Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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As obesity epidemic rages, CMs have an opportunity to step in

Modifications in diet, exercise, behavior are essential for success

You read it in the newspaper or hear about it on the news almost every day: The country's obesity epidemic is out of control. And with Americans' ever-growing girth comes an epidemic of health problems, ranging from hypertension and diabetes to osteoarthritis and heart disease.

It is estimated that 93 million Americans are obese and the figure is expected to rise to 120 million in the next five years, says **James Zervios**, spokesman for the Obesity Action Coalition, a Tampa, FL-based organization formed to educate the public about obesity.

About 65% of Americans are overweight or obese, according to the American Obesity Association. Medical costs attributed to obesity and being overweight accounted for 9.1% of total medical costs, or $78.5 billion, in 1998, according to the Centers for Disease Control and Prevention.

According to the Agency for Healthcare Research and Quality, hospital stays for obese patients increased 112% from 1996 to 2004. Patients admitted for weight loss surgery had 126,000 hospital stays at an average cost of $11,700 per stay. Those admitted for other diseases had 1.6 million hospital stays for conditions such as hardening of the arteries, congestive heart failure, osteoarthritis, depression, diabetes, and chronic obstructive pulmonary disorder. The average cost per stay for those patients was $8,800.

More than 400,000 deaths each year are attributed to obesity, according to the American Obesity Association.

"Obesity affects every body system. As the BMI goes up, not only does the incidence of co-morbidities go up, but the severity increases," says **Pamela Davis**, RN, CCM, clinical coordinator for bariatric surgery at Baptist Metabolic Surgery Center of Baptist Hospital in Nashville, TN, and a member of the advisory board for the Obesity Action Coalition.

For instance, up to 80% of morbidly obese patients have some degree of depression. There is a higher instance of cardiovascular disease, gall bladder disease, osteoarthritis, diabetes, esophageal cancer, and stroke among the morbidly obese, Davis says. Women are likely to have gynecological abnormalities that affect their menstrual cycle and fertility, she adds.

What constitutes obesity? It's all determined by body mass index (BMI), a formula that is based on height and weight. A BMI of 19 to 24.9 is considered normal. A person with a BMI of 25 to 29 is overweight. A BMI of 30 to 39 is considered obese. People whose BMI hits 40 are considered to be morbidly obese.

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Editorial Questions

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BlueCross BlueShield of Tennessee includes obesity management as part of the company's Total Health Management program and takes a proactive approach to weight loss, says **Nancy Alsgard**, RN, managing director of medical clinical strategy for the Chattanooga-based health plan.

"We have an obligation as a leader in the health care industry to influence peoples behaviors to help combat obesity. We feel a responsibility to educate our members on the evolving concept of the foundational principles of being overweight and obesity so members can make more informed decisions about their health. Our goal is to aid members in avoiding illness burden that may lead to chronic or acute disease or even hospitalization," Alsgard says.

Case managers in the Total Health Management program help members with weight loss as part of the continuum of care of disease management, says **Jackie Flowers**, RN, CCM, manager of total health management. "Many of our obese members are referred to the Total Health Management program in conjunction with an acute or chronic illness that has obesity as an underlying factor," Flowers says.

For instance, a member may be referred following a diagnosis for hypertension or diabetes or after a stroke or hearth attack.

"We look at the whole picture of the patients health. Dealing with obesity as a single disease is very short-sighted. We view a patient's health as a whole and how it potentially impacts not only their clinical health but also their psychological and financial well-being. It would be detrimental to focus on weight as the end point because obese patients typically have co-morbidities and associated personal matters they must also cope with, "Alsgard says. For that reason, the health plan's Total Health Management program is closely linked with BlueCross and BlueShield of Tennessee's dental division.

"We have found that many obese people have enormous amounts of dental hygiene problems, which can lead to heart disease. We concentrate on facilitating care for the member as a whole, not just delivering care structured around a particular component," Alsgard says.

When the case managers get a referral to manage the care of a member who has obesity as an issue, they provide telephonic case management and support to help the member lose weight. The case managers provide the members with educational materials, refer them to support groups within the community, and work with them to develop diet and exercise goals. "We take it in baby

steps, setting small goals that the member can reach. The next time we talk to the member, we repeat the goals and see if they have met them," Flowers says. Managing obesity involves more than just losing weight, Davis adds.

"Morbid obesity is a problem that must be dealt with on many levels. A person's social and emotional issues need to be addressed as well as the physical issues. Too frequently people think of a diet as a temporary means to an end. But once they meet their goal, they go back to their previous way of eating and the weight comes back," she says.

Patients may be eligible for weight loss medication or weight loss surgery depending on their body mass index but they still have to address diet, exercise, and behavior modification, she says. "All three components need to be addressed whether someone is trying to lose three pounds or 300 pounds," she says. In many cases, the medications a patient may take to treat a co-morbid condition may predispose him or her to weight gain, Davis points out.

"Co-morbid conditions and weight gain are interrelated and it's typically a vicious cycle that involves far more than just pushing away from the table to combat it," she says. Following patients across the continuum can help reinforce the lifestyle changes necessary for weight loss, Davis adds. Many need psychological help to deal with the lower self-esteem that being overweight can bring, she says. ■

Bariatric surgery patients need long-term support

Case managers follow them before and after surgery

Bariatric surgery works wonders, but it's not a miracle cure. That's why insurers and hospitals alike take pains to make sure their patients are prepared for the surgery and the lifestyle changes it requires.

"I make it clear to the surgical patients that they're not going to get out of diet and exercise. The surgery is a tool to allow diet and exercise to work for them," says **Pamela Davis**, RN, CCM, clinical coordinator for bariatric surgery at Baptist Metabolic Surgery Center of Baptist Hospital in Nashville, TN.

Davis, who underwent laparoscopic gastric bypass surgery in 2001, understands firsthand the challenges that her patients face.

Weight loss surgery can have a positive effect on the disease process, Davis points out. "We see patients who come in taking 60 to 100 units of insulin and they go home on a low amount or no insulin," she says.

Case managers working together on the payer and facility side help the patient ensure the long-term success of weight loss surgery, she says. (For details on how one health plan works with bariatric surgery patients, see p. **29**.)

There are three types of metabolic surgery:

Laparoscopic adjustable band

This laparoscopic procedure is the least invasive form of surgery and involves placing a band around the upper part of the stomach. The patient receives an access port that is used to periodically inject saline into the inner portion of the band to restrict the amount of food the patient can take in. It typically takes three to four saline injections to achieve optimal results.

Gastric bypass

This surgical procedure, typically done laparoscopically, creates a small stomach pouch and bypasses part of the small intestine. This results in restriction and a mild degree of malabsorption of food.

Duodenal switch

This surgery, usually done by open incision, removes a portion of the stomach, leaving room for about eight ounces of food at a time and provides a higher degree of malabsorption of food.

"In the health care field, we tend to think that once we've fixed the problem, the patient doesn't need us. Patients with morbid obesity can flip into their old habits at any time. We need to support the patients for a lifetime to make sure they maintain the weight loss and prolong the health benefits," she says.

Davis works with bariatric surgery patients through the entire process, beginning with the new patient seminars the surgery center presents for patients considering weight loss surgery.

The session typically takes one to three hours and includes details from a surgeon on the various types of surgical procedures. Davis talks to participants about the steps they must go through, dietary and other lifestyle changes that will be necessary after surgery, and what is expected of them as patients to make the surgery successful.

For instance, patients who have weight loss surgery must give up carbonated beverages and must make changes in their eating behavior such

as not drinking with meals and eating carbohydrates last.

Depending on the type of surgery they have, patients have to take vitamin and mineral supplements to compensate for what their body will no longer absorb.

Patients leave the seminar with packets of information about the criteria for eligibility and the process leading up to surgery, which can be lengthy depending on their insurance company's approval process.

At Baptist Metabolic Surgery, like other bariatric centers of excellence, patients are required to have a psychological evaluation before surgery.

"We need to make sure they are capable of understanding the lifestyle changes they must make and the long-term effects of surgery. If food is how they handle emotional issues, they may need help in developing other coping mechanisms," she says.

When the patient makes the decision to have surgery, Davis starts the educational process of case management and makes sure patients attend support groups and educational sessions before the surgery.

"It's important to take things slowly. It takes time for the patients to make the mental preparation and time for them to get used to the dietary changes," she says.

The insurance coordinator in the metabolic surgery program works with the insurance company to make sure the documentation is in place.

"Once we know the insurance company will cover the surgery, we help the patient collect the information to submit to the insurer," she says.

Typical requirements include a letter of referral from the primary care physician, documentation of weight loss attempts in the past few years, and a five year history of morbid obesity.

Davis meets with the patients to educate them on the lifestyle changes required for an optimal outcome from surgery. She is available by telephone to answer their questions in between visits.

"We see our patients multiple times for the first two years after surgery and at least once a year after that," she says.

When patients move out of state, Davis continues to follow them by telephone. She gets the results of their annual check-up and discusses it with them.

"We help support the patients in maintaining their weight and other long-term outcomes. I work with them to make sure they're not struggling with weight gain," she says.

Davis encourages the patients to continue taking their vitamins and follow their treatment regimen to avoid side effects such as fatigue and itchy skin.

"Once they start feeling good, they may think they don't need their vitamins. These patients need long-term support," she says.

Case managers in the insurance field whose clients include bariatric surgery patients, should make their own resources book, Davis recommends. She suggests asking the centers of excellence within your state for educational materials to keep on file.

"If insurance case managers have all the educational materials from the hospital where the surgery was performed, they can better help patients follow the recommended treatment regimen," she says.

For instance, if a patient isn't taking iron, the case managers can point out where the requirement is listed in the educational material and find out if the patient isn't taking the iron because he or she can't afford it.

When members of BlueCross Blue Shield of Tennessee are referred for bariatric surgery, their care is coordinated by an insurance case manager certified in bariatric surgery, who reinforces the education the member is receiving from the surgical team, says **Jackie Flowers**, RN, CCM, manager in total health management.

The case managers spend a lot of time on the telephone with members before the surgery to make sure they understand the process and to help them prepare for the surgery and the lifestyle changes that must occur, she adds.

"We emphasize that bariatric surgery is not an easy fix. Members need a lot of education to make sure they are committed to being compliant with the diet and exercise program they must follow," Flowers says.

The health plan conducts extensive evaluations of the member to make sure that he or she is a good candidate for surgery, adds **Nancy Alsgard**, RN, managing director of medical clinical strategy.

"Bariatric surgery is a major procedure and we take it very seriously. We are absolutely committed to assuring safety and success. We look at the members very critically to determine if they are prepared to make lifestyle changes in order to retain the long-term health benefit," Alsgard says.

The health plan's case managers follow the

members by telephone for at least six months after surgery to make sure they understand their post-operative instructions and that they are complying with the exercise and dietary regimen. ■

Multi-pronged program targets childhood obesity

Health plan works with schools, communities

With an eye to improving the health of their members over the long term, BlueCross and BlueShield of Tennessee has taken aim at childhood obesity.

"The goal of our childhood obesity program is prevention. We approach the problem from multiple angles, involving the schools, community, and providers," says **Ron Trammel**, RN, CPHQ, regional nurse liaison for childhood obesity for the Chattanooga-based insurer.

About 32% of all children are overweight, adds **Pamela Davis**, RN, CCM, clinical coordinator for bariatric surgery at Baptist Metabolic Surgery Center of Baptist Hospital in Nashville, TN, and a member of the advisory board of the Obesity Action Coalition.

"We're seeing school-age children with hypertension and type 2 diabetes. This may be the first generation that doesn't outlive their parents," she says.

When Davis worked with a vascular surgeon, she frequently saw patients in their late 30s who were having limbs amputated as a result of diabetes.

"Now that we're seeing children who are 9 or 10 with type 2 diabetes, we can expect that in a few years it won't be uncommon for people 24 to 30 years old to need an amputation as a result of diabetes," she said.

In Tennessee, at least one of three children are overweight, due to poor lifestyle choices they or their parents have made, Trammel points out. Many families eat fast food predominately, in part because it's cheaper than eating a balanced diet, he adds.

"If they don't change their lifestyle habits, they are going to end up as obese adults with all the underlying health problems," he says.

Keeping in mind that providers are reluctant to talk with patients about weight problems, the health plan has created a childhood obesity kit for providers. The kit, available on-line, includes links to educational materials and other resources including body mass index calculators and clinical practice guidelines for the treatment of childhood obesity.

"The physicians can download educational materials for parents from the site and distribute them to families," Trammel says.

The health plan employs masters'-prepared nurses in each of their regions with duties that include education with physicians and community organizations.

The regional nurses have met with more than 200 health care providers to discuss childhood obesity, to encourage them to measure and record BMI, and to explain how to address it with parents.

"The Childhood Obesity Tool Kit contains pointers on how to approach the issue without making the parents mad. This simple message has made a lot of difference," says **Nancy Alsgard**, RN, managing director of medical clinical strategy.

The nurses also are available to PTAs and other community organizations to present the health plan's community outreach program to help families make lifestyle choices that can help their children maintain a healthy weight.

The presentation includes information about diet and physical activities and includes simple things families can do such as turning off the TV and computer and taking the children outdoors every day.

"We promote small, incremental changes in diet and activity, such as taking a walk as a family or reviving the practice of having the entire family sit down to a meal together," Trammel says.

In addition, the health plan has developed a 30-minute DVD presentation on diet and exercise that it has distributed to PTAs, doctors' offices, health departments, and employer groups across the state.

The company has developed WalkingWorks for Schools, based on the BlueCross Blue Shield Association's WalkingWorks program. Participants are asked to walk for at least five minutes each school day for 12 weeks.

"This is a formal program that gets kids out every day to walk around in the school yard. We have created rewards associated with it and had a huge response," Trammel says.

Students get a WalkingWorks wristband when they agree to participate and certificates for completing the program. Schools that reach their goals

are designated "Extra Mile Schools" and receive a banner and recognition on the health plan's web site.

The health plan provides teachers with educational materials and suggestions for enhancing the program.

The company has worked on a statewide level to support legislation that regulates the type of snacks children have access to in vending machines at school and on a program in which school nurses track the body mass index of students.

Employer groups are beginning to recognize the importance of addressing the issue of childhood obesity and of working with the family as a whole, not just the employees, Alsgard says.

"We have spent a great deal of time creating our unique model that addresses childhood obesity. The program heightens awareness for the entire family and emphasizes that the parents have the responsibility to help the children change their eating habits and their lifestyle," she says. ■

Early screenings benefit kidney disease patients

Case managers educate members face to face

A case management program for members with chronic kidney disease provides one-on-one education that helps members of U-Care Minnesota manage their comorbid conditions and make lifestyle changes that slow the progression of the disease.

The KidneyCare program is a collaboration between U-Care and a local nephrology group, Kidney Specialists of Minnesota, which developed the program and provides the case managers who work with patients coming to their clinic, says **Jodie Milner**, RN BSN, U-Care's manager of disease management.

"We wanted to go with the model of using a provider specialist as a vendor. This way it keeps the primary care provider in the loop and ensures that a nephrologist intervenes with the member at an early stage," she adds.

The KidneyCare program promotes early screening for kidney transplants and early surgery to create a fistula or a graft for vascular access if it's determined that the member ultimately will have to have dialysis, Milner says.

"The vascular access of choice is a fistula, which takes several months to mature. It is essential that members have the fistula in place several months before they need dialysis," she says.

The other type of dialysis access, a "permacath," which is used mainly for starting emergency dialysis in a hospital setting, can cause complications such as sepsis and is not desired for long-term use, Milner says.

Since the KidneyCare program began in 2003, about 180 members have enrolled. All of the members enrolled have had a discussion with their physician about early-access placement for dialysis and have been assessed for transplant status.

Among members who have a hemoglobin count of less than 11, 98% meet criteria for the National Kidney Foundation's Kidney Disease Outcome Quality Initiative for anemia control by having vascular access put in early.

Before U-Care started the program, the majority of members saw a nephrologist for the first time when they were hospitalized for kidney failure and needed to start dialysis immediately.

"In this kind of instance, there is no time to put a dialysis fistula in place or screen the member for a transplant. The costs were high. When members are enrolled in the chronic kidney disease program early, there is more time between diagnosis and dialysis, and this allows for better and more cost-effective care," Milner says.

Getting members into the program early helps them learn to control co-morbidities, such as hypertension, which starts to cause kidney damage over time unless it is under control. The same thing is true for diabetes, which causes kidney damage unless the member's hemoglobin A1C is under control.

"The program is preventative as well as helping the members manage their disease," Milner says. When people are assessed for a kidney transplant early, they have a better likelihood of finding a donor.

"The costs for transplantation are high but after two to three years, it's equal to the cost of dialysis," she says.

Dialysis typically costs several thousand dollars a month, she adds.

U-Care Minnesota identifies eligible members from a claims search of kidney-related diagnoses. The health plan sends a list of potential participants to primary care providers and asks providers to screen patients for eligibility, and then refer them to the program if appropriate.

Members must have a glomerular filtration rate (GFR) of less than 60 and must have the approval of their primary care physician to participate in the program.

When members are referred to the program, a nurse case manager (KidneyCare nurse) from Kidney Specialists of Minnesota contacts them and sets up an appointment if the member agrees to enroll. On the first visit, the member sees the nephrologist who confirms the diagnosis. After that, he or she sees the KidneyCare nurse, who specializes in renal diseases. The KidneyCare nurses conduct an assessment every time they see patients and continuously screen them for eligibility for transplants.

The KidneyCare nurses refer members to other programs and providers from which they could benefit, such as smoking cessation programs or a renal dietician consultation. They encourage members to bring their family members to a class that includes an overview of kidney disease and the various types of dialysis, access types, dialysis options, and transplantation education.

They can refer members to a transplant program in conjunction with the nephrologist and to a vascular surgeon for an appointment to create a vascular access point for dialysis.

The KidneyCare nurses are a resource for U-Care members and their families whenever they have questions about kidney health, Milner says.

"One-on-one education is a big component of the program. When they visit the KidneyCare nurse, the members get high-quality one-on-one time with a clinician who understands their disease and can educate them and help them manage it," Milner says.

The members come into the office regularly to see the KidneyCare nurse who covers basic facts on chronic kidney disease, ways to slow its progression, and manage co-morbidities. The nurse educates the member on lab values and what they mean, stresses the importance of getting blood pressure or diabetes under control, and talks about ways to protect veins for future dialysis, she says.

The frequency of visits is determined by which stage the patient is in. Stage 1 means minor kidney dysfunction; people in Stage 5 are heading for dialysis.

"Most members are enrolled when they are in Stage 3. The frequency with which they see the KidneyCare nurses will escalate as their condition worsens," she says. The members see the KidneyCare nurses mostly for educational purposes.

The health plan notifies the KidneyCare nurse when members in the program are hospitalized so the members can receive post-hospitalization follow-up care.

U-Care works with the nephrologists and primary care physicians to collect and share data and to track the members' progress.

"The nephrologists and primary care physicians have established good relationships and they collaborate for good patient care. Proactive change is much easier if all the partners work together," she says. ■

'Urgent care' after triage not easy decision to make

Use these criteria, expert advises

One of the EMTALA-related questions he hears most frequently from providers is whether it is permissible to send patients to an urgent care setting following triage in the emergency department (ED), says **Stephen Frew,** JD, a web site publisher (www.medlaw.com) who specializes in interpreting the Emergency Medical Treatment and Labor Act.

The answer, Frew says, depends on several things, as he explains below:

Is the urgent care owned and operated by the hospital where the patient presented?

If the answer is no, the patient may not be triaged to urgent care.

Is the urgent care facility classified as a rural health clinic (RHC)?

If the answer is yes, the patient may not be triaged to the urgent care RHC.

Is the urgent care facility on the campus of the hospital where the patient presented?

If the answer is no, the patient may not be triaged to urgent care.

If the provider's urgent care question survives those three filters, Frew continues, it's time to consider these rules:

• All patients of similar condition, complaint, and acuity must go to the same location. The purpose of this is to prevent unequal treatment ("disparate" treatment in court terminology) and "cherry picking" of cases based on insur-

ance or revenue issues.

• There must be a valid medical reason for moving the patient. This means that patients must not be moved to the urgent care area for discriminatory reasons, revenue-related reasons, or for physician convenience.

• The patient must be escorted to the area, not sent there. This is to prevent patients from being sent out of the ED before assessment without any medical management between locations.

If the patient refuses to go to the urgent care setting and wants to be seen in the ED, the situation enters a "gray zone," Frew says. "From an EMTALA perspective, the patient came to the ED, and the ED is still an available option. On the other hand, the patient does not have an adequate basis to determine where he or she is best seen."

In such a case, Frew adds, he recommends advising the patient that the urgent care option is quicker and is just as reliable. Threatening patients with long waits, however, could be viewed as intimidation, he points out. "If the patient persists in wanting to be seen in the ED, by all means see the patient in the ED," Frew says. "Be polite. Remember, the alternative is that the patient may leave without being seen, which could lead to an EMTALA complaint or an adverse outcome with resulting malpractice issues."

While patients can be "unreasonable and manipulative," he adds, arguing with them is not worth the time, energy, lower customer satisfaction scores and risk that could result. Frew also notes that urgent care areas must follow all the same rules for compliance as the ED.

"Many urgent care [areas] are covered with co-payment signs, insurance requirements, and upfront registration procedures that are not EMTALA compliant," he says. "If you are using the urgent care for medical screening exams of presenting patients, then it is officially a 'designated emergency department' and must operate just like the ED for EMTALA compliance purposes." ■

Discharge change less oppressive in final form

Rule requires 'Important Message' revision

A potentially onerous hospital discharge rule proposed in April 2006 by the Centers for Medicare & Medicaid Services (CMS) is significantly less burdensome in its final form.

The new rule, released Nov. 29, 2006, will require hospitals to issue a revised version of the Important Message from Medicare that fully explains patients' discharge rights. Rather than issuing a second and different notice 24 hours before discharge as was proposed, hospitals will issue the Important Message within two days of admission, answer any questions, and get the signature of the patient or his or her representative on the notice.

Hospitals will be required to provide a copy of the signed notice before the patient leaves the hospital, but not more than two days before the departure. For short stays, this means the copy of the notice need be provided only once.

CMS has said that it will be developing the revised notice text, but before submitting it to the Office of Management and Budget for public comment and paperwork clearance will test it with beneficiary focus groups. The rule becomes effective July 1, 2007.

Opponents of the proposed rule had noted that it would add more bureaucracy to an already complicated and confusing discharge process for a patient population — generally more than age 65 — that needs assistance and guidance.

Proponents, meanwhile, had contended that the Important Message is not timely notice because it is not issued close enough to discharge.

The American Hospital Association (AHA) had expressed several concerns about the proposed rule, including that it would have the unintended consequence of unnecessarily extending the hospital stays of Medicare patients by an extra day because hospitals often cannot predict the date of discharge one day in advance.

"By requiring that [the notice] be rendered after the discharge decision is made and yet 24 hours before discharge, you end up in many cases keeping people another day," noted **Ellen Pryga,** AHA's director of public policy development. "With diagnosis-related groups, hospitals don't get paid for that."

Another concern was that the proposal was written in an "alarmist" way, Pryga said not long after it was issued. She said it would have created the impression that it was likely the patient would be sent home too soon and should automatically be asking a quality improvement organization to review the decision.

In other action, CMS has finalized its proposal to relax four requirements or conditions that hos-

pitals must meet to participate in the Medicare and Medicaid programs.

That final rule, effective Jan. 26, 2007, gives hospitals up to 30 days before a patient's admission or 24 hours after admission to complete a medical history and physical examination, and allows more health care professionals to perform the exam.

The record of the exam must be entered into the patient's medical record within 24 hours after admission.

In addition, the rule provides that all verbal orders given by a medical professional must be recorded within 48 hours in the patient's record by the medical professional or another practitioner responsible for the patient's care.

Previously, verbal orders could be entered in the medical record only by the physician who issued them.

The regulation also requires hospitals to secure all drugs and biologicals and, finally, permits any individual who is qualified to administer anesthesia, rather than just the person who administered it, to conduct the post-anesthesia evaluation. ■

Clinicians seek program to program uniformity

While the rapid growth of hospital-based palliative care programs is the good news, the bad news is the wide range of quality and standards that exist, notes **Betty Ferrell**, PhD, RN, research scientist at City of Hope National Medical Center in Los Angeles and chair of the National Consensus Project for Quality Palliative Care (NCP) Task Force.

"It is wonderful if Mercy Hospital in Des Moines and M.D. Anderson in Texas start programs, but what is more important from the patient's perspective is that there is some uniformity in programs," she asserts.

The fact that of the 2,000 plus hospital-based programs no two are alike is "a huge challenge," Ferrell continues. "What if you had a wonderful experience with your mom in your town but grandma is 100 miles away and gets sick, and you tell your brother he should definitely get her into a program? You might then find out the staff is an art therapist and a social care provider."

The idea behind the task force, she says, "is that we need a common definition and an assured framework, so consumers and payers and accrediting bodies can begin to have some shared understanding of what this is all about."

The NCP has taken significant steps in this direction, says Ferrell. "If you go to our web site [www.nationalconsensusproject.org], there are eight domains — a sort of simple template," she points out. The domains are: structure and process of care; physical; psychological and psychiatric; social; spiritual, religious, and existential; cultural; the imminently dying patient; and ethics and law. The NCP site also includes clinical practice guidelines and other detailed information on what a palliative care program should include.

"If you have a program now, or are starting one, refer to these. This is what will direct the future of reimbursement and accreditation, and you can look at them and assess how you are doing," Ferrell suggests.

Within the next couple weeks, for example, the National Quality Forum will have available on its web site written preferred practices for the field, after having reviewed the NCP's clinical practice guidelines, according to Ferrell. "We served on the NQF group, and they have developed preferred practices for each of our eight domains," she adds. "These measures indicate where the field is going."

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Family-centered care enhances patient ed

Model takes the focus off the teacher

List the components of patient- and family-centered care and many would think it was the formula for good education. The four core concepts include "dignity and respect," "information sharing," "participation," and "collaboration."

The family-centered care model takes the focus off the teacher, whether the nurse or another discipline, and places it on the learner. Patients and family members are seen as partners rather than as pupils, says **Kathy Ordelt**,

RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta. "It helps us to individualize the teaching a little better," she adds.

With the focus on the patient and/or caregiver, a good learning needs assessment to determine how they would like to be taught and what they would like to know becomes vital, says **Linda Broz**, RN, MS, patient/family education coordinator at Children's Hospitals and Clinics of Minnesota in Minneapolis. The information gathered from the learning needs assessment is used to individualize the education.

Individualized education is important in all situations, says Broz. Frequently, education is delivered in the same way for everyone, especially during a short length of stay, but that is not ideal.

When patients say reading is not their preferred learning style, yet written materials are used anyway, the educator is being disrespectful, says Broz. There are many ways to make sure the education is delivered in a way that is dignified and respectful.

Visual learners can be taught in a variety of ways including videos or with the aid of models, pictures, or hands-on demonstration.

Providing interpreters for patients and families that do not prefer to learn in English as well as giving out written materials in the appropriate translation shows respect, says Broz.

"It is a mind shift. You are looking at what they need and what is the best way to get that information to them," agrees Ordelt.

During a learning needs assessment, a family member or patient may say he or she learns best with a video but if there isn't a video on that topic then the health care professional must find the next best way to teach and present the information, she explains. If a less effective teaching method is used, the information may need to be repeated or other methods of teaching also incorporated into the process, she adds.

If patients and family members are not learning, one reason may be that the education has not been individualized enough so that learning can take place. Another reason might be that there are barriers prohibiting them from learning. When this is the case, the medical team needs to determine how to address them, says Ordelt.

Patients and family members are part of the actual educational planning process in a family-centered care model. While there are certain skills that must be taught for a safe discharge, the determination of how and when the information is delivered should be collaborative.

Also, patients and family members should be able to request additional information that would be added to the teaching plan. Of course, if their questions require in depth research, they might be referred to the learning center or advised to ask their physician.

Ordelt explains that a nurse may only have the time he or she is on shift to educate a caregiver or patient about a topic; Ordelt tells the family about the time constraints so they can work out the details. While scheduling the teaching session, she also can find out if family members would like any additional information.

"Sometimes in an emergent situation you have to teach immediately, but it is the attitude and the way the information is delivered and the way it is negotiated based on the mutual respect and trust you develop in those relationships; it is also seeing people as partners rather than us as the professional expert telling them what is and what is not going to be," says Ordelt.

To deliver patient education in a respectful and collaborative way, patients and family members need to be a part of the organization-wide planning of educational materials, programs, and processes through committee work, as part of task forces, and

other means, says Broz.

When Children's Hospitals and Clinics of Minnesota decided mechanical lifts needed to be used with some children with weight problems, families were involved in determining how these new patient lift procedures would be introduced to families. "They also helped write an education piece that would be given to families," says Broz.

Sometimes staff members think including patients and families in the planning will slow the process. However, the result is a better product in the end and it better meets the needs of patients and families, she says.

Ordelt says patients and family members can also provide insight into topics for new teaching sheets. "A family member might say 'I would have liked to have had a resource on this topic in the beginning; a teaching sheet would be helpful,'" she explains.

Another key component of patient- and family-centered care — information sharing — is directly related to education.

Many health care institutions have added resource centers, an invaluable resource Ordelt says, because family members can get information there they are not given at the bedside.

"At resource centers they can go on the web and also find different books on various topics. It is supplying a resource that will meet the needs of people who choose to use it to enhance their learning," says Ordelt.

However information sharing is more than providing good educational resources. It also involves good communication between patients, family members and the health care providers. Often family members will wait and wait to get information from the physician and as soon as they leave the patient's room the physician comes, says Broz.

Methods to remedy this problem might be to give family members a pager so the physician can notify them when he is available to see the patient, she adds.

Also it is important that the medical team communicate clearly by defining the medical terms they use and also pausing during the discussion often enough so family members or patients can ask questions.

"In patient satisfaction surveys a lot of the pieces that have to do with satisfaction relate to information sharing and that is a piece of education," says Broz.

[Editor's note: Kathy Ordelt recommends an 18-page "Family Centered Care Self Assessment Inventory," found in the back of a book produced by the Society of Pediatric Nurses and the American Nurses Association (ANA) titled Family-Centered Care: Putting it Into Action. *It is published by the ANA.]* ■

COMING IN FUTURE MONTHS

- Taking a proactive approach to cancer care
- Prenatal case management pays off
- Why behavioral health should be a part of any case management program
- Helping members deal with chronic pain

CE questions

9. Which is the least-invasive form of bariatric surgery?
   A. laparoscopic adjustable band
   B. tummy tuck
   C. gastric bypass
   D. duodenal switch

10. According to **Jodie Milner**, RN BSN, U-Care's manager of disease management, a graft is the vascular access of choice if a patient will ultimately have to have dialysis.
   A. True
   B. False

11. According to CMS, how long do hospitals have after a patient is admitted to complete a medical history and physical exam?
   A. 30 days
   B. 24 hours
   C. 48 hours
   D. 10 hours

12. The family-centered care model can improve patient education because it does which of the following?
   A. focuses on the needs of the patient
   B. seeks to individualize teaching
   C. allows patients to dictate education plan
   D. A & B

Answers: 9. A; 10. B; 11. B; 12. 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 **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■