Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Take a holistic approach to managing the care of your health plan members

Look at the whole person, not just the disease

Health plans are beginning to take a holistic approach to managing patient care, focusing on the member's overall health instead of just one condition or episode of care.

They're combining previously separate disease management, case management, and health coaching efforts into one program, assigning a care manager who provides continuity of care and works with the member no matter what his or her needs.

"Rather than just looking at the symptoms or the member's immediate needs, we look at the entire individual and all his or her health care needs across the continuum of care. We offer whatever interventions our members need, from wellness to illness and back to wellness," says **Steven Goldberg**, PhD, director of case management/utilization management for Regence BlueCross and BlueShield of Oregon.

In this issue of *Case Management Advisor*, we'll tell you about three programs that provide holistic care for three very different member populations.

We'll show you how Philadelphia-based Keystone Mercy Health Plan saved $6.1 million in the first year with its highly successful PerforMED program, which provides case management, disease management, and behavioral health coordination for publicly insured members.

You'll learn how the care advocates at Regence BlueCross and Blue Shield of Oregon provide whatever the member needs, whether it's help with smoking cessation, care management through an acute illness, or working with members to get their chronic conditions under control.

And we'll give you details on the case management program at Crescent PPO in Asheville, NC, where case managers conduct wellness education and make home visits as they coordinate the care for self-insured employer groups. ■

Multi-tiered model helps manage chronic diseases

Plan takes a holistic approach to care coordination

An intensive case management program that provides case management, disease management, and behavioral health coordination for high-risk, high-cost members has resulted in savings of $6.1 million in a 12-month period for Keystone Mercy Health Plan.

Members who are selected for the PerforMED program were based on their predictive risk score. The typical member:

- has three or more chronic illnesses plus one behavioral health diagnosis;
- is taking five or more prescription medications, not counting over-the-counter medications;
- receives care from three or more physicians;
- uses all health plan services at three to four times the rate of the average plan member;
- has a predictive risk score of 4.5, indicating that their risk is 4.5 times higher than the plan average.

The PerforMED intensive case management program is a product of AmeriHealth Mercy, the umbrella organization for Keystone Mercy Health Plan, which provides coverage for publicly insured members.

The savings calculated by an actuarial firm compare the members' baseline health care expenditures and the current expenditures, but the actual savings are likely to be significantly higher, says **Karen Michael**, RN, MBA, vice president for clinical services for the Philadelphia-based health plan.

"With this membership, if someone isn't helping them manage their care, their costs continue to rise. We know, based on people we have not been able to contact, that the health care costs of members in the program would be higher now than the baseline year if we had not intervened," she says.

Members are identified by predictive modeling, new member assessments, and referrals from providers and community partners.

Once the members are in the program, they are stratified based on past utilization of health care resources, diagnosis, laboratory results, medication profile, and medical history. Based on their stratification, members are placed into levels of care intensity.

Members who are eligible for the program work with one care coordinator, instead of talking to one RN for case management and another for disease management.

"Members with chronic conditions don't usually have a single disease. They typically have a complex medical history. Our goal is to address all of their issues and to coordinate with the member and his or her primary care provider to set priorities and goals," says **Robin Griffin**, RN, BSN, CCM, director of rapid response and outreach of the PerforMED program at Keystone Mercy Health Plan.

The health plan has a dedicated rapid response team, which works mainly to resolve any urgent issues that arise.

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Editorial Questions

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"If the member telephones in with a problem or we identify a need, it is triaged by the rapid response team, which works to resolve any immediate barriers," Michael says.

For instance, the team may help a member get his or her prescriptions filled, arrange transportation for a visit to a specialist, or refer the member to a behavioral health specialist.

"The rapid response team works beyond the medical sphere, helping with other stressors in the member's life. If a member's power is turned off or she doesn't have food for her children, she can't focus on her own health care needs," Michael says.

The rapid response team can connect members to community resources or government agencies who can help with their needs.

The rapid response team includes nurses, social workers, and case management technicians, nonclinical staff who have been trained in health care delivery, medical terms, and how to coordinate access to the health care system.

Case management technicians answer the rapid response team telephones the majority of the time, gathering information about the member's condition and purpose of the call. The case management technician works to resolve nonclinical issues and triages the member to the appropriate staff member for clinical or social work assistance.

Once the rapid response team has the member's immediate problems stabilized, the member is turned over to a case manager.

The health plan's case managers are registered nurses and master's-prepared social workers.

Case managers typically handle the care of between 150 and 200 members with the support of a case management technician.

"We assign cases based on acuity. We know that the new cases are more time - intensive," Michael says.

The case management technicians assist the case managers by arranging transportation, making reminder calls about physician appointments to members, and other tasks that free the case managers to concentrate primarily on health care issues.

When case managers connect to the members, they conduct a comprehensive assessment and work with the members and the provider to develop individual goals, then continue to work with the member over time to execute the treatment plan.

For instance, an immediate goal may be to work on getting the member's hemoglobin A_{1C} down a point or sending the member to a physician's office for tests to measure his or her lipid level.

"Our intensive case managers provide constant education and reminders to help the members keep their chronic condition under control and assist in removing the barriers to compliance," Griffin says.

The case manager maintains an ongoing relationship with the member, working on issues in the care plan and assisting members with any problems that arise.

For example, the members may need assistance in getting an appointment with an endocrinologist or financial assistance for their medication copay.

The case managers call members at intervals that are determined by the members' individual needs.

"In the beginning, the case managers may make weekly or even daily contact with the members if they are working on a problem together. As the situation stabilizes, the contacts are less frequent. We never discharge anyone from the PerforMED program. The only time they are removed from the program is when they lose eligibility or die," Michael says.

In addition, Keystone Mercy Health Plan has a nurse advice line, accessible to the entire membership, 24 hours a day, seven days a week.

The rapid response team follows up with callers to the nurse line to make sure that their problems or concerns have been resolved. For instance, if someone needs help getting in to see a physician or has transportation needs, the nurse refers the call to the rapid response team.

Members may reach any component of the PerforMED program by calling the health plan's main number in addition to calling the direct line for their case manager.

"We have created an umbrella of services around our members. The key to that umbrella is to have a system in place to feed information from one part of the umbrella to the other," Michael says.

If a member who is working with a case manager calls the rapid response team, the call is transferred to the case manager if he or she is available. Otherwise, the rapid response team takes care of the issue.

All members of the PerforMED team have received training on the current national guidelines, best practices, and other health care resources. The health plan also calls on its pharmacy partners to conduct case reviews and consult on medication management issues.

The health plan's medical director has provided

education on chronic conditions and assisted with the creation of computerized teaching tools, including talking points and questions to assist the care coordinators in working with members.

"Coordination of all elements of care is the critical differentiator for Keystone Mercy's Care Coordination unit. The support from the medical directors and pharmacy partners, combined with the focused efforts of the case management teams, assures that members receive the advocacy needed for enhanced self-care, improved health status, and achievement of personal quality-of-life goals," Michael says. ■

Program follows members through continuum

Members managed through illness and wellness

Under a new holistic case management program at Regence BlueCross BlueShield, one case manager, called a care advocate, follows members along the continuum of care, no matter what their health care needs.

"We have created a single umbrella of care so that members no longer have to talk to multiple people because they have multiple health care issues. Our main focus is putting our members first. We're not really putting the members first when they call and have to talk to one person about behavioral health, then be transferred to someone else for disease management," says **Melanie Westrick**, RN, BSN, CCM, CCP, assistant director of health care services for the Portland, OR - based health plan.

The health plan began phasing in the holistic care management program in June 2006, with a goal of being fully functionally in early 2007.

Care management can't be a one-size-fits-all proposition, points out **Steven Goldberg**, PhD, director of case management/utilization management.

"We can have a diabetic who is relatively healthy and follows his doctor's advice and another diabetic who is a train wreck. There's no single formula for managing these two types of individuals," Goldberg says.

Instead of focusing on a particular disease state, the care advocates focus on each member's individual needs and what areas of the member's health care experience Regence BlueCross and BlueShield can impact, he adds. The care advocates follow members through wellness to illness and back to wellness, working with physicians and other health care providers to tailor an individual treatment plan.

Clinicians who work in the health plan's care management department include RNs, social workers, behavioral health experts, and health coaches.

To identify members for the program, the health plan mines its data using an elaborate predictive modeling system that determines what types of interventions members need, from education to more complex interventions for someone who is acutely ill.

Complex interventions include supporting the member's contact with his or her provider and arranging appropriate care and services.

"We approach our members according to their current state of wellness or illness and what we can do as a plan to support their interaction with their providers," Goldberg says.

Members are assigned to a care advocate who can best meet their needs.

For instance, when members want to stop smoking, they are likely to work with a health coach.

If they have a chronic illness, they'll be assigned to a care advocate who is an RN.

"We assign members to clinicians who can work with members on all their health care needs, throughout the continuum of care," Westrick says.

The care advocates have received extensive training from both internal and external resources and are skilled in motivational interviewing.

"We understand we can't be experienced in everything. Some clinicians are more experienced in certain areas, and we try to assign members accordingly," she says.

When a member becomes ill, the care advocate doesn't deal just with the incident of illness but looks at the member holistically and addresses all of his or her health care needs.

"Rather than looking just at symptoms, we want to understand the entire individual and reinforce a wellness orientation. We focus on the particular disease state as well, but in addition, we look at each member as an individual with unique health care needs," Goldberg says.

For instance, in the case of members with congestive heart failure, monitoring the weight and being compliant with diuretics and other medications are vital ingredients of a health management plan, but there may be other fac-

tors that affect their health.

"We look at the treatment plan, but that's not where it ends. What is causing the disease to exacerbate is the key. We look at why they don't fill their prescriptions or why they don't see their doctor regularly and help remove any obstacles for care," Westrick says.

About 70% of medical conditions involve psychosocial issues, such as depression and lack of motivation, Westrick points out.

"In order to better manage the condition, we need to deal with these issues early on in the disease," she adds.

Recognizing the member's behavioral health care needs from day one improves the impact a health plan can have on the member's condition, Goldberg says.

Treating the member holistically means dealing with the mental health issues and the medical issues at the same time, Westrick adds.

"You can't just put someone in a depression program and think that's taking care of the whole person. It might help them with depression, but the reason they are depressed may be that they have a chronic illness. Instead of trying to silo them into a specific disease management program, we look at our members holistically to see where we can help them," she says.

When members are identified for the program, the health plan sends them an introductory letter, a biography of the advocate who is assigned to them, along with business cards and a direct-dial number.

The care advocates get in touch with the members and conduct a standard assessment, which helps them identify the actionable points with each member. They develop a care plan and work with the member to make sure that all of the health care needs are covered.

"We don't just remind them to get their medication filled; we look at why they aren't taking it. If we can identify the reason they aren't compliant and help them with it, we can achieve better long-term success," Westrick says.

The lengthy assessment typically takes place during several telephone conversations.

"It's amazing how much information the clinician can glean just from listening to the member, particularly over time. The more the clinician talks to the member, the more information the member will reveal. That's why a long-time relationship with a member is so important," Westrick says.

The health plan has created Regence RX, an on-line database that members can use to look up their drugs and potential interactions. The care advocate can go on the web site with the members and help them learn to use the database.

The care advocates follow up at intervals based on the members' conditions. "The level of interaction is defined by the acuity level and changes with how the member's condition develops. Sometimes the member needs more interactions, and once it's resolved, the care advocates won't be in touch so often," she says.

They may follow up by e-mail in addition to calling the member on the telephone.

"The assessment helps us understand what kind of information the member wants and how they want to receive it. Some are into health and wellness and want all the information we can give them. Others want to get their information from their health care provider. How we support those two members is very different," Goldberg says.

If a member is going in for a doctor visit and has been newly diagnosed with a chronic disease, the care advocate can help develop a list of questions for the doctor. If someone comes back from a visit and is confused about a treatment plan, the care advocate can contact the provider and get clarification.

"When someone has a chronic illness and visits the doctor, they usually retain only a percentage of the information they are given. Our care advocates support the member's relationship with the provider and help them get the information they need," she says.

The health plan monitors its data on a regular basis, looking for patterns in how individual members are caring for themselves and initiates interventions when changes in health care patterns indicate it.

"If a member whose condition has been stable, suddenly has an emergency room or a specialist visit that would then give the care advocate an opportunity to look at what has changed," she says. ■

CMs coordinate all their clients' health care needs

DM, CM, home visits are part of the program

At Crescent PPO, case managers follow their clients through the continuum, helping them with all of their needs, whether it's disease man-

agement, case management, education about a chronic condition, or help navigating the health care system.

"People do truly want to get better, and when a member of the health care team cares that they succeed, it does make a difference. Since I've been working with my clients, I have seen diabetics' hemoglobin A_{1C}s drop from 13 to six and below. I've seen people quit smoking and their cholesterol drop. Claims for the employers have dropped. It's all a matter of providing individual care," says **Teresa Fugate**, RN, BBA, CPHQ, CCM, a case manager with the Asheville, NC not-for-profit PPO.

The PPO provides health management and pharmacy services for self-insured clients including hospitals and other employers in western North Carolina.

"Our goals are to help people improve their health status to prevent them from getting chronic disease, reduce chronically ill patients' risk of complications, and/or prevent the progression of the disease," Fugate says.

The company uses claims data to identify the high-risk areas for health management among the employer groups, then offers programming for a comprehensive case management program, Fugate says.

The PPO's case managers are assigned by employer group and coordinate all of the employees' needs, including conducting educational sessions at the work site and visiting seriously ill patients in the hospital or their homes.

"I manage the care for a group of patients, regardless of their diagnosis. For each group of enrollees, I also provide education and work to help them improve their health as well as managing their care as long as needed," Fugate says.

Fugate visits the employer sites and conducts educational sessions, such as smoking cessation, diabetes education, or seminars on controlling hypertension or high cholesterol.

Many of the employers offer incentives for their employees to participate in a disease management program. For instance, the employer may offer diabetes medication with no co-pay if employees with diabetes attend classes on diabetes management.

"The individuals in the disease management program also become my case management patients. We don't just drop in and educate them. We keep up with them and follow them through the continuum," she says.

Fugate works with five employer groups and manages the care of all their employees. She gets to know her clients as individuals and makes sure they get the services they need in a timely manner and that they have all the information and tools they need to follow their treatment plan.

"Nobody wants to be sick. Patients want to get well, but they have to have the right information and education. You can't talk to them about their disease for 15 minutes and expect them to figure it out. Nonmedical people are not always savvy enough to be able to search out reliable information on the Internet," Fugate says.

Fugate leads her clients through the often-bewildering health care system, making sure that that they receive their benefits in a smooth and timely manner.

"I tell the patients that I'll take care of their hassles for them. All they have to do is call me if they are having problems, and I'll smooth the way," she says.

If her clients have questions about their claims, Fugate will go over the paperwork with them and answer any questions they may have. "Crescent's other case managers and I are supported by a first-rate client service team at the company's Asheville office. Even though the company does not administer claims, the case managers and client service personnel work together to help clients resolve claims issues and our efforts have been very successful," she says.

She works with the pharmacy to make sure the client's medications are accurate and that they are not taking medications that could interact with each other.

If patients are having problems getting their prescriptions preauthorized, all they have to do is call Fugate and she gets it handled, often by the Crescent pharmacy benefit customer service team.

If they are required to have a procedure or visit a specialist, Fugate contacts the physician's office to ensure that it has been pre-certified.

"Our philosophy at Crescent is that providing cost-effective quality care doesn't mean limiting certification. We'd prefer that a patient have an MRI on Wednesday rather than ending up in the hospital the next Friday," she says.

If a patient is going to have chemotherapy and the employer has a contract with a particular infusion company, Fugate makes sure the physician refers the patient to that company for treatment.

"I follow up and make sure they are getting the treatment they need. If I ever have a ques-

tion about the care a patient is getting, I bring in the Crescent medical director to talk with the physician," she says.

Fugate and the other case managers at Crescent PPO take a proactive approach to managing the care of their clients. They are notified whenever a pre-certification request comes in for a procedure that may indicate that one of their clients is at high risk.

For instance, Fugate may receive information that one of her clients is having a biopsy to detect possible breast cancer.

When the results are back, she calls the patient and introduces herself.

"I ask for the results, and if they are clear, I celebrate with them. If they are not, I explain what case management is all about and start to help the patient navigate the health care system," she says.

Fugate visits patients who need her services in the hospital and makes home visits to patients with serious illnesses, such as multiple sclerosis or cancer.

"I sit down with them and go over their condition and the treatment plan so they will understand their illness. I take educational materials and give them a list of web sites they can consult," she says.

For instance, when one client with cancer didn't understand her treatment plan, Fugate requested the physician notes and reviewed what the physician had told the patient. She talked with the doctor to make sure she was on the right track, then wrote down instructions in detail. Next, she went to the patient's home and spent more than an hour going over the instructions.

The woman had been forgetting to take her medicines and making other mistakes in caring for herself. After Fugate helped her understand, the patient became compliant. Her doctor told her that she had done better than other patients who had received the same treatment. She was less sick than most patients and was able to go back to work during treatment, Fugate says.

"My relationship with my patients is very rewarding. I am in awe of the things they are going through and how they are overcoming the obstacles. I do whatever I can for them to make it easier," she says.

Fugate goes to employers' health fairs and lets the employees know that she is available to help. She works with the organization's human resources department to get the word out about her services.

When Fugate receives a referral, she calls the patient, then follows up with a letter and her card.

"I encourage the patients to call me. They don't have to go through a main number. They can get to me directly on my cell phone," she says.

Crescent PPO encourages the members to be proactive about their health care and to contact the PPO whenever they have problems or questions about their health.

"People don't necessarily understand what their responsibility is. They think it's their doctor's problem to make them better. We help them understand their role in managing their health and support them as they make changes," she says. ■

Programs face challenge with older patients

Physiological, psychological, emotional needs differ

With individuals who are ages 65 and older undergoing almost one-third of the 25 million surgical procedures performed annually, and with people ages 85 and older representing the fastest growing segment of our population[1], it is important that any surgical program pay close attention to the special needs of older patients. Because you send patients home within hours of their procedures, it is especially important for outpatient surgery staff to be aware of these special needs, according to experts.

"Perioperative nurses must become geriatric specialists in order to fully meet the needs of this burgeoning population," says **Patricia Stein**, RN, MAOL, CNOR, nurse education specialist for perioperative services at Palomar Pomerado Health System in Escondido, CA. "An elderly surgical patient has less 'bounce back' after surgery, and there is less wiggle room for error of any kind," she says.

While perioperative care for all patients requires thoroughness and attention to detail, it is particularly important to pay close attention to your assessment of an older patient, says **Jim B. Wilkerson**, RN, BSN, CCRN, outpatient surgery supervisor at Pomerado Hospital in Poway, CA. "Older patients are often on a number of medications, and you must be aware of how those

medications, as well as their own physiological changes, might affect surgery," he says.

"The definition of elderly or older may differ for various outpatient programs, but generally it is defined as age 65," says **Jackie Close**, RN, MSN, certified nurse specialist in gerontology at Palomar Pomerado Health System. "Age 65 is used only because it has been set by the government as the age for retirement and therefore the beginning of 'old age,' but 65 is nothing more than an arbitrary number with no scientific data to support the decision," she says. Nurses must consider individual differences and characteristics when planning and implementing care for the older adult, such as overall health, activity level, and cognitive function, Close recommends.

One example of a difference between a younger patient and an older patient is skin resilience, Wilkerson points out. "A patient that might have been on steroids for a long time will have fragile skin," he says. This fragile skin means that the patient might bruise easily from a blood draw or have skin torn by adhesive bandages, he adds. "Also, be sure to ask if the patient is bruised or suffering from skin breakdown anywhere on their body so you can pad and position the patient to prevent further pressure on these injured areas," he suggests.

Even starting an intravenous line should be done with special care, recommends Stein. An everyday elastic tourniquet can injure fragile skin, so consider using a blood pressure cuff instead of a tourniquet to apply a more even, less pinching device to properly obtain access, she suggests.

Another key difference between an older patient and a younger patient is mental status, Stein says.

"There is a decrease in short-term memory, and patients are at risk for postoperative dementia and confusion," she says. Add these cerebral function changes to the effects of multiple medications for a variety of medical conditions, and you must be especially careful that the older patient understands what will happen during their time in the surgery program and after discharge, she points out.

Patients also experience sensory changes that they may not want to admit, says Wilkerson.

"A patient may not be able to see clearly enough to read discharge instructions or may not clearly hear or comprehend the instructions you give verbally, but they will nod and react as if they do," he says. To ensure comprehension, Wilkerson suggests that nurses ask the patient to point to or read something, such as the phone number of the physician to call if there are problems. Asking the patient to repeat information back to the nurse also is effective, he adds.

Requiring a family member, friend, or other responsible adult who will be with the patient when he or she goes home to listen to the discharge instructions is also critical, Wilkerson says. "We require the responsible adult to sign the discharge forms because the patient is still under the effects of anesthesia and won't know what is being signed," he says. "Older patients often don't remember being told anything about care at home, so it is important for another adult to be there to hear the instructions and remind the patient that the nurse explained everything before discharge."

An important point to explain to the adult caregiver is an older person's susceptibility to delirium following anesthesia, says Wilkerson.

It doesn't occur with every patient, but it is not uncommon for a patient to become delirious, confused, and even combative in the middle of the night following surgery," he says. Because this can be very frightening to a caregiver, be sure that you explain the possibility of this occurring so that they are not surprised, he adds.

Because the first step in caring for an older surgical patient is the initial assessment, Close suggests, "allow yourself extra time for the interview and assessment. We must not hurry our older patients because when we don't listen, we miss out on very valuable information that could impact their surgical experience."

Reference

1. Muravchick S. *Geriatric anesthesia — Are you ready?* American Society of Anesthesiologists 2006; Web site: www.asahq.org/clinical/geriatrics/geron.html. ■

Documentation confirms educational needs met

Communicate what was taught

Similar to teaching, documentation must meet the needs of a patient. While some documentation is better than no documentation, more detail benefits the patient because it directs staff

members on the status of the education process.

"With documentation as a tool, staff can better determine what to do next," says **Carol Ptasinski**, RN, MSN, MBA, associate director of standards interpretation for the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

A statement such as "medications reviewed with patient" is so vague other staff members wouldn't know what was covered; good documentation reflects what was done, including ways educational barriers were addressed, says Ptasinski.

The documentation sheet, which is part of the medical record, is a communication tool, agrees **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta.

"The medical record is the only communication tool we have for that patient. Certainly word of mouth doesn't do it and shift-to-shift reports don't do it — those are all verbal and they get lost and jumbled up. The medical record is the only thing we have that completes the picture of that patient's care," says Ordelt.

To make her point, Ordelt tells staff to imagine walking into a room and trying to take care of a patient without a medical record. She tells them to imagine having to go back and retake a history and physical, redo all the tests that have been done, and redo all the consults from all the therapists and physicians and everyone who sees the patient because nothing was recorded. Staff always responds that they could not care for the patient.

"We document for a reason. The medical record is our guide for that patient's care; therefore what that translates into is safe, quality care for a patient when it is done properly. Documentation helps contribute to that safe, quality care," explains Ordelt.

Patient education is part of quality care, she says. Just as it is impossible to treat a patient properly without information about previous medical interventions, it is impossible to teach effectively without information on learning assessments, prior education, and the patient's comprehension of what already has been taught.

Teaching without regard to what patients have already learned or what they still need to know is unsafe, inconsistent, and frustrating for patients, says Ordelt.

Although it is helpful to create patient education documentation forms with check boxes and codes, such as "V" for "patient verbalizes understanding," in order to make the process quick and easy, some detail must be provided, she says.

For example, if a handout was used to educate the patient, it would not be enough to write "H" on the documentation sheet. The title of the resource would need to be written in the comment section as well so others would better understand what information was given.

While documenting that the education provided pertinent to a patient's plan of care is important, such as information about newly introduced medical equipment or supplies, it is not the only information needed.

To meet Joint Commission standards, documentation needs to reflect what was taught, when it was taught, whether the patient had any difficulties learning because of cultural, emotional, or cognitive barriers, and if the teaching was completed, says **Jodi L. Eisenberg**, CPHQ, CPMSM, program manager for accreditation and clinical compliance at Northwestern Memorial Hospital in Chicago.

When there are barriers to learning, a note on how they were addressed should be included. For example, when language is a barrier, stating that an interpreter was present during teaching would be appropriate.

If the teaching was not completed, there should be some sort of statement that the education needs to be reinforced or that the patient was unable to learn and the family was taught instead. The Joint Commission looks at evaluation of comprehension every time teaching occurs, and it needs to be documented, Eisenberg says.

It is not only the Joint Commission that requires proof of comprehension. "While providing education is good, more important is that the patient was able to repeat back what was taught. That is the basics of informed consent. Unless the patient can repeat back what was taught, it isn't really consent and it is not education unless they get it; otherwise it is just people blabbering words at them," says **Geri Amori**, PhD, ARM, CPHRM, DFASHRM, senior director for education and professional development with the Risk Management and Patient Safety Institute in Lansing, MI.

"Again, any documentation is better than no documentation," says Amori. However, when discussing what constitutes adequate documentation of patient education, the question is: Adequate for what? Adequate to be defensible in court or adequate to know it was done? To be defensible in court, the information documented must be as specific as can be provided. Anything that needs to

be recalled in five years or more should be written down.

Documentation is important for defending a health care institution in litigation and ensuring that providers remember what happened, says Amori. And communication is important in preventing litigation in the first place, because it builds the relationship and the trust, she adds.

The literature indicates that when something goes wrong, medical lawsuits are triggered because patients feel there was a breakdown in communication. Patients believe they did not get adequate information or it was poorly presented. Also, they feel their perspective was dismissed.

Documentation that meets Joint Commission standards doesn't have to be as comprehensive as the records that would provide a good defense in court, as long as the health care institution has in place teaching protocols that are routinely followed and resources that are consistently given or used, says Ptasinski. As much detail as needed for patient education to be effectively completed is what is required.

"We would expect that if a patient was on a particular medication, he or she would be educated on that medication. We would say, 'Show us where you documented the patient received education,' and then see what process is in place," says Ptasinski.

With the new tracer methodology of surveying, the Joint Commission surveyor would interview staff and the patient to make sure an adequate educational process was in place. To ensure the same educational process was followed for each patient, the surveyor might trace another patient.

Adequate documentation for the Joint Commission means that any education needed as part of a patient's plan of care be documented. Documentation can be general as long as the resources are available that show the patient's educational needs were met, says Eisenberg.

"Our rule of thumb is that if it wasn't documented, it wasn't done. However, if you put down everything you educated a patient on, your medical records would weigh 50 pounds," she explains.

The expectation is not verbatim documentation but to cover the four basics: what was taught, when the teaching took place, the educational barriers, and whether the teaching was completed. If this information is included in the documentation of patient education, an institution should be covered from a regulatory standpoint as well as a legal one, says Eisenberg. ■

SHHH takes NY hospital 'back to the basics'

Patient complaints sparked effort

To enhance patients' satisfaction levels, not to mention their ability to rest and heal — Montefiore Medical Center in Bronx, NY, has gone "back to the basics," says **Elodia Mercier**, RNC, MS, ANM, administrative nurse manager.

Evoking the time of Florence Nightingale and the image of a nurse raising a finger to her lips and whispering, "Shhh," the hospital has taken aim against the rising decibel levels of modern health care, she explains.

"We have so much new technology and equipment, which is a great thing, but sometimes we forget the concept of the quiet zone, that state of quiet that was part of providing care."

A program called Silent Hospitals Help Healing (SHHH) came about because of patients expressing concerns both in conversations and in Press Ganey patient satisfaction surveys that the hospital was getting too noisy, Mercier says. "Since it was important to the patient, it was important to us."

In an effort spearheaded by Mercier, who works in one of Montefiore's med-surg pavilions, staff began to identify the barriers to a quieter environment and how to tackle them, she adds. "The goal was not to eliminate noise — that's impossible — but when possible, to reduce noise."

The No. 1 complaint, employees discovered, was about the sound made by the heavy metal hammer-like pill crusher, especially when it was used in the middle of the night. Now, Mercier says, nurses use a small, hand-held pill crusher instead.

Nurses complained that the cart taken around to check patients' blood sugar "sounded like the 'D' train going through at five in the morning," she says. "It would wake up the whole floor. The wheels were horrible."

When she asked nurses why they put up with the disruption, Mercier adds, the answer was, "It's always been like that." A trip to the bioengineering department, however, resulted in new wheels and a lube job, and that problem was

solved, she says.

"It's simple, basic things," Mercier says. "Some physicians and nurses were wearing clogs that made a clicking sound in the hallway, and they converted to soft-sole shoes."

Much of the problem was due to what she calls "the cocktail-hour effect," where overhead pages are being broadcast, alarms are going off, and staff are talking louder and louder because they can't hear each other.

When four patients are in a room and each turns up the volume on the television in order to hear over the other person's TV, the result is "four TVs blasting into the hallway," Mercier notes. The simple solution: headphones for the televisions.

To reduce the intercom noise, she says, the hospital now has two systems — a major one, used for announcing cardiac arrests, and an individual intercom on each nursing unit. "With reeducation, the secretary now knows to talk in a low tone of voice."

Plans are to eventually have a Star Trek-style system, Mercier says, whereby nurses can hear their own pages individually, rather than having them announced throughout the unit. Another noise-reducing change has been setting beepers to vibrate, she adds.

Previously, Mercier says, the nursing floors often reverberated with the sound of keys jangling interspersed with people yelling out, "Who has the keys?" as nurses took medicine from the narcotics cabinet. Now the hospital has a computerized system that allows nurses to punch in an individual access code and take out the drugs that are needed for their assignment of patients.

Reducing that kind of noise she points out, allows clinician's to better hear the ambient sounds such as a ventilator alarm or an air mattress alarm, which helps them take care of patients.

In 2004, the hospital began monitoring decibel levels on a monthly basis, Mercier notes. For comparison, the noise from a train or motorcycle is about 95 decibels, and the decibel level in a library is about 50, she adds. "Sometimes in certain hospitals at the change of shift, it can go as high as 113 decibels."

From a starting point of between 90 and 115 decibels (equal to the roar of a subway car), Montefiore has reduced its noise range to between 55 and 60 decibels, as measured by the hospital staff using sound-measuring devices, Mercier says.

"We have been working aggressively to maintain this, and the staff is doing a wonderful job," she says. "To get patients and families to buy in, we have buttons that we like to hand out. Instead of saying, 'You have to be quiet, we have a SHHH program,' we say, 'We have a SHHH program on the floor, and we want to provide you with very good care. We will make you an honorary member for helping us with that program by using headphones for your television.'"

In the admissions area, Mercier says, there is likely to be a television on as a service for customers and perhaps a radio as well. "When you add the noise from different offices and from staff coming in, laughing and having a good time, the noise level can be quite high."

Staff can help create a calmer and more restful environment for patients who are waiting for service by simply "toning it down," she suggests. "Walk up to each other and talk as opposed to yelling across the room."

To kick off the SHHH program, Mercier notes, the hospital held a contest to choose the design of a promotional poster and button. The winning entry, she adds, showed a close up of someone's mouth, with a finger over the lips, and the words, "Quiet, please. Silent hospitals help healing."

Now there is a huge copy of that poster on the elevator that goes to her floor, Mercier says. "I didn't think people paid much attention to it, but one day I was in the elevator and a gentleman got in with his son, who was talking loudly and making a lot of noise."The father looked down at the boy and said, 'Patients are healing, we have to talk quietly,'" she recalls. "That made me feel really good." ■

COMING IN FUTURE MONTHS

- How prenatal care can pay off your health plan
- Ways to help Medicare members stay healthy
- Managing the special needs of bariatric surgery patients
- Why behavioral health should be a part of any case management program

CE questions

1. Which of the following is typical of members selected for the PerforMED program at Keystone Mercy Health Plan?
A. Has three or more chronic illnesses plus one behavioral health diagnosis.
B. Is taking five or more prescription medications, not counting over-the-counter medications.
C. Receives care from three or more physicians.
D. All of the above

2. Approximately what percentage of medical conditions involve psycho-social issues, according to Melanie Westrick, RN, BSN, CCM, CCP?
A. 70%
B. 50%
C. 40%
D. 30%

3. What is one way to start an intravenous line on an elderly patient without injuring their fragile skin, according to Patricia Stein, RN, MAOL, CNOR, nurse education specialist for perioperative services at Palomar Pomerado Health System?
A. Use a standard tourniquet
B. Use a blood pressure cuff to apply pressure
C. Use different locations for each IV
D. Use smallest IV tube

4. In certain hospitals at the change of shift, the decibel level can rise as high as what number, according to Elodia Mercier, RNC, MS, ANM?
A. 55
B. 65
C. 90
D. 113

Answers: 1.D; 2. A; 3. B; 4. 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. ■

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 credit letter. ■