profile the asthma management programs of four health plans, which take different approaches to helping members keep their disease under control.

Asthma is one of the few chronic conditions that appear to go away for a period of time. The lack of ongoing symptoms prompts people to stop taking their medication, thus precipitating an asthma attack, says **Janis Sabol**, RRT, team coordinator for the asthma program at Optima Health, a Virginia Beach, VA, insurer.

The American Lung Association's National Asthma survey revealed that although patients and parents of patients say asthma is easy to control, most have a high tolerance for recurring asthma symptoms, lifestyle accommodations, and negative family impact.

Among those replying to the survey, 83% of parents of asthma patients and 75% of adult patients with asthma reported unscheduled visits to the physician over the past year due to asthma attacks.

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Most patients and parents of patients who responded to the survey believed that asthma should be treated when symptoms appear and do not recognize the difference between controller and reliever medications.

The lack of understanding of the treatment and management of asthma is present even among those with persistent asthma, the survey showed.

When asked to name a controller medication, 73% of adult patients and 79% of parents of asthmatics named a reliever medication.

"One of the reasons people are not compliant with their medication regime is that they don't see immediate results from inhaled steroids. Patients have to use them every day for a while before they notice a change in symptoms. When they use the rescue medication, they notice a difference as quickly as 30 seconds later," Sabol says.

When she talks to members about asthma management, **Amy Vissing**, RN, BSN AE/C, asthma disease manager for Passport Health Plan, compares using the controller medication to using sunscreen when you go out into the sun.

"People with asthma have sensitive airways, and they are very sensitive to things they breathe in. The controller medication helps them avoid attacks, just like sunscreen helps them avoid a sunburn," she says.

Among the misconceptions that people with asthma have is thinking that they outgrow asthma. Although the symptoms can abate as people age, once someone has asthma, they always have sensitive airways and can experience an asthma attack at any age, adds **Terry Watson**, RN, manager of Passport's health management department.

"We need to circle the wagons to get around this disease process. We have to work together because there are so many people being diagnosed," says **Pamela Persichilli**, RNC, director of clinical operations for Horizon NJ Health. ■

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Comprehensive approach includes educating docs

Decreases asthma-related admits, ED visits

Blue Cross of California State Sponsored Business takes a comprehensive approach to asthma management, partnering with the Fresno Valley Air Quality Board on ways to improve air quality in Fresno County, piloting a project to help physician practices improve their asthma treatment methods, and developing a three-tiered approach to managing members' asthma.

The health plan experienced a 60% decrease in asthma-related hospital admissions and a 46% decrease among members enrolled in its comprehensive asthma interventional program, according to an evaluation of claims for services performed between 2004 and 2006.

In an effort to reduce asthma attacks among its members, Blue Cross of California State Sponsored Business went beyond the standard asthma management programs and created a unique private-public partnership to deal with air quality issues that precipitate asthma attacks.

The health plan received the 2006 National Environmental Leadership Award in Asthma Management from the U.S. Environmental Protection Agency for its comprehensive asthma intervention program.

The health plan compiled information on hospitalizations, emergency department visits, and physician's office visits related to asthma among its members residing in Fresno County and shared the information with the local air quality board, Fresno Public Health Department, and researchers at California State University, Fresno, to see if there was a correlation between asthma attacks and air quality issues in the community, according to **Dawn Wood**, MD, vice president, medical director of the health plan, an operating subsidiary of WellPoint Inc. with headquarters in Thousand Oaks, CA.

The data showed that asthma attacks increased during the time that landfill fires were burning out of control in Fresno County.

"At the time we did the study, there were periodic fires in county landfills that burned out of control. Our data helped the county and other community partners take steps to get the fires under better control," Wood reports.

The health plan is continuing to work with the air quality board on ongoing air quality management, Woods adds.

"The landfill fires are not as much of an issue now, so the project is working to identify other air quality factors that contribute to asthma attacks," she says.

Practice improvement project

As part of its initiatives to find better ways to control asthma, the health plan is piloting a practice improvement project with five physician practices in San Francisco, says **Margot Lisa Miglins**, PhD, clinical research manager.

"We are helping physicians and their staff learn what they can do to educate the patient and family about environmental toxins, pollutants, and asthma triggers in the home, the school, and the work environment," she says.

The insurer provides the physician practices with asthma education materials to share with the members, along with pillow covers and mattress covers that the physicians can give to the patients whose asthma is triggered by allergies.

The health plan's health promotion consultant in San Francisco makes periodic visits to the physician offices, bringing them materials and working with them on practice modifications.

The project has resulted in four practice modifications that have made a big difference in improving services to asthma patients, Miglins says.

The clinics have begun to use registries for asthma patients. These are computerized databases that allow physicians to immediately identify who has asthma, how severe it is, and when the patient was last seen.

Instead of taking patient encounter notes on a blank piece of paper, the physicians in the pilot project have begun using guided, structured progress notes that prompt them with questions to ask and procedures to implement.

At least one person in each physician practice has taken a comprehensive training program and become certified to be an asthma educator. The asthma educators work with the members with asthma and those involved in their care, including schools and day care centers.

All of the practices have revitalized their procedures for involving families in the management of the member's asthma.

The health plan's asthma intervention program takes a takes a three-pronged approach to asthma management, intensifying the interventions based on the severity of the member's asthma.

When members are identified as having made an asthma-related ED visit, they are enrolled in the asthma program and screened for case management.

"Some of our members go to the emergency room two or three times during the high season when their allergies are the worse. These members most likely end up being case-managed by a nurse who helps them learn to manage their environmental triggers," says **Thi Montalvo**, MHA, senior health services analyst.

Members who have been to the emergency department receive additional interventions, including more educational material and an easy-to-read handbook covering 200 conditions and how to manage them.

Members are encouraged to call the insurer's 24-hour nurse information line if they have questions about their condition and are unable to reach their physician.

"If members are repeatedly going to the emergency room and not to the primary care physician, this tells us the member has not established a medical home. These are the kinds of members that we know interventions will help," Montalvo says.

Using claims and pharmacy data, the health plan stratifies members with asthma by risk level.

There are about 47,000 members with asthma.

All members who are identified with asthma are enrolled in the asthma disease management program and receive an educational package. The materials include an offer to send members an inhaler case, a pillowcase cover, or other asthma-related items if the members send in a form indicating that they have seen their doctor.

The plan's proactive case management and/or clinical operations specialists call patients who are at moderate risk if they have not been to the primary care physician for an office visit and encourage them to work with their doctors to develop an asthma action plan.

High-risk members go through an intensive screening process to see if they are appropriate for the asthma case management program.

"After our annual sweep of claims data, all moderate and high-risk members with asthma are mailed educational materials that focus on how to manage asthma, how to reduce exposure to environmental triggers, and the importance of going to the doctor and working with him to develop an asthma action plan," Montalvo says.

Low-risk members are eligible to receive the asthma education packet upon request. All identified members are put into the asthma registry, which tracks and trends each member's asthma condition over the years, she adds.

The case management nurse works with the physician and patient to manage the disease, prompts the patient to go for office visits, and works with them on taking their controller medication regularly and relying less on the rescue medicines.

The plan provides physicians with triplicate copies of the asthma action plan — one for its medical files, one for the patients, and one to forward to the specialist if the patient is referred to an allergist or pulmonologist.

The health plan provides primary care physicians with a member-specific asthma fact sheet to insert into the medical record.

The fact sheet includes information on emergency department visits, inpatient hospital stays, specialist visits, primary care visits, the number of times the controller medicine and rescue medicine were refilled, and any comorbidities the patient may have.

The pharmacy information helps the physicians understand how much medication their patients are using and if they are following the prescribed medication regimen.

"We encourage the physicians to utilize the information. For instance, if they see that the patient has had no primary care visits, we hope that they will take the next step and try to get the patient to come in for a visit," she says. ■

Disease managers visit asthma patients in the ICU

Members are more agreeable when in crisis

When members of Passport Health Plan are hospitalized in the intensive care unit for asthma, the plan's asthma disease managers visit them on-site and work with the hospital's asthma educator to help them learn to manage their disease.

"In the beginning, we attempted to reach the high-risk members telephonically, but the high volume of members was difficult to manage on a one-on-one basis. We decided to concentrate on members who are in the intensive care unit because they are at most risk and tend to be more willing to allow the disease manager to work with them when they receive a personal visit while they are still in the crisis mode," says **Amy Vissing**, RN, BSN AE-C, asthma disease manager for the Louisville, KY-based HMO.

Last quarter, the disease managers provided one-on-one care management to 88 members in the intensive care unit. The majority of members who receive individual disease management visits in the hospital are children.

"We have a large population of children with pure persistent asthma. The adult population tends to have emphysema or chronic obstructive pulmonary disease as well, says **Terry Watson**, manager of Passport's health management department.

The disease managers have worked with the hospital's case managers, utilization review nurses, and asthma educators, asking to be notified when a member is hospitalized in the intensive care unit with asthma.

"When we find out about a member who is in the hospital, we attempt to make a visit to the hospital and talk with the parent or guardian and the patient about the asthma. If they are in agreement, we follow them one-on-one and may accompany them on their first follow-up visit to their physician and get them connected to a specialist, when needed," Vissing says.

At one time, the disease managers provided

individual care management following reports culled from the claims data.

"That data was old, since it was based on claims. It had been two to six months since the member was in the intensive care unit. By then, their acute episode was over and we had trouble getting them to agree to continue our interventions," Vissing says.

Many of the health plan's members are transient and often are difficult to locate.

"When we meet them in the hospital, often they will give us their new phone number or their new address. That's been one of the biggest pluses for the one-on-one piece," Vissing says.

The disease managers follow the patients for as long as they need interventions, sometimes for a year or more.

"Some of the children are very severe and require a lot of interventions," Vissing says.

Passport Health established its asthma disease management program in 2000 with a goal of improving the quality of life for members with asthma and reducing unnecessary asthma-related hospitalization and emergency department use.

HEDIS data from the National Committee for Quality Insurance rank Passport Health Plan in the top 10% of plans nationally for use of appropriate medications by people with asthma.

Using claims data, the health plan divides members with asthma into five groups, based on the severity of illness and the services they have used.

All members with asthma receive a welcome package, a peak flow meter, and monthly educational mailings.

The health plan sends members with asthma periodic educational materials, such as an asthma pocket guide that explains what patients should do every day and what steps they should take in case of an emergency.

"What members don't recognize are the persistent symptoms of asthma. They can be very inconspicuous, such as frequent nighttime coughs," Vissing says.

High-risk members are those who have been hospitalized with asthma, who have utilized the emergency department, or have been admitted to the intensive care unit.

Quarterly, out of about 6,000 members with persistent asthma, about 200 are considered high risk.

Passport Health mails extra information to high-risk members, urging them to talk with their physicians about controller medications. Additionally, Passport sends letters to providers, alerting them that members have been designated at high risk, based on their utilization of services for asthma.

"We attempt to make telephone contact with adult high-risk members and tell them about the program. We have access to information about their medication. If we can't talk with them, we send them a letter saying we noticed they have not refilled their controller medication and ask them to contact the pharmacy for a refill as soon as possible," Vissing says.

The plan pays for an environmental assessment and a follow-up visit by a home health agency.

The health plan mails asthma assessments to newly identified members with persistent asthma. Last month, the health plan received 354 completed assessments.

"We're filtering through the assessment and contacting members who need more interventions," Watson says.

The asthma disease managers work closely with providers who see a high volume of members, visiting them in person, providing them with educational materials, and encouraging them to follow guidelines from the National Institute of Health's Heart, Blood and Lung Institute.

"When we go into the physician offices, we teach the staff providing asthma education to our members how to use the various types of inhalers. There are a lot of different types of devices, and the amount of medication that patient receives is directly related to how well they are able to use the device," Vissing says. ■

Asthma management program shows a 2-1 ROI

Program provides home visits for severely ill patients

Optima Health's asthma disease management program has generated $2.10 in savings for every dollar spent on members who have been continuously enrolled over a five-year period.

In addition, the Virginia Beach, VA-based program, which provides home visits by a respiratory therapist or a nurse for severely ill asthma patients, has resulted in a 20% decrease in emergency department visits.

About 10,000 of the health plan's 350,000 members have asthma. More than 60% of the members are part of Optima's Medicaid health plan.

Members are identified through claims and pharmacy data, primary care and specialist office

visits for asthma, inpatient admissions, or home health care with a primary diagnosis of asthma, according to **Janis Sabol**, RRT, team coordinator for the asthma program.

Once members are identified, they are stratified into risk levels by their resource consumption and the number of interventions their asthma has required.

Members at highest risk are eligible for a home visit by a nurse or a respiratory therapist, who conducts one-on-one asthma education and does an environmental assessment of the home, looking for mold, dust, or other allergens and offering suggestions for how the member can remediate them.

The health plan contracts with a home care agency, which sends a nurse or respiratory therapist into the home as often as necessary and assumes responsibility for coordinating the care of the member for a one-year period.

The lowest-risk members, about 80% to 85% of members with asthma, receive educational brochures and a card with the name of a contact person they can call with questions or concerns.

The case managers concentrate on the moderate- to high-risk patients, those who don't access emergency department care but have the potential to have a severe asthma attack if they don't change the way they are managing their disease.

"We are aware that you can throw a lot of time and energy into the sickest individuals. With some of the more severely ill members, we tend to be spinning our wheels. Sometimes we think we make an impact and then they end up back in the emergency room or hospital again and again. It depends on the nature of their disease, their desire to treat the disease, and their attitude toward health care," Sabol says.

When members are identified as being at moderate to high risk, the case managers call them and discuss their disease.

"We find out what medications they are taking and when, whether they've seen their doctor, if they have identified their asthma triggers, and other asthma-specific information. We ask questions to get the total picture and to offer assistance in whatever area they need most," Sabol says.

The case managers periodically check back with the members, depending on their needs, and help them overcome any obstacles to care.

For instance, one patient who lives in a rural area was supposed to be getting injections for an allergy, but her pulmonologist died suddenly and she had not been able to find another physician. The case manager helped her find a doctor and checked on her frequently until her condition was stabilized.

To overcome the transportation barrier for its Medicaid population, Optima Health Plan has contracted with a transportation service that members can use to get to and from their physician appointments. ■

Plan takes a collaborative approach to asthma

Program stretches across multiple departments

The saying, "It takes a village" applies to asthma control as well, says **Pamela Persichilli**, RNC, director of clinical operations for Horizon NJ Health.

Asthma management is a collaborative effort across multiple departments at the West Trenton, NJ, health plan, which provides care for publicly insured members.

"At Horizon NJ Health, we work together throughout all the departments in the company to provide support for our members. Our disease managers, case managers, and asthma educators work in teams to help asthmatics learn how to manage their disease. Pharmacy has a role, the medical director has a role, the provider representatives have a role. We all work together," she says.

The health plan analyzes claims data and seeks patients who have been hospitalized or utilized the emergency department and reaches out to those who are not filling their medications or are using rescue medications frequently. In addition, members may be referred by their primary care physicians, by social workers, and by self-referral.

All members who are identified with having asthma receive educational materials. Disease management nurses call the most severely ill members and work with them to manage their disease.

"We focus on utilization. If a patient is hospitalized or visits the emergency room frequently, we know they're not managing their asthma well," says **Dee Rago**, RN, BSN, director for health and wellness.

The health plan gets a list each week of members who have made a visit to the emergency department. The disease managers look at the members' pharmacy data and evaluate the member's medication therapy, looking for

opportunities for intervention.

"We've found that claims for emergency room visits hit much quicker than other claims. We can identify patients who have been to the emergency room within 14 days or less. They're still in that acute stage and are agreeable to interventions," Persichilli says.

Depending on what the results indicate, members may be referred to an asthma educator, a pharmacist, or a case manager.

"If we see someone who is utilizing rescue medications too frequently and isn't on a controller medication or hasn't been filling it as often as they should, we can contact the member and talk with them about managing their disease," Rago says.

The health plan's social work case managers, who are on site at some partner hospitals, meet with members in the emergency department and visit them in the hospital at the bedside, offering them asthma educational materials and linking with a disease management nurse they can contact with questions or concerns.

The hospital-based case managers make sure the patients are linked to a disease management nurse, often calling the nurse and introducing the patient while he or she is in the hospital.

When members are selected for individual disease management, a disease management nurse conducts a thorough assessment of the patients, their knowledge of asthma, and what they do to control it, says **Susanne Gronostjski**, RN, CCM, DDE, manager of health and wellness.

"We determine if they have the right equipment and if they know how to use it. We also find out if they have the right medication and if they are taking it as recommended. We help them identify their asthma triggers. An asthma trigger can be something as simple as carpet deodorizer or using bleach to clean, and these might create a problem for them," she says.

The goal is to find out what is causing the members' asthma attacks and to come up with interventions that can make a difference.

For instance, some members are not aware of triggers, such as room temperature that could cause an asthma attack. Many members live in housing developments where there is no individual control over the thermostat. In these cases, the disease manager suggests that the member use a room thermometer and open windows when the temperature gets to a certain level.

"We try to determine the problem or trigger and approach the problem with a solution in mind. The member may not understand what triggers the asthma attack, but we work to educate them and assist them before the trigger causes a problem, Gronostjski says.

For instance, one family lived in a basement underneath a laundry, an environment that could aggravate an asthma attack because of chemicals and mold. The damp air was precipitating a child's asthma attacks. With the help of a social worker from the health plan, the disease manager found them another place to live.

The members are assigned to a particular nurse depending on their risk level.

Through the screening process, Horizon NJ Health nurse specialists seek to match the member with the appropriate specialist nurse, Gronostjski says.

Community outreach is another component of the health's plan's asthma management program. The health plan's community educators attend health fairs and other statewide community and school events to help educate the public about asthma and other chronic diseases.

One educational tool that both adults and children enjoy is a 6-foot-tall interactive asthma storyboard that features a talking dog that tells a story about asthma in English and Spanish.

"Children and adults relate to the method of education and learn from the experience to control or manage their asthma," Persichilli says.

The asthma management nurses educate physicians about the health plan's asthma program and present asthma education programs in both English and Spanisha.

The health plan is working with state agencies in New Jersey on a program that encourages schools to get rid of asthma triggers and partnering with community agencies to make people aware of the importance of having an asthma action plan. ■

System shows diversity in rapid response teams

Facilities find ways to make the approach work

The implementation of rapid response teams in seven different facilities in the Seton Healthcare Network in Austin, TX, is a virtual "living laboratory" of the many different ways hospitals can create and implement rapid response teams — and they all seem to be working, says **Alice Davis**, RN, BSN, senior project

coordinator, medical staff services.

"Seeing seven different facilities do this — with all of them staffed differently, with each facility unique — and seeing it work everywhere — that's the thing that amazes me," she says.

In fact, the teams seem to touch both ends of the spectrum. For example, Davis notes, the first teams started in early 2004 at Brackenridge Hospital, a 150- to 200-bed facility. "They have a residency program and are a city/county trauma center, and they literally flipped it out there," she recalls. "It was not a methodical approach at all; they thought it was a great idea, they talked to the critical care nurses, sent out fliers, gave everyone the number to call, and started it up."

The team has worked well, Davis reports. Yet at Seton Medical Center, which is the largest of the facilities with about 400 beds, the approach was very methodical. "We took it to a committee, formed the team, had great representation, really deliberated a lot to try to identify all the various pitfalls that might occur, and rolled it out one unit at a time starting in July 2004," she says. In preparation, they used flow diagrams, created different scenarios that might warrant a rapid response team call, and educated every nurse on every unit. All units were rolled out by November 2004, "and it's become so firmly entrenched that the people just love it," Davis recalls.

RRT concept

Davis and her colleagues heard about the rapid response team concept from another hospital within Seton's national network and reviewed the early literature. "Our medical director came back from an off-site visit and shared that this was an initiative that would definitely be beneficial," Davis recalls. Later that same year, they joined the Institute for Healthcare Improvement's 100,000 Lives Campaign and subsequently "sequenced" each of the 100,000 Lives initiatives to assure every site had implemented each of the six strategies for improvement. "This strong message from our leadership, as well as the timeline for implementation, helped everyone focus," she says.

Davis notes that the diversity of the seven different facilities was one of the largest implementation challenges. The hospital network is comprised of one large tertiary care facility, one city/county trauma center with a residency program, two smaller facilities with surgical services but somewhat lower acuity, one children's hospital, and two critical access hospitals.

"We quickly identified that implementation across such a wide range of facilities needed localization," she says. After identifying the importance of the concept, it was adapted to the unique population and resources available locally. "In hospitals with a critical care unit and 24/7 respiratory therapy it posed primarily a staffing challenge," she notes. In these facilities, the staff quickly identified that an earlier response to a challenged patient was important and yielded an improved outcome.

At the other end of the continuum were the critical access hospitals in small communities, and the smaller sites without critical care. "They needed to be especially creative and identify all possible responders with the critical thinking and communication skills necessary to be a rapid response team responder," Davis says.

There was some commonality, where possible. "Uniformly, if a site had critical care services, they chose the critical care nurse and the respiratory therapist," Davis shares. "We did not have any physicians on our team, so you don't get hospitalists or residents."

At one of the smaller critical care facilities, they decided to rotate in different staff in the beginning, based on who was on shift. "It might be an ED nurse, a PACU nurse, or a clinical manager, based on their particular skills," Davis says. "They quickly evolved to fill the position, which was a house supervisor, and hired someone who had critical care experience and rotated out the rest of the time," she explains.

In all cases, choosing team members always began by identifying nurses who could think critically and had good communication skills. "In sites with critical care and respiratory therapy, it was obvious that those two specialties were needed to staff the team," adds Davis.

The planning and implementation processes also varied across the range of sites. At Seton Medical Center, for example, the planning team that was formulated had representation from each area and included key physician champions. "We put articles in our medical staff newsletter and nursing monthly newsletter and informed our medical executive committee and nursing leadership team of the concept and plan," says Davis. "Our work team then identified a specific unit whose acuity was high and where, at times, we had some physician reluctance to transfer to a higher level of care."

As mentioned previously, the program was spread a unit at a time. "As we spread to each

unit, we educated the nurses about the rapid response team concept and the various scenarios that would warrant calling the team," says Davis. "We eventually included areas such as endoscopy and radiology." She adds that she met very little opposition from either staff or physicians.

"We worried about meeting resistance from physicians, but they have totally appreciated having an additional skilled nurse and respiratory therapist assess and intervene on their patients and communicate clearly the patient's need," says Davis. "We also worried about communication and turf battles between the critical care responder and patient care nurse, but the rapid response team has brought increased communication and teamwork between critical and acute care. Nurses actually assemble to see what the responders think, and it's become a teaching opportunity for critical thinking skills and advanced expertise."

The nurses calling the rapid response team quickly saw it as a much needed and valuable service to summon extra help when required, adds Davis. "The responders also recognized getting to patients early would improve outcomes and reduce codes."

In all cases, she says, developing a backup plan was helpful, so if the primary responder was not available to go, there was a backup person who could be summoned.

There also is quite a bit of variation in the way the teams are called. "Some sites overhead-page, others have special pagers that responders carry, others have a dedicated phone," says Davis. The children's hospital has a pager and an elaborate system to key in the area the team is needed. Another hospital that uses the phone finds it helpful to hear about the patient's problem as they are on the way.

The average response time is between two and five minutes — far better than the established response goal of 10 minutes.

Davis says she has learned a number of lessons from this experience. "We should implement new ideas more quickly, even though our culture is to implement new programs more slowly and methodically," she asserts. "We should recognize that all physicians and staff do have improved patient outcomes at the forefront of their priorities."

The rapid response team and its implementation are evolutionary, she continues. "The first step is to assemble appropriate resources and activate them to respond to patients' needs. The second step is to assess the need for increased resources; some of our hospitals have dedicated positions to do just this and search for patients in need. The third may be to add prescriptive authority — a physician, resident, advanced practice nurse."

An important strategy, she adds, "is to evaluate the effectiveness of your team and continue to allow it to evolve to meet the need and reduce preventable mortality and complications in our patients."

For example, her staff monitors and examines all codes that occur outside of critical care. "We review these cases very quickly after the event and search for preventability in these codes," Davis says. "Were there early warning signs that were apparent before the code? Is there something that could have been done to prevent the code from occurring?"

She reports that now her team rarely finds codes that it deems to be preventable. "We measure how many CRT calls there are each month, how many codes, were those codes preventable, what was the rapid response team response time, and how long did the team spend on the unit," Davis says. "We look at the reason for the call, did they transfer to a higher level of care, what interventions did the team perform while there, and what was the outcome for the patient?"

This information is reported on a monthly basis to leadership, site safety teams, and individual units. "When our number of rapid response team calls dwindles, we re-educate and continue to promote the program," she says. ■

Be vigilant: Sharps safety still tops OSHA citations

Injuries occur with safety devices

Despite widespread conversion to sharps safety devices, hospitals are more likely to be cited for violations of the bloodborne pathogens standard than any other standard.

The U.S. Occupational Safety and Health Administration (OSHA) issued 136 citations to hospitals in FY 2006. Sharps injuries also contributed to the overall high rate of injury among hospitals.

In 2006, OSHA sent letters to 105 hospitals, cautioning them about their rate of six or more injuries or illnesses resulting in days away from work, restricted activity, or job transfer. The average rate

for hospitals is 3.4, and the average for all industries is 2.5.

"What we're seeing there is not only the nonuse of engineering controls, but also [problems with] work practice," says **Dionne Williams**, MPH, senior industrial hygienist.

For example, in one case, a facility was cited for a needlestick that occurred when an employee put an unprotected sharp in her pocket. She needed to carry it to a sharps container down the hall because no container was available in the patient care area. As she pulled it out of her pocket, she accidentally stuck another employee.

The hospital needed to have sharps containers available for immediate disposal, says Williams. But the hospital also is responsible for monitoring work practices to make sure safety devices are being used properly, she says.

Safety rounds, in which employee health or safety professionals observe everyday activities, can identify problems with work practice, she says. You also can evaluate the incidents on your sharps injury log, Williams says.

Hospitals should develop a safety culture that encourages employees to discuss potential problems in a nonpunitive environment and "to be vigilant about things they see," says Williams.

More than half (57%) of sharps injuries occur with the use of safety devices, and about 70% of those were not activated, according to the EPINet data compiled from about 48 hospitals by the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville.

With the rapid growth in the use of safety devices, it's not surprising that they would be involved in a higher proportion of needlesticks, says **Jane Perry**, MA, associate director of the center. Hospitals should evaluate injuries to determine whether better training is needed or perhaps a switch to a device with a different safety mechanism, she says.

"There are always new devices coming on the market," Perry says. "They need to be continually evaluated to see if there's a new technology that would be better accepted by the staff."

Other standards frequently cited by OSHA include personal protective equipment (PPE), hazard communication, and respiratory protection. For example, in the past year, hospitals have been cited for failing to have an available eyewash station.

"Everything in the health care facility isn't going to fall under the bloodborne [pathogens standard]," says Williams. "It's important for hospitals to make sure they're ensuring PPE for other types of hazards."

Although OSHA has been prohibited from enforcing the annual fit-testing requirement related to tuberculosis and N95-filtering face piece respirators, hospitals must follow the other requirements of the respiratory protection standard, such as annual training.

Hospitals also have significant hazards in nonclinical areas, particularly related to facility and equipment maintenance. Among the top 10 most-cited standards involve lockout/tagout, woodworking, and cadmium.

One type of violation is missing from the list. The general duty clause of the Occupational Safety and Health Act has not been used to enforce ergonomics-related hazards, despite the high number of musculoskeletal disorder injuries in health care due to patient handling.

"Because there's no standard, it makes it incredibly difficult for us to be able to cite," says Williams. "We do inspect hospitals when we get complaints, but the bar is raised very high as far as documenting for citations. We do issue hazard alert letters, which is the next best thing to get some action." ■

Hospice offers end-of life planning to community

Hospice's census rose 59% with program

Hospices sometimes find it challenging to meet a community's needs in end of life planning and bereavement services, since these are only a small part of the services a hospice provides.

But there are many benefits to expanding this area of outreach, as one Virginia hospice discovered after it opened last year, the Center for Hope & Outreach Services, a program where anyone in the community could receive bereavement services, counseling, assistance with end of life planning, and education about hospice care.

Blue Ridge Hospice in Winchester, VA, has found that an extension of community outreach and end-of-life planning has resulted in a 71% increase in its daily census, from 81 patients to 139 patients, since the center opened last August.

"We're trying to educate the community and provide resources to them about the process of planning to make end-of-life decisions," says **Lynn Gray**, LCSW, director of clinical services.

The hospice opened the Center for Hope as an expansion of existing grief and life planning services, says director **Pamela Richards**, LCSW.

For 25 years, Blue Ridge Hospice has provided grief support for people who have lost a family member in the hospice's care, she notes.

"We mail out grief support material every two or three months and offer individual counseling," Richards says. "What we've found is there are many people who needed more than that, and there are community members who would call us for grief support after someone they loved died suddenly and was not a hospice patient."

In just the past four years, the number of calls for grief counseling has increased by nearly one-third, she reports.

With a federal grant, the hospice opened the Center for Hope as a free-standing grief center that provides one-on-one counseling, family counseling, group counseling, and serves as a resource center where people can come in and get materials on grief and loss, Richards says.

The center has been so successful from the start that the hospice made plans to open two more Center for Hope sites, she says.

"The center's reception is fun by volunteers, and we have two full-time therapists and a part-time bereavement counselor," Richards says. "We also have one spiritual counselor, who is employed by Blue Ridge Hospice."

Word has spread quickly about the center's services: Through the first week of May, the center had received 529 calls from people who had experienced a loss and wanted help, Gray says.

The hospice's bereavement staff will screen calls to make the appropriate referral, she adds.

"As we continue to educate the community about our services and the word gets out about these services, the contacts grow and grow," Gray says.

"The local hospital refers people to us if they've had a loss in the emergency room," Gray adds. "And lately, long-term care facilities have referred their staff to us after they experience the loss of a long-time patient."

When the center was initiated, hospice outreach staff made 300 community contacts in six months, spending an hour discussing the center's services with funeral home directors and others, Richards says.

To save resources, the center is located within a satellite office that is used by hospice staff.

"It's located in a 100-year-old home on Main Street," Richards says. "There's a curved banister, high ceilings, wood floors, and we turned the downstairs into two individual counseling rooms, a child's play therapy room, and a group counseling room that's located in an old living room parlor."

The atmosphere is cozy and comfortable, and there's always hot tea brewing. The waiting room is filled with resource material, and there's a lending library as well, Richards says.

"It's a safe place to come and talk about your feelings," Richards says. "We have sound machines in every room by the door, and we've laid carpet and hung quilts, made by volunteers, on the walls."

Also the doors are solid wood, so the counseling rooms are soundproof, she adds.

Hospice clinical staff work in the upstairs rooms.

"The staff who work out of that office live in that area, and if there's some kind of traumatic death in the community, the next morning the staff can talk about what's going on and be prepared for fielding phone calls from the community," Gray says. "They also might help local

CE instructions

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

COMING IN FUTURE MONTHS

- Legal issues confronting case managers
- Proving the value of your disease management programs
- How specialty case management programs can pay off

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schools and police officers who might have responded to an emergency call."

Having the bereavement staff working in the same building as the clinical staff provides continuity, Gray adds.

The center's resource material has been translated into Spanish, and this has helped with outreach to the area's Hispanic community, Richards says. "We have had a significant focus on the Hispanic community and have a growing number of Hispanic referrals now," she says.

"We are convinced the center has increased awareness of hospice," Richards says. "It was a great lesson for us about how a well-organized outreach program can help you get out and educate the community."

The center's grant funding has ended, but there's the possibility of more grant money, she notes.

Meantime, the hospice is absorbing its costs into the general budget, Richards says.

The center accepts private insurance, as well as fees on a sliding scale, but it will serve clients regardless of their ability to pay, Gray says.

Family members of a hospice patient still receive bereavement services at no charge, but when someone is referred to the Center for Hope, there is expanded counseling that can be provided at a fee as small as $15 for a session to people who cannot afford to pay more, Richards says. "If they come here for end-of-life care and don't have insurance or resources, we still provide care, and it comes from the patient care fund," she explains. "We're always doing fundraising events for that patient care fund." ■

CE questions

5. Blue Cross of California has experienced a decrease of ____ in hospital admissions for members enrolled in its comprehensive asthma interventional program.
   A. 20%
   B. 40%
   C. 60%
   D. 80%

6. Out of about 6,000 members with persistent asthma at Passport Health Plan in Louisville, KY, ___ are considered high risk.
   A. 200
   B. 500
   C. 1,000
   D. 1,400

7. In identifying members for asthma management, Horizon NJ Health analyzes claims for patients who:
   A. have been hospitalized.
   B. have utilized the emergency department.
   C. Neither A nor B
   D. Both A and B

8. Each of the seven facilities in the Seton Healthcare Network in Austin, TX, implemented ___ strategies for improvement recommended by the 100,000 Lives Campaign.
   A. three
   B. four
   C. five
   D. six

Answers: 5. C; 6. A; 7. D; 8. 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. ■