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Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Take depression into account when managing chronically ill members

Mental health has a big impact on physical health

For many years, many people thought of depression as an imaginary disease, but the health care industry is beginning to recognize how prevalent depression really is and is taking steps to help people learn to cope with this devastating disease.

One in 10 adults experiences some form of depression or anxiety every year, according to **Peg Audley**, LICSW, assistant director of operations for CIGNA's disease management program.

"Depression is far more common than people realize. A huge percentage of individuals experience depression at some time in their lives, but it's often overlooked," says **Mary Clare Solky**, MA, LLP, director of behavioral medicine at Health Alliance Plan.

People who suffer physical pain get help, but emotional pain often is pushed aside, Solky points out.

"It's not only important to a person's well being and productivity, but it can also affect chronic medical conditions and general medical health," she says.

When it comes to the link between depression and chronic illness, it's kind of like the riddle about what came first, the chicken or the egg, Audley says.

Chronic illnesses can cause depression, and depression can make it difficult to get the chronic condition under control, she says.

"If someone is diabetic and also depressed, we have to help them deal with both problems. They have to have enough energy and feel well enough to be able to take charge of their life, watch their diet, and stay on insulin," she says.

Chronic illnesses can lead to depression because people may not be able to do the activities they enjoy, because they are under stress or in chronic pain, and because chronic conditions can change their self-concept and their plans for the future, Solky says.

In addition, depression can result from the metabolic effects that

chronic conditions can have on the brain, she says.

"The only way to help a member become compliant is to find the underlying condition, such as depression, that affects his or her ability to follow the treatment plan. It's easy to miss when you are talking to someone who is physically ill, but depression could be what is fueling lack of compliance," Solky says.

In this issue, we'll look at two depression management programs and how they are integrated with the health care plans' disease management programs.

You'll learn about CIGNA's program that targets people who are treated for depression in primary care settings and HAP's team approach to treating depression and chronic diseases. ■

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Editorial Questions

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Program targets members treated in primary care

Coaches' help members comply with plan

Members who seek treatment for depression and anxiety from a primary care physician are getting help managing their condition through a new program from CIGNA HealthCare.

The program targets the 83% of people who have symptoms of depression and anxiety but who do not go to a mental health specialist, says **Peg Audley**, LICSW, assistant director of operations for CIGNA's disease management program.

"Our program fills a gap. The people we serve have never accessed their mental health benefit. Many are not therapy candidates, but they do benefit from the support and information the behavioral health coaches provide. We want to impact the kind of care that people receive in the primary care setting," Audley says.

Just giving people medication for depression doesn't change their behavior, Audley points out.

"We have to find a hook, something that is so important that members will want to change and become compliant. We guide them in finding what will work for them," she says.

The health plan identifies members from medical claims and pharmacy claims and excludes those members who are already seeing a behavioral health specialist. For instance, the database identifies people who have filled a prescription for an antidepressant medication but who do not have behavioral health claims.

Members whose claims from a primary care office include a diagnosis for depression but who have not filled a prescription for an anti-depressant are also flagged for inclusion.

"We also include anxiety in our program, which makes us unique in the industry. In the primary care setting, it can be difficult to differentiate between anxiety and depression, and people who are diagnosed with depression also have a high incidence of anxiety as a comorbidity," she says.

The program is staffed by master's level behavioral clinicians who act as coaches to help the members comply with their treatment plan.

Members who are identified receive a welcome letter telling them about the program, which is free

to them, along with a workbook reference guide about depression.

If the members have comorbid chronic conditions, such as cardiac conditions, chronic obstructive pulmonary disease, low back pain, asthma, or diabetes, the health plan notifies them that a health coach will be contacting them by telephone to determine if they want to take part in the program.

If members do not have a comorbid condition, the health plan's letter offers them the same program but asks members to call the health coach if they are interested.

"Our claims data shows that 50% of people with medical conditions have comorbidities that include anxiety or depression. Those with medical conditions typically have health care costs that are 2.5 time higher than the rest of our population. We focus most of our energy on people with comorbid conditions who are at higher risk for medical costs," she says.

The program is essentially the same for both groups. If a member has a medical condition in addition to depression and is in a case management or disease management program, the health coach collaborates with the case manager who is coordinating the medical care.

"They work closely together to make sure that we get the best outcome," she says.

The first contact between the coach and the member is an hourlong session that includes several assessments that determine how depressed the member is, the type of symptoms he or she is experiencing, and the effect on the member's level of function and ability to continue working.

The health plan also screens for alcohol use, because that cuts the effectiveness of antidepressants by 50% and because people with depression are at a higher risk for abusing alcohol than the general public, Audley says. If the problem is severe enough, the members are referred to an alcohol treatment program.

The coaches work with the members to set goals and follow up with a half-hour appointment a week later.

"All contact is by set appointments. This ensures that we reach the member at a convenient time. Members receive a reminder call the day before to make sure they will still be available," she says.

The coaches make phone calls from 7 a.m. to 10 p.m. CST Monday through Friday and 7 a.m. to 5 p.m. CST on Saturdays.

"Our hours of operation are designed to cover the country. We want to be accessible to our members. If they need to call us in between sessions, we are available as well," she says.

"As people progress, we focus on their understanding of their illness and their medication and how it works," she says.

Medication compliance is one of the top focuses, Audley says. The goal is for all members to be at an 80% or higher compliance rate.

"People don't like to think of depression as a chronic condition. Some people will need to stay at a therapeutic dose of an antidepressant for six to eight months. It's hard for them," Audley says.

The coaches work with members on what lifestyle choices they need to make to ensure that they will be compliant with their medication.

"People who have side effects may end up feeling worse physically, and the chance that they will discontinue the medication is very high. It's very common for people to stop taking their medication and continue to get worse," she says.

The coaches help the members come up with plans for self care and lifestyle changes that can improve their functioning, such as nutrition, exercise, and handling stress.

"A lot of people who are depressed are easily overwhelmed and can't think of where they want to go with their lives. A coach will help them take a step at a time," Audley says.

The coaches don't provide therapy, she emphasizes. Rather, they encourage the members to look at what is happening today and what will happen in the future.

"A lot of times, people who are depressed look at the past. We are working on improving their day-to-day level of functioning," she says.

In urgent cases, the health coaches or a CIGNA medical director will contact the physician's office directly, but in most cases, the coaches work to empower the members to take charge of their own health.

Once someone has agreed to work with a coach, with the member's permission, the health plan sends a letter to the member's physician telling him or her about the program and sends progress reports that include scores on a depression scale, medication compliance, and the problems that the member is working on with the coach.

When members are severely depressed, the coaches urge them to seek ongoing, face-to-face therapy.

"It takes a combination of antidepressants and therapy to treat depression effectively. If they aren't open to the idea of therapy, we can at least help them manage their depression," she says.

The program began January 1, 2006.

"We're still gathering data on the outcomes, but there are a lot of anecdotal outcomes that show the positive effect of the program," she says.

For instance, a 42-year old worker had been on a subtherapeutic level of an antidepressant for two years and had decided that he was never going to feel any better. He was hopeless and withdrawn from his coworkers and his family.

The member and the coach worked together on listing symptoms and documenting them. They rehearsed what the member was going to say to his physician. The doctor increased the medication and the member began to feel better.

"As a result the man has his life back. He's engaged at work and at home and has a new hobby. He says he never wants to come off his medication because it makes him feel so good," Audley says.

The coaches work to find out what might motivate people to change, Audley says.

For instance, when Audley was a coach, she worked with a 50-year-old woman who was tired of trying medications that didn't work and, because of her irritability, was in danger of losing her job.

"She couldn't tell me anything that was giving her pleasure. To her, everything was dark and dismal, but after about two weeks, she started talking about her 18-month-old granddaughter and her tone of voice changed. I asked her to picture what she and her granddaughter could do together if she was feeling like her old self," Audley says.

Eventually, the woman agreed to see a psychiatrist, who worked with her until she started feeling better.

"You have to find out what will move people to take their medicine and to make changes in their lives. They don't have time for that in the primary care physician's office, but when we take the time to work with these members, it makes a tremendous difference," she says. ■

DM behavioral health case managers work together

Case managers sit together, share notes

A team of behavioral health case managers and disease management case managers work together to manage the care for members with chronic diseases and depression at Health Alliance Plan.

"We integrated our disease management and behavioral health programs a year ago and are beginning to see positive outcomes, including a reduction in multiple admissions to the hospital," says **Mary Clare Solky**, MA, LLP, director of behavioral medicine at the Detroit-based health plan.

"It is important to treat depression in chronically ill members because depressive symptoms can make it difficult for people to take care of their chronic diseases. We have had some very good outcomes when two case managers work jointly with a member who has a chronic disease and depression," she adds.

The case managers in the behavioral medicine and disease management programs work collaboratively and use software that enables them to share information. The team has formal meetings to discuss care plans for members in both programs and talks daily on an informal basis to discuss the care of members.

"Because the two departments work so closely together, we find a lot of opportunities for case management. A behavioral specialist may be on a call with someone who is depressed and learn that he has diabetes, then refer him to a nurse case manager," Solky says.

When someone enters the disease management program for a chronic medical illness such as asthma, diabetes, or congestive heart failure, a short depression screening is part of the initial case management assessment.

If someone screens positive for depression, the disease management case manager refers the member to a depression management case manager, either by scheduling an appointment or transferring the member directly to the behavioral medicine specialist if the nurse identifies that the member is in crisis.

The behavioral health case manager conducts a more indepth assessment, begins working with the member on an action plan and goals, and schedules a time for a follow-up call.

The case managers can talk to each other informally about the patient's condition and collaborate on treatment plans and the best way to intervene with the member. They use a software system that allows them to reach each other's notes so they are always aware of what is happening with the member.

The behavioral health team and disease

management team hold case conferences every two weeks, or more often if needed, to discuss complicated cases. The teams also bring in difficult cases that they have successfully managed and talk about how they solved the problems.

"The case conferences are a learning opportunity for both sets of case managers and serve as a forum for crosstraining. The behavioral health specialists increase their knowledge of medical conditions, and the nurses enhance their skills for working with people on behavioral issues," Solky says.

The conferences also include an educational component, often reports from team members who have attended an educational conference or seminar.

"If someone on one of the teams attends a seminar on medication compliance, we'll look for a case where they can apply what they learned and discuss that at the case conference," Solky says.

The depression case management program is staffed by a team of 12 behavioral medicine specialists who are masters-prepared social workers or who have a master's degree in psychology.

In addition to the screening by case managers in the disease management program, HAP identifies members for its depression management program through self-referral by phone or HAP's web site, and through referrals from physicians who refer patients for extra followup and monitoring for compliance.

When a member is identified for the program, the behavioral medicine case manager makes an outreach call and conducts a detailed screening.

The case manager works one-on-one with the member to educate him or her about the condition and to develop an action plan for getting the depression under control, and sets an appointment for a followup call. With the member's permission, they notify the member's physician that he or she is in the program, along with information on treatment recommendations.

In some cases, the case managers may refer members to specialty care, such as a clinical therapist or a psychiatrist.

"The behavioral case managers spend a lot of time educating the members on the importance of staying on depression medications for at least six months to retain remission. People often feel better much sooner and need a lot of encouragement to stay on their medicine," Solky says.

The case managers explain how it sometimes takes several tries for patients to find an antidepressant medication that works for them.

"It's not always a straight shot. Many people do feel better with the first medication, but for some, it may take trying a second or even a third medication to feel significant improvement," Solky says.

The length of the program and the number of followup calls depends on the needs of the member. Some receive only one or two telephone calls.

Some members go into long-term depression management, particularly if they have a chronic medical condition that needs assistance over time.

Members are typically in the depression management program for three to six weeks.

If the member has mentioned a time that he or she feels particularly depressed, such as during the Christmas season or the anniversary of some significant event, the case manager sets up a reminder and calls the member during the difficult period.

If a member has missed filling a prescription for an antidepressant, the health plan's computer system triggers the case manager to make a reminder call.

"We usually know within a day or two if a member has missed filling a prescription," Solky says.

When the case managers call members who have failed to fill an antidepressant prescription, they educate them about the value of staying on the medication long enough for it to be effective and help them work with their physician to find a medication that works best for them.

"A lot of people go off the medication, either because it didn't fully eliminate their symptoms or they felt better and stopped taking it before they were on it long enough to sustain change," Solky says.

The case managers are assigned to patients depending on their primary care physicians. "Each case manager is linked to a group of primary care physicians and the specialists who work with them. The physicians and members like the consistency because they know that they will be working with the same case manager," Solky says. ■

Patients get support for discharge instructions

Health plan calls members after discharge

Patients who recently were hospitalized but who may not be eligible for disease management or care management programs get support in complying with their post-discharge instructions through a care management followup program by

BlueCross BlueShield of Minnesota.

"The members in the discharge follow-up program generally have not experienced catastrophic illnesses or injuries and have not yet been picked up by our disease management or case management programs. They are members who have experienced a short hospital stay and who fall into a gap where no one is touching," says **Kim Quesnel**, RN, director of care management.

The goal of the program is to support the discharge instructions from the hospital or short stay unit and to make sure the patient follow up with their physician after hospitalization or inpatient confinement.

"We want to coach, educate, and empower our members and their families to assume accountability for their own health and to follow up with their doctor," Quesnel says.

The company instituted its discharge follow-up program in June 2005 after many months of planning.

"If all goes well, our mission is to have an impact on reducing readmissions and emergency department visits," Quesnel says.

Before beginning the program, the health plan collected data on utilization and cost and chose the areas where the follow-up program had the potential to make a difference, eliminating those patients who were being followed by other care managers.

For instance, at the time of the data review in 2005, the health plan's most costly diagnosis group was neonatal care. "Case managers were already working with the families and hospital staff regarding the care for these infants, therefore it didn't make sense to include these patients in the discharge call back program," Quesnel says.

The health plan identified opportunities for anyone going through obesity surgery; cardiac diagnoses, including heart attacks, stents, or bypass surgery; and respiratory diagnoses such as asthma, pneumonia, bronchitis, and chronic obstructive pulmonary disease, she says.

"Because the company's behavioral health program is integrated into the medical care management model, it was also appropriate to identify which population of members with behavioral health diagnoses should be followed up on post-hospital or inpatient confinement," she says.

Children and adolescents being released from long-term treatment centers, members younger than 16 or older than 65 who have been admitted for inpatient mental health treatment, and anyone hospitalized with mood or anxiety disorders are targeted for a discharge follow-up call.

The health plan no longer requires precertification for hospitalization but does require that a provider notify it when one of their its is admitted to the hospital.

"The automatic notification allows us to know immediately when members have an acute episode of illness instead of waiting several months for claims data. It allows us to get in touch with them when we still can make a difference. The inpatient notification by the provider and has a domino effect because we can identify patients who need case management and disease management earlier, in real time," she says.

The insurer's software creates a list of new hospital admissions every day using the admissions notification data.

The care management department's support staff receives the list and compiles demographic and geographic information along with the diagnosis and anticipated discharge date. The nurse care managers call the members a few days after they are discharged.

The health plan sends a letter to all of its members eligible for the program, telling them they will receive a follow-up call and giving them a phone number to call if the care manager can't reach them or if they have any questions.

"We have found that the best window of opportunity to make a difference comes within the first 48-72 hours after discharge. Then we can reinforce the discharge instructions and help them become compliant," she says.

The nurses who make the follow-up calls ask the members if they have questions about their discharge instructions or questions that they didn't think of when they were in the hospital.

"The goal is to start a conversation with the members to find out how they are doing now that they're home," Quesnel says.

For instance, if a nurse calls someone who has had surgery, he or she would ask if the patient had taken care of the wound, if he or she has a fever, and whether the patient has made a followup appointment.

"We encourage people to call us back with any questions they have. We want to establish a good rapport with our members and be their advocates," she says.

The nurses answer any questions the members or family members have about their condition and discharge instructions. They arrange for any kind of post-discharge services the members need and provide whatever assistance they need to comply

with the discharge instructions.

For instance, the care manager talked with the wife of a man who was discharged with a heart attack and lives on a farm several hours away from the hospital where he had surgery. His wife was uncertain about how to prepare the low-fat, low-sodium meals that the physician had recommended for her husband. She had no computer and was 35 miles from the nearest clinic.

The case manager asked about the patient's favorite foods, researched and found heart-healthy recipes, and sent them to her. She put the woman in touch with a dietician near their home who could help her plan and prepare meals.

"There were so many post-hospital instructions that the wife didn't even think about the diet while her husband was in the hospital. The care manager also referred the member to our disease management program so that they could begin working with the family immediately. Without this discharge call back program, this member would have fallen through the gap with their questions when he went home," she says.

There was a member who had been taking oncology drugs and was admitted to the hospital for a respiratory diagnosis. The member complained to the follow-up care manager that her oncology medicine was making her sick and that she wanted to stop it.

The care manager reinforced the importance of continuing her medications and set up a referral to the physician for a discussion about the medications' side effects. In most cases, the care manager calls the member only once for followup.

Patients who have been hospitalized for behavioral health diagnoses or for obesity surgery receive two calls: one upon discharge and another in 30 days. "It generally takes longer than a few days for these patients to get back to their normal activities or back to work. We make a follow-up call to see how things are going and to reinforce the discharge instruction and to make sure that follow up appointments with their provider have been made," she says. ■

Consumer driven health plans not so alluring

Enrollment almost unchanged from 2005

Americans are not signing up for consumer-driven health plans (CDHP) that offer reduced premiums with higher deductibles of $1,000 or more for employee-only coverage and $2,000 or more for family coverage, according to a recent survey by the Employee Benefit Research Institute (EBRI) and The Commonwealth Fund.

Despite expectations from some policy makers that the lower premiums and tax benefits would encourage participation, the survey reveals that the uninsured are not signing up for the plans. Those who do participate in the plans, however, show more cost-conscious behavior in their health care decision making than individuals with more comprehensive health insurance.

Another survey, conducted by the Kaiser Family Foundation of enrollees in CDHPs, found that those individuals appear more likely to ask their physicians and other health care providers about costs than those in more traditional employer-sponsored health plans.

Relatively few of those enrolled in CDHPs, however, say they have used their plan's web site to compare price (5%) or quality (7%) across health care providers, about the same rates reported by those in traditional health plans, according to the Kaiser survey results.

The federal government has been highlighting CDHPs as a way to make patients more price sensitive. Their existence also has been expected to put pressure on the health care industry to be more price-competitive and could mean greater responsibilities for access staff, since more patients will need financial assistance before receiving hospital services.

The EBRI/Commonwealth Fund Consumerism in Health Care Survey for 2006, its second year, was conducted to provide national data on the growth of CDHPs and high-deductible health plans (HDHP) and their impact on the behavior and attitudes of health care consumers.

The on-line survey of 3,158 privately insured adults ages 21-64 resulted in the following findings:

- Enrollment in CDHPs and HDHPs is virtually unchanged from 2005. Only 1% of privately insured individuals ages 21-64 are enrolled in CDHPs, representing 1.3 million people in that age group. Another 7%, representing 8.5 million people ages 21-64, were enrolled in plans with deductibles high enough to meet the threshold that would qualify to make tax-preferred contributions to a health savings account, but do not have such an account.
- The survey finds that adults in CDHPs are no more likely to have been uninsured before enrolling in their plans than those in more com-

prehensive plans. Ten percent of CDHP enrollees were uninsured before being covered by their current plan, compared with 20% of HDHP enrollees and 24% of individuals with more comprehensive plans.

• As in 2005, individuals in CDHPs and HDHPs continue to be less satisfied with various aspects of their health plans than individuals in more comprehensive health plans, are less satisfied overall with their health plan, and are less likely to recommend the plan to a friend or colleague.

• While the law that created HSAs allows people to have high-deductible health plans that cover the cost of preventive services — that is, preventive services are excluded from the deductible — more than half of individuals in CDHPs are in plans with deductibles that apply to all health services.

• Individuals in CDHPs and HDHPs are more likely than those with comprehensive health insurance to report that they delayed or avoided needed care because of cost. However, few differences were found among adults in the three plan types in reported use of health services and preventive care. Also, people in CDHPs and HDHPs are about as likely as those with comprehensive coverage to follow treatment regimens for a set of chronic health conditions that the survey asked about.

• As mentioned above, people in CDHPs and HDHPs exhibit more cost-conscious behavior in their health care decision making than those with more comprehensive health insurance. However, in many questions that addressed this issue, those in more comprehensive plans were just as likely to report such behavior as adults in consumer-driven or high-deductible health plans.

• Despite the emphasis on informed choice surrounding consumer-driven health care, people in CDHPs and HDHPs were less likely to report that their health plans provided information on the cost and quality of providers than those in more comprehensive plans. ■

Complacency could be deadly in pandemic

Hospitals are ill-prepared, reports say

Hospitals are ill-prepared to cope with even a mild pandemic and are likely to face shortages of staff, protective equipment, bed space, and other supplies.[1]

The pressures that face hospitals daily would be magnified and health care systems would quickly become overwhelmed if there were a sudden influx of patients suffering from a novel influenza virus, according to a panel of preparedness and public health experts and hospital leaders convened by the Center for Biosecurity of the University of Pittsburgh Medical Center.

That conclusion echoes other warnings. Complacency could be deadly, says **William Charney**, DOH, a national occupational health consultant based in Seattle who compiled the recent book, *Emerging Infectious Diseases and the Threat to Occupational Health in the U.S. and Canada* (CRC Press, 2006).

"We are taking for granted that our health care systems are going to be able to deal with thousands of sick and dying people, when in fact at the current level of preparedness they will be overwhelmed and chaos is quite predictable," Charney writes.

About half of the nation's emergency departments (48%) function at or above capacity, according to the Center for Biosecurity report. About 30% of hospitals lose money, and the total number of hospital beds, hospitals, and emergency rooms has been declining.

"We have a lot less surge capacity in our health care system now than we did even 20 or 30 years ago," says **Eric Toner**, MD, senior associate with the Center for Biosecurity and lead author of the report.

The pandemic of 1968 was one of the mildest on record. But Toner says, "I doubt we could handle a 1968 pandemic now. Our hospitals have trouble dealing with a bad flu season as it is."

One of the greatest areas of weakness involves the protection of the health care workforce. Hospitals already struggle with staff shortages, particularly with respect to nurses or other licensed practitioners. Yet more than a third of hospital employees may fail to show up if there is a pandemic; in one survey, 42% of health care workers said they would not report to work during a flu pandemic.[2]

"The already existing shortage of health care workers will certainly be worse in a pandemic," says Toner. "How bad it will be is anybody's guess, but certainly it will be significant."

Even now, hospitals are competing with corporations and governments for a limited supply of respirators, and some are having trouble getting the respirators to meet their current needs, such

as protection against tuberculosis.

Rural hospitals, with limited local resources, face particular difficulties preparing for a pandemic. "Every hospital in every community needs to be working in collaboration with its neighbors and [local] emergency management organization to plan cooperatively," says Toner.

For rural hospitals, that may mean reaching out to other health care facilities that are miles away, Toner says.

Preparing for a pandemic will be costly; the Center for Biosecurity estimates that to be ready for a severe pandemic, similar to the historic influenza pandemic of 1918, an average-sized hospital of 164 beds would need to spend $1 million, including $200,000 to develop a pandemic-specific plan, $160,000 for staff education and training, $400,000 to stockpile "minimal" personal protective equipment, and $240,000 to stockpile basic supplies.

Hospitals also will need to spend about $200,000 a year to maintain preparedness, the center estimates.

Meanwhile, a pandemic would financially cripple hospitals, as they would lose money on delayed or canceled elective procedures while paying more for staff and supplies and treating more uninsured patients.

The solution: more government spending for preparedness, tied to specific goals, and funds to reimburse hospitals for uncompensated care and extraordinary costs in a pandemic, the center said.

But don't rely on the federal government to save the day when a pandemic hits. Although there is a national stockpile of antiviral medications, N95 respirators, and vaccine, the supply is small compared to the immediate demand that would occur. Preparation must be local and regional, says Toner.

Yet for most hospitals, pandemic planning has been sketchy. "Hospitals are not taking this nearly as seriously as they should," says Toner. "Few hospitals have started stockpiling [PPE, antivirals, and other supplies] to the extent that they should. Almost every hospital has some sort of pandemic plan, but they've not been committing the resources necessary to get prepared."

Without HCWs, all is 'moot'

Occupational health is one of the most critical areas of preparedness. "The No. 1 priority is protecting the health care workers. If we don't have health care workers, then everything else is moot," says Toner.

Yet Charney worries that hospitals are not planning to provide adequate respiratory protection. Charney and contributors to his book, Mark Nicas, John H. Lange, and Giuseppe Mastrangelo, contend that health care workers caring for patients with emerging infectious diseases need respirators that are more protective than the N95 — either the elastomeric half-mask respirator or powered air-purifying respirator (PAPR).

Both of those respirator types are reusable; the PAPR does not require fit testing. Currently, the Centers for Disease Control and Prevention says that the use of an N95 during an influenza pandemic would be "prudent" and that an N95 or greater respiratory protection should be used during aerosolizing procedures, such as a bronchoscopy.

"We don't know how many viruses will be emitted and how far they'll travel and what the dose response will be [with an emerging infectious disease]," Charney asserts. "While the experts are arguing about [how influenza is transmitted], they're recommending lower-quality safety measures."

In their planning, hospitals must think through issues of supply for disposable products and disinfection of reusable ones. Toner recommends tiered levels of protection based on the health care worker's patient contact and degree of risk.

"Hospitals can't just stockpile one [item]," he says. "They need to really think this through and stockpile a number of different measures."

Cohorting patients can reduce the potential employee exposure and allow the hospital to concentrate its protective measures on those employees at greatest risk, he notes.

Lining up volunteers

If your health care workers don't feel safe, they won't show up for work. That is a maxim that many occupational health experts emphasize in pandemic planning.

HCWs also may stay home to care for ill family members or as the only caregiver for children whose schools have been closed as an infection control measure. Meanwhile, you'll need more health care workers than ever to care for a surge of patients.

As part of pandemic planning, hospitals need to identify volunteers, including retired health care workers and those who have left clinical

care, who can help during a crisis period, according to the Center for Biosecurity. Their credentials would need to be verified, and the registration of volunteers would need to be kept up to date.

The U.S. Department of Health and Human Services is developing a state-based Emergency System for Advanced Registration of Volunteer Health Professionals. Hospitals should contact their state public health departments for more information on those efforts.

Meanwhile, hospitals should plan for just-in-time training for volunteer workers and employees who may take on new duties when elective procedures are cancelled.

"What are the essential things they need to be taught in order to do what we ask them to do?" says Toner. You should also consider "what functions in a hospital can be done by relatively untrained people."

References

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Statewide campaign slashes VAP rates

Follow-up provides strong support for facilities

The Minnesota Hospital Association (MHA) recently completed a successful pneumonia prevention program for hospital patients on ventilators, crediting it with saving an estimated 53 lives and $7 million in health care costs. All 84 Minnesota hospitals that treat ventilator patients participate in the Ventilator-Associated Pneumonia (VAP) Initiative, which MHA estimates reduced pneumonia cases by 175, or 57% over 15 months.

The effort, part of the Institute for Healthcare Improvement's (IHI) 100,000 Lives Campaign, was launched in the spring of 2005. "We received an invitation to participate in a day-long presentation and discussion on how to reduce VAP in Minnesota," recalls **Roberta Basol**, RN, MA, CNA, BC, department Director of the ICU at St. Cloud Hospital. "They made recommendations on things to do, such as implementation of the ventilator bundle, oral care, subglottic suctioning, and so forth."

A head start

The MHA benefited in turn from the experiences of Mercy Hospital in Coon Rapids, which began its own initiative in 2003. "As soon as they heard our data, they knew we were a little bit ahead of the curve," recalls **Pam Madrid**, RN, CNS, CCNS, CCRN, a clinical nurse specialist at Mercy's ICU. Accordingly, she says, MHA asked Mercy to participate in presentations to other hospitals.

Three key elements contributed to success at Mercy, according to Madrid: Good hand hygiene, ventilator bundles, and good oral care.

"We started using alcohol-based foam [for hand hygiene] and put colorful 'foam in, foam out,' signs on the doors. We even encouraged family members to foam when going in and out of the room," Madrid shares.

Some of the staff, she continues, would try to call each other and offer reminders. "One weekend some nurses even started yelling 'Foaming in, foaming out,'" she says.

Foam dispensers are located "everywhere," adds Madrid. "We also started using some wipes to help wipe off stethoscopes." Compliance was measured by counting how much foam was used. "We doubled our count," she reports.

The second element, the ventilator bundle, included three elements: Head of the bed elevated 30 degrees; DVT (Deep Vein Thrombosis) prophylaxis by 24 hours; and stress ulcer prophylaxis by 24 hours. "We scheduled a weaning readiness assessment and lightening of sedation at least once a day to see if the patients were ready to be weaned off the ventilator," she adds.

The oral care initiative involved brushing patients' teeth twice day, and in between that doing swabs with a bicarbonate of soda base. New endotracheal tubes were purchased that make suction of secretions easier.

The result? "We have gone 515 days without a single case of VAP," Madrid reports.

Because of the experiences of Mercy and other facilities across the country, the MHA's VAP initiative was an "easy sell," says Basol. "There was a lot of supportive data, so it did not take much for you to participate. For example,

IHI's data showed that if you just elevated the head of the bed to 30 degrees, you could reduce VAP by 18%." In addition, she notes, VAP has a 25% mortality rate, "So it was so convincing to say, 'We can save lives.'"

All participating facilities submitted data on what their past VAP rates had been, and reported ongoing VAP rates monthly to MHA. "The data process was really quite easy, and the measures were clear (i.e., VAP rate per 1,000 days) so we all compared the same things," says Basol.

Upon leaving the seminar, recalls Basol, the MHA challenged all the hospitals to immediately do one new thing. "We did two," she says. "We made signs to remind ourselves to keep the head of the bed elevated at 30 degrees, and we also put little reminder cards at the entrance of the room to use alcohol foam. We also had a 'Foam in, foam-out' sign."

Those 'little' things made a big difference, she says, as did improved oral care and subglottic suctioning. "We also looked at how frequently we changed vent tubing and how frequently we change suction canisters; we even changed where we were storing resuscitation bags," says Basol. At the start of their initiative, the staff also conducted an extensive search of the literature to identify best practices.

The staff really took to the initiative, she adds. "We are very proud, for example, that we have had 100% compliance with the ventilator bundle for going on over a year," says Basol.

At the project's end in June 2006, St. Cloud reported a 75% reduction in VAP. "This was very significant, even though I did not think we had very high rate to begin with." says Basol. "By CDC statistics, we had been outperforming more than half the hospitals in the country, but I did not realize there was an opportunity to really reduce VAP."

Basol is now a big supporter of the IHI's collaborative model. "We shared successes with other hospitals, and we would send e-mails back and forth, offering assistance, and checking on how each other was doing," she says. "You also get good ideas from other people; we took ideas from other hospitals, and we implemented them here." ■

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COMING IN FUTURE MONTHS

- How wellness programs can affect the bottom line
- Helping members cope with chronic kidney disease
- Managing the special needs of bariatric surgery patients
- Ways to integrate case management, disease management programs

CE questions

5. In the depression and anxiety management program at CIGNA, one goal is for all members to achieve a medication compliance rate of at least ____.
A. 80%
B. 75%
C. 70%
D. 50%

6. At Health Alliance Plan in Detroit, members typically are in the depression management program for how long?
A. one to two weeks
B. three to six weeks
C. six to eight weeks
D. at least two months

7. According to the EBRI/Commonwealth Fund Consumerism in Health Care Survey for 2006, enrollment in consumer-driven health plans:
A. has slightly decreased since 2005
B. has increased sharply since 2005
C. is virtually unchanged from 2005

8. According to the Center for Biosecurity at the University of Pittsburgh Medical Center, how much would it cost an average-sized hospital of 164 beds to prepare for a pandemic?
A. $100,000
B. $500,000
C. $1 million
D. $2 million

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

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. ■