Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Social workers in the ED help members access primary care

Plan cuts non-emergency visits by 45%

By locating a social worker in hospital emergency departments to help members overcome barriers to primary care, Horizon NJ Health was able to decrease ED visits by 45% among members who had a face-to-face conversation with the social worker.

The statistics compared the emergency room visits by members enrolled in the Medicaid managed care plan for a year before and a year after the initiative was begun, explains **Pamela Persichilli**, RNC, manager of clinical services and utilization management for the Trenton, NJ-based managed care organization.

Horizon NJ Health is the state's largest managed care organization for the publicly insured, serving members in all 21 counties in New Jersey.

The health plan embarked on a pilot project, locating a social worker in the ED of a large hospital, after a data analysis showed that a large number of members were using the emergency department for primary

Creativity helps health plans provide cost-effective care

With rising health care costs and an aging population, health plans are developing creative strategies to ensure that their members get the care they need in a cost-effective manner.

In many instances, this means face-to-face encounters with members whose health care costs are above average or who could be served as well in a lower level of care.

In this issue of *Case Management Advisor*, we'll look at some of the ways that health plans reach out to members. We'll show you how locating a social worker in the emergency department has helped an insurer connect its publicly funded members with a primary care physician. We'll show you how a Florida insurer has found advantages to integrated case management services in regional offices throughout the state. You'll learn how patient centered-management can dramatically reduce the cost of care and increase satisfaction among members with life-limiting conditions.

care purposes, such as treatment for sore throats and earaches.

The project was so successful that other New Jersey hospitals asked Horizon NJ Health to locate a social worker in their emergency department. As a result, the health plan has social workers located in the EDs at five hospitals.

"When somebody comes in with a minor ailment, such as a sore throat, they tie up the staff and take up the bed for someone who needs to be seen urgently," she says.

It's a capacity issue for the hospitals, Persichilli points out.

"Even when they have a fast-track system to handle non-urgent care, patients with primary care needs can cause a backup in the emergency department," she says.

The purpose of the initiative is to help members establish relationships with physicians they trust and who can develop a relationship with them while managing their care over time, Persichilli says.

For instance, a bladder infection could be an indication of other health issues. A primary care physician who has access to the member's medical condition can monitor it and make sure there is no underlying condition. When a member gets care in the emergency department, the ED physician takes care of the immediate needs but not the follow-up care.

"A primary care physician can not only take care of the earache or sore throat, but can provide continuity of care and ensure that the member gets regular check-ups and other procedures, such as mammograms," she adds.

When a Horizon NJ member comes into the participating EDs, the social worker is alerted. After the member has been treated, the social worker asks to talk with them and conducts a brief assessment to determine the barriers that kept the member from seeking care from a primary care physician.

"We don't interfere with the hospital's operation or the treatment team. We are absolutely respectful of EMTALA and don't interfere with the patient being seen. We don't turn anybody away from the emergency department," she says.

The social workers see all members who were discharged from the emergency department and who don't refuse the interaction. They conduct a short assessment and update telephone numbers, addresses, and family members to contact in case of an emergency.

During the assessment, the social worker asks the members why they didn't go to their primary care physician and if they want to change physicians.

The social workers have wireless computer and cell phones, which give them the tools they need to access the member's coverage and to find out and, if necessary, to change the primary care physician to whom the member was assigned at enrollment.

The majority of members who seek primary care in the emergency department do so because they don't like the physician to whom they were auto-assigned, Persichilli says.

When people are enrolled in managed Medicaid, they don't always do the paperwork

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Editorial Questions

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

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up front and choose a physician. In that case, they are automatically assigned to a physician in their area, Persichilli says.

Listening to patient preference

"When that happens, they may see the doctor's name on their card and, for some reason, they don't want to go there. Or, they went to the physician and it wasn't the right fit for them. They don't understand that they can call and change to another physician," she adds.

If the physician to whom they are assigned is what is keeping the member from going to a primary care provider, the social worker can pull up the names of physicians in the area and assign the member to the physician they choose.

The social worker helps the members and may make a follow-up appointment with the primary care physician of their choice. The member will receive a card with the time and date of the follow-up visit, the physician's name and address, and will set up transportation if it is needed.

If transportation is a problem, the social worker can link the member to Horizon NJ Health's transportation network, either through county transportation services or through a contract with a transportation company, to get them back and forth to appointments.

"Once you remove the barriers to care, there's a lot more success in follow-up and adherence," she says.

If the member has a chronic condition such as asthma or diabetes and could benefit from case management or disease management, the social worker gets them enrolled. Often she is able to set up a three-way telephone conversation and introduce the member to the case manager or disease managers who will be working with them.

Before implementing the program with any hospital, Horizon NJ Health conducts a claims analysis to identify the times during the day when the most members visit the emergency department.

"It's not a 9 a.m. to 5 p.m. job. We want to capture as many people as we can. The social workers staff the emergency departments during the times when there are the most visits among our members," Persichilli says.

For instance, peak hours for member visits are 11 a.m. to 7 p.m. at one hospital but are 2 p.m. to 10 p.m for another hospital in another part of the state.

The health plan conducts a claims analysis every six months to make sure that the data haven't changed.

The social workers are off during the days of the week when the volume tends to be lowest. Many work on Saturday and Sunday because those are some of the busiest days in the emergency department.

The master's-prepared social workers who participate in the emergency department initiative were chosen for their ability to understand the culture and language of the community in which the hospital is located.

For instance, the social workers in hospitals with large Latino populations are bilingual and are able to communicate with members who do not speak English.

The program has helped Horizon NJ Health establish a presence in the communities in which the hospitals are located, Persichilli adds.

People in the community have come to the emergency department, not for care, but to talk with the social worker, for help with a variety of issues, such as finding a doctor in their area or getting an appointment with a specialist.

The initiative has helped Horizon NJ Health with the perennial problem of keeping in touch with its publicly insured members who tend to be a transient population.

"We're updating our records and getting new cell phone numbers, new addresses, and relatives we can contact. Some members have said they haven't lived at that address for 10 years but it's what was in their records when they came into the Medicaid system," Persichilli says.

Using the wireless computers, the social workers are able to tap into the system and update the member records in real-time. ■

Integrated program takes proactive approach to care

Care coordinators link members with local resources

When members of Blue Cross Blue Shield of Florida are seriously ill, injured, facing surgery, or need help negotiating the health care system, their care is managed by a care coordinator located in their region.

The Jacksonville-based insurer consolidated its utilization management and case management functions and added member outreach, discharge

planning, and cross-training registered nurses to handle all of the functions.

Members now have a single point of contact — locally based care coordinators who are registered nurses and who can support them in making decisions about their health care, help them understand the alternatives available under their benefit, assist them in managing their health care dollars effectively, and promote compliance with their treatment plan.

Members happy with single-point contact

Since the company rolled out its Regional Care Coordination on Feb. 14, 2006, member satisfaction has soared, according to **Claudia Castro**, RN, CHCQM, FAIHQ, senior manager of regional care coordination for the northern region.

Recently, the care coordination program received a score of 4.82 out of a possible 5 points on the health plan's member satisfaction survey.

"With the complexity of today's health care system, members are very appreciative that someone is there to help them," she says.

The enhanced model provides a single point of contact for members, eliminating handoffs and the need for members to talk to multiple individuals as they move through the continuum of care.

"Now a single care coordinator handles member outreach, concurrent review, discharge planning, member education, case management, and member satisfaction. Our members have a single point of contact and one person they can call when they have questions or issues. They are also the single point of contact for facilities and physician providers for that member as well," she says.

Before the health plan went live with its integrative care coordination program, the utilization review nurses and the case managers went through an intensive skills assessment process and were cross-trained to perform all components of the job.

The insurer has three regional care coordination offices with field offices located throughout the state that help the company provide care and options that are tailored to the regional differences and different cultures located in various areas of Florida.

The care coordinators in the local markets are knowledgeable about the local health care delivery system as well as community resources that the members might need, Castro says.

"Care coordinators who are familiar with the local market can provide enhanced assistance for members as they navigate through the entire health care spectrum. They are informed about our participating providers and any type of service the member may need, whether it's acute inpatient care, home health, or durable medical equipment," she says.

The fact that the care coordinators have established a relationship with local providers makes it easier to facilitate care for the member, she adds.

Members are referred for care coordination by all internal departments at Blue Cross and Blue Shield of Florida, facility providers, physicians, ancillary network providers, and self-referral.

Any member with complex needs is referred for care coordination. For instance if a member is having difficulty getting an appointment with a specialist or is having problems getting precertified for a certain test or procedure, the care coordinator can review the provider network and options for the member and, if necessary, ask the medical director to assist in bridging any access to care issues.

"We take a personalized approach based on the member's need. There is no cookie-cutter plan for care coordination. Someone may be in care coordination for one or two months or through the entire continuum of care over a long period of time," she says.

For instance, a member might have a complex infection or serious injury that requires intensive wound care and may result in care from providers from the acute inpatient setting to a skilled nursing facility, then home care, and then outpatient care.

"We continue to actively participate in the member's care throughout the episode so we can ensure that the member is getting the right services in the right setting at the appropriate time and is moving to the next level of care when appropriate. At the same time, we make sure that the member is aware of his or her responsibilities and options based on their benefit structure," she says.

The arrangement results in increased efficiency because the care coordinators are already familiar with the members when they call and they don't have to spend a lot of time reading someone else's notes, allowing them more time to address the needs of the members, she adds.

The company takes a proactive approach to reach out to members who may be facing surgery or another health care event by initiating calls to the member as soon as the provider requests precertification for treatment.

As soon as a care coordinator is notified that

members are scheduled for orthopedic surgery, he or she calls the member, conducts an assessment, and starts to develop the discharge plan before the surgery takes place.

Proactive approach to discharge planning

The proactive approach to discharge planning is a benefit for members who have to assume responsibility for part of the cost of their health care, Castro points out.

"Our care coordinators prepare the members for what to expect depending on their benefit structure, such as what their covered benefits are and what they will have to pay out of pocket. They discuss discharge planning options, such as rehabilitation, discharge to a skilled facility, or discharge to home," she says.

In the case of members who are having orthopedic surgery, such as total knee replacement, the care coordinators educate them about a home exercise program they can do in advance of the surgery to facilitate the recovery process.

The care coordinators call members after discharge to make sure everything is going well and that their discharge needs have been met and that they have made an appointment for a follow-up visit with their physician. They answer any questions or concerns the members have and refer them to a physician if the situation warrants it.

"This is a proactive step to help the members avoid rehospitalization. If things are not going well, the case manager can assist the member getting the care they need," she says.

If the member is discharged to a post-acute rehabilitation center, the care coordinators follow them while they are in the facility and after they are discharged to home to make sure their needs are being met. When a member is home from the hospital and stable, the care coordinator closes out the active part of care coordination and follows up with a member satisfaction survey.

The health plan is rolling out the next wave of member outreach to members who have been precertified for other surgical procedures.

When hospitals notify the health plan that a member has been admitted, within a day after admission, the care coordinator assigned to that facility is aware the member has been hospitalized. The care coordinators then make outreach calls while the member is still in the hospital, if he or she meets the outreach criteria.

"We triage our members who are hospitalized to ensure that we reach the people who can most benefit from an intervention," she says.

For instance, a healthy 19-year-old member with appendicitis who is moving through the continuum of care on schedule is not likely to receive an outreach call.

On the other hand, a 19-year-old with appendicitis who stays in the hospital beyond the normal two-day stay will receive an outreach call.

"The care coordinator will call to determine what is keeping the member in the hospital. It may be that there is a comorbidity, such as diabetes, or a ruptured appendix with a level of infection that may require antibiotic therapy after discharge," she says.

When a hospitalized member has a chronic disease, the care coordinator takes the opportunity to link the members with the BluePrint for Health disease management program if the member is not already enrolled.

The care coordinators work with the discharge planners at the hospital to complete the discharge plan in advance of the discharge day. The members are active participants in creating the discharge plan and are aware up front of what their financial obligations will be, depending on the post-acute options they choose.

"In the previous model, concurrent review and case management were handled by separate nurses. The discharge planning was largely relied on as a facility obligation. We've taken a lot of the burden off the facility. They're not spinning their wheels creating a discharge plan and finding on discharge that the patient does not have that benefit," she says.

The care coordinators work with other community resource local providers to ensure that all of the members' health care needs are met.

"It's a collaborative process. We work with all providers, whether it's a surgical coordinator, a physician, a hospital, a skilled nursing facility, rehabilitation facility, home health agency, durable medical equipment provider, or infusion care company," she says. ■

Patient-centered care management saves money

Provides contact for people with late-stage illness

Patients with life-limiting conditions who received patient-centered management had dramatically reduced utilization and cost of care

compared to patients with similar conditions who received regular case management, a study by Blue Shield of California has concluded.

The study was so successful that the health plan opened the program to its entire commercial population who meet the criteria and has begun providing patient-centered management to its seriously ill Medicare HMO population with late-stage illness, according to **Andrew Halpert**, MD, senior medical director for the San Francisco-based health plan.

During the 18-month study, half of the patients received typical telephonic case management and half received patient-centered management, which included an initial home visit followed by an average of 10 hours a month of telephonic contact.

All of the participants in the study had access to the same benefits, network of providers, and HMO approval process.

The average utilization cost for the patients receiving patient-centered management was $49,742 during the 18 months of the study compared to $68,341 for the control group.

The patient-center management reduced hospital admissions by 39%, hospital days by 36%, and ED visits by 30%, while increasing home care by 22% and hospice care by 62%.

In addition, patients in the program gave it high scores in patient satisfaction studies, Halpert adds.

"We knew that patient-centered management was beneficial for our members who had complex medical needs. This study showed that it has value to the company as well," Halpert says.

The study included 756 patients in California with a life-limiting diagnosis and multiple comorbid conditions. About 75% of the participants in the original study were oncology patients. All were members of Blue Shield of California. The patient-centered management was provided through a contract with Paradigm Health Inc., a medical management company based in Upper Saddle River, NJ.

Blue Shield has continued its contract with Paradigm Health to provide management for patients in the expanded program.

"They have the infrastructure, expertise, and experience to run the program. We felt it would be more effective to continue to work with them, rather than doing it ourselves," Halpert says.

Currently, about 900 members are enrolled in the patient-centered management program at any one time. The RN case managers who coordinate their care handle a total of about 1,500 to 2,000 cases a year, Halpert says.

The expanded program includes Medicare patients who have neurological conditions, such as stroke and late-stage cardiac disease, as well as terminal cancer.

"We don't have the results of the interventions on the managed Medicare population but I anticipate it will work as well as in the commercial population. This program works very well for people who have very complicated diagnoses," Halpert says.

The health plan is conducting another study involving patients who have multiple complex conditions that do not qualify as late-stage illness. The program has the same design and structure with fewer interventions and no home visit, Halpert adds.

The patient-centered management team includes a care manager, a team manager who acts as a liaison with the health plan, and a physician advisor.

When members are enrolled in the program, the care manager makes a home visit and works with the patient and family members to create goals in six "care domains" — disease knowledge; treatment plan; terminal care planning; benefit plan management; family and living environment; pain and symptom management; and provider support.

A goal for the pain control domain might be to work with the physician to obtain better pain medications for the member, Halpert says.

"The nurse might encourage the patient to alert the physician to issues of poorly controlled pain. Often patients are hesitant to broach this issue, " he says.

A goal for the care plan domain might be to come up with a plan to deal with the side effects of medication and keep the patient from the emergency department.

Terminal-care goals might be to deal with financial issues or family support, such as having a caregiver in the home, he adds.

For instance, in one situation, a nurse worked with an employer so the wife of a terminally ill man could telecommute instead of leaving her husband to go to work.

"What these nurses do goes off the typical playbook for case management. They do whatever their patients need," he says.

The care managers in the patient-centered management program have a caseload of about 22 patients at a time, compared to typical health

plan case managers who oversee the care of 75 to 100 or more people at a time, usually working intensely with the members for only a week or two then calling them occasionally, Halpert says.

After the home assessment, the patient-centered management care managers make frequent telephone calls, an average of 14 a month, to the patients.

The outbound calls from the RNs to patients helped identify potential lapses in care, such as the case of a brain cancer patient who was about to run out of his anticonvulsant medication.

During a home visit, the nurse discovered that a patient with metatastic lung cancer, who was repeatedly being admitted for diarrhea, had confused his Lomotil with milk of magnesia. She removed the milk of magnesia from the medicine cabinet and the hospital admissions ended.

Members of Blue Shield who have chronic illnesses but don't qualify for the patient-centered program are enrolled in the health plan's disease management programs.

If their illness intensifies, Blue Shield of California's disease managers can refer them to the patient-centered program.

"Our disease management programs are very robust but they aren't geared to the late-stage illness paradigm. When patients' conditions become life-threatening, they can benefit from more intensive care management," he says. ■

LegalEase

Understanding Laws, Rules, Regulations

When physicians refer post-acute providers

Elizabeth E. Hogue, Esq.
Burtonsville, MD

Discharge planners/case managers may encounter physicians who insist upon making referrals to specific post-acute providers. These physicians may serve as medical directors or provide consulting services to the providers to whom they insist upon making referrals. Are these types of arrangements appropriate?

The "short answer" is that they are permissible, if applicable requirements are met.

Specifically, these types of arrangements must comply with the following:

- Federal statute governing illegal remuneration or kickbacks and rebates and regulations that provide for exceptions or "safe harbors."
- Federal Stark laws and regulations, including exceptions.
- State statutes and regulations that may govern referrals by physicians to other providers.

The federal statute that governs illegal remuneration says that anyone who either offers to give or actually gives anything to anyone in order to induce referrals has engaged in criminal conduct. There are, however, exceptions or "safe harbors" that often apply to arrangements between referring physicians and providers who receive referrals, as described below.

The so-called Stark laws and regulations prohibit physicians from making referrals to providers in which they have a financial interest, including contractual arrangements, unless the arrangements meet the requirements of an applicable exception described below. Stark applies only to designated health services (DHS). DHS include home health and home medical equipment (HME) services but do not include hospice services.

State legislatures also have enacted statutes that govern referral arrangements between physicians and other providers. These statutes vary from state to state.

Payments by post-acute providers to physicians who provide consulting/medical director services and also make referrals are kickbacks and violate the Stark law and regulations. As indicated above, however, there are a number of exceptions to both statutes. If physicians and post-acute providers meet the requirements of applicable exceptions, these types of arrangements are appropriate even though they would otherwise violate the anti-kickback and Stark statutes and regulations.

Specifically these types of arrangements must meet the requirements of the personal services and management contract safe harbor under the anti-kickback and rebate statute and the contractual exception to the Stark statute. They must also meet the requirements of applicable statute statutes and regulations, if any.

The basic requirements that must be met to comply with the exceptions to federal laws are as follows:

• Providers must enter into written agreements with physicians that are signed by providers and physicians, which specify the services covered by the arrangement.

• The arrangement must cover all of the services to be furnished by referring physicians to providers.

• Aggregate services provided cannot exceed those that are reasonable and necessary for the legitimate business purposes of providers.

• The term of these arrangements must be for at least one year.

• Compensation paid over the term of the agreement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

The services to be furnished under such arrangements do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

If these requirements are met, it is permissible for physicians who provide paid consulting/medical director services to make referrals to providers who pay them for their services. The "bottom line" is that these types of arrangements may be acceptable and should not be viewed as illegal or unethical by case managers/discharge planners unless the applicable requirements are not met. ■

Joint Commission focuses low health literacy issues

Communication gap addressed

When The Joint Commission released information on how to narrow the communication gap between patients and health care practitioners to improve patient safety, some people in the field of patient education said, "It's about time."

That's because The Joint Commission finally put muscle behind educational strategies patient education managers have been trying to make common practice for years.

"It's like the 200-pound gorilla speaks. When accreditation bodies take on these kinds of initiatives the health care systems start to take notice, and they put in place processes to make sure it happens," says **Sandra Cornett**, PhD, RN, director of the OSU/AHEC Health Literacy Program at The Ohio State University in Columbus.

"JCAHO is a key driver for our organizational change and priority setting," says **Cezanne Garcia**, MPH, CHES, associate director for patient- & family-centered care and education services at the University of Washington Medical Center in Seattle. Therefore, she expects good communication practices to become more commonplace.

For example, one established communication method specifically highlighted by The Joint Commission is "teach back," a technique that is very familiar to patient education managers.

Teach back is the best and easiest way to evaluate understanding, says **Fran London**, MS, RN, a health education specialist at The Emily Center at Phoenix (AZ) Children's Hospital. Using the teach back method, for evaluating understanding of the information taught, health care practitioners ask patients how they would explain a procedure, treatment, or self-management skill to their spouse or mother.

"It's time to get back to basics with patient education and realize the intent of patient education is to equip patients and families to be able to participate in informed consent and decision making; participate in their care and decisions; know how to care for themselves at home; and know when and how to call their health care provider," says **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta.

Health care institutions have responded favorably to many issues The Joint Commission has pushed, such as hand washing, says London. "It's hard to argue against communication. However, it is a much more complex skill than hand washing and will need more attention to get results," she adds.

The Joint Commission plans to give it the attention. During the news conference, **Dennis S. O'Leary**, MD, president of The Joint Commission, said the national patient safety goals and related requirements, such as medication reconciliation, relate to the communication issues in the white paper. However, the way in which the requirements are framed do not draw explicit attention to the issue of low health literacy; therefore, The Joint Commission would look at reframing the requirements.

He also stated there is a table in the paper that focuses on how to implement patient safety goal

requirements in a health literacy context.

"Helping practitioners recognize health literacy problems begins with providing them with an awareness of the problem. Many practitioners really don't know much about health literacy and how it impacts health outcomes," says Cornett.

Therefore, Cornett first provides a basic explanation of low health literacy before teaching practitioners the clues to look for and questions to ask to determine if there is a communication problem.

She says the use of case studies is a good way to get the key points across as well as showing videos on low health literacy. She has written a handout that includes clues to look for and questions to ask to assess a patient's ability to read.

Some of the clues to watch for include a patient listening or watching attentively to try to memorize information or having difficulty following directions.

Questions to broach the subject of reading problems may include:

- Do you like to read? How often do you read?
- Medical terms are complicated and many people find the words difficult to understand. Do you ever get help from others in filling out forms, reading prescription labels, insurance forms, and health education sheets?
- A lot of people have trouble reading and remembering health information because it is difficult. Is this ever a problem with you?
- When you have to learn something new or unfamiliar to you, what ways do you prefer to learn the information? Do you like to read, watch TV or videotape, listen to tapes or CDs, use the computer, talk to other people, or practice how to do something?

Communication methods such as "teach back" need to be a part of staff education programs and included in orientations, in-services, continuing education programs, or self-directed learning modules.

"If every program on a clinical topic had a section on not only what patients should be taught but also how to teach it we would be further ahead in establishing a norm for patient communication methods," says Cornett.

London agrees, "Skills such as the 'teach back' method may not be part of the education health care professionals receive. It is not a skill incorporated early in training," she says.

To make sure patients understand what is being taught, patient care pathways or patient education plans used by staff need to reflect some of the methods for clear communication. In addition, policies and procedures for patient education and patient-centered initiatives need to have communication methods spelled out, says Cornett.

For example, at The Ohio State University Medical Center, the guidelines for creating teaching tools state "ideas on how to implement the educational plan and teach the content" are to be included.

Also staff competencies in effective patient communication methods need to be written into job descriptions and performance appraisal systems and evaluated with other clinical competencies.

When included as part of staff competencies, effective patient communication methods then become a staff expectation in giving care and the message that "it is valued" is sent to staff, says Cornett.

While many of the recommendations for clear communication made by The Joint Commission seem to be core patient education strategies, they have not become a common part of health care practices because the "system" has not held the practitioner accountable for these practices and often the support for the staff to implement the strategies is nonexistent, says Cornett.

"We set up practitioners for failure because we expect unrealistic results in a fast-paced, highly emotive environment when patients are least likely to be able to learn. Patient education managers need to help practitioners better prioritize what is needed and choose realistic ways to accomplish the patient education," explains Cornett. ■

Better education needed to prevent hepatitis

Often liver is 'out of sight-out of mind'

Love your liver, says **Thelma King Thiel**, chairwoman and CEO for Hepatitis Foundation International based in Silver Spring, MD. Thiel would like this statement to be as common as "Fasten your seatbelt."

Why? Few people give much thought to their liver. While they think about other organs, such as the heart and lungs, the liver rarely comes to mind, yet it is vitally important.

A "healthy liver is essential to a healthy life," according to the American Liver Foundation located in New York City. The liver performs over 5,000 functions minute by minute including converting food to nutrients, storing vitamins and minerals, and detoxifying harmful substances.

An important part of liver health is preventing hepatitis, which is inflammation of the liver, in its various forms categorized as A, B, C, D and E, says Thiel. That is why Hepatitis Foundation International has declared May as Hepatitis Awareness Month.

A large percentage of people with hepatitis do not know they are infected because the liver is a non-complaining organ, says Thiel. Therefore, they do not seek treatment and are spreading their disease to others and damaging their liver.

To curb the spread of hepatitis, people with behaviors either in the past or present that put them at risk for contracting the disease should be tested. Also, more people need to learn the steps to preventing hepatitis and healthful habits that keep the liver in good condition.

"I feel very strongly that if you do not know how important your liver is, you will not be motivated to either change your behaviors or assess your own risk behaviors," says Thiel.

There are many areas in which hepatitis awareness must be increased. Health care professionals need to do a better job of teaching about the liver and the dangers of hepatitis, says Thiel.

To teach the difference between hepatitis A, B, C, D, and E Thiel suggests the use of vowels — A, E, I, O, U. Hepatitis A and E, which are vowels, are found in the bowels, while the others are found in the blood. Hepatitis D and E are not common in the United States.

This simple definition helps clarify the different types of hepatitis in a person's mind so they can more easily understand how the disease is transmitted and what puts them at risk.

At-risk behaviors

For hepatitis A and E the virus is transmitted via the feces of an infected person either directly or indirectly from contaminated food, raw shellfish, drinking water, cooking utensils, or someone's fingers.

"If someone who is infected does not wash their hands after they have a bowel movement and prepares your salad in a restaurant you are eating their virus," says Thiel.

Hepatitis A is an acute condition with flu-like symptoms if any are present. Most people recover completely from hepatitis A; however B and C can result in a chronic, lifelong infection.

Hepatitis B is transmitted through sexual contact or exposure to an infected person's blood through transfusion, cuts, open sores, or sharing sharp instruments such as needles and razors. It can also be spread from mother to child at birth.

About 90% of people who contract hepatitis B clear the virus on their own, says Thiel. Those who don't are considered chronic and are at risk for cirrhosis of the liver, which is caused by damaged cells. They are also at risk for liver cancer or liver failure. While there is no effective treatment for the cure of hepatitis B, there is a vaccine available to prevent it.

Thiel says people with at-risk behaviors, such as those in prison and those being treated at clinics for sexually transmitted diseases, are now being given the vaccine. She adds the virus would not be so widely spread today if health care professionals treating patients at STD clinics had begun routinely using the vaccination in the 1980s when it became available.

Hepatitis C is mainly transmitted via direct blood contact. Prior to 1992, blood donated for transfusions was not routinely screened for the virus and, therefore, about 15-20% of people who had a transfusion prior to that date could be infected with hepatitis C.

About 75% of hepatitis C cases are chronic and can lead to cirrhosis. While there are drugs available to treat hepatitis C, not everyone responds to these treatments, says Thiel.

While physicians routinely order blood tests as part of a physical examination, they do not automatically screen for hepatitis B or C. While it would not be cost effective to routinely screen for hepatitis, those who should be screened could easily be identified if the right questions were

asked during the health assessment, says Thiel.

For example, patients could be asked if they have ever done any of the following behaviors that put them at risk for hepatitis: used IV drugs, had extensive dental work, had a blood transfusion, had unprotected sex, shared needles or other sharp instruments such as a razor or ear piecing tools, or snorted cocaine.

Table tents in a physician's office with similar information could prompt people who might be at risk to get tested.

Professionals who work in clinics and other areas where patients are at high risk should routinely tell them how to adopt healthier lifestyles to avoid hepatitis. About 70% of all new cases of hepatitis C are related to injection drug use.

School-age children should be taught about their liver and the prevention of hepatitis. Just as children are taught how to brush their teeth they should be taught how to wash their hands after going to the bathroom, says Thiel.

"Prevention is a team effort, starting in the schools and continuing into adulthood," says Thiel.

To aid in this effort, the Hepatitis Foundation International has created several short educational videos. The organization also routinely develops campaigns to increase awareness, such as the Social Drinkers Alert to educate about hepatitis C.

"Alcohol accelerates the disease process for those who have hepatitis C," says Thiel. "People may feel fine yet be infected and therefore damage their liver each time they drink a six-pack of beer while watching a football game."

When awareness of viral hepatitis, a disease affecting more than 500 million people around the world, is raised through education the chances of eradicating it are increased, says Thiel.

[For more information about ways to raise awareness about liver health and the dangers of hepatitis, contact:

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California launches hospital report card site

A new web site, www.CalHospitalCompare.org, enables Californians to compare the performance of more than 200 hospitals statewide on a variety of quality measures from maternity services to cardiac treatment.

The free service allows consumers to search for hospitals by location, name, or by medical condition. Hospitals are rated on 50 performance indicators, including patient satisfaction measures and specific conditions, such as heart disease, maternity, and pneumonia.

CalHospitalCompare is the result of a two-year collaboration by The California Hospital Assessment and Reporting Taskforce, whose members include hospitals, health plans, doctors and nurses, consumer groups, employers, and the California HealthCare Foundation (CHCF). The data collection and analysis was performed by the University of California at San Francisco's Institute for Health Policy Studies.

Beyond consumers, CalHospitalCompare is also intended to benefit health care organizations. The report card is intended to provide health plans with relevant information to make decisions about which hospitals to include in their networks and offers hospitals reliable data to help improve the quality of care at their facilities. Physicians, nurses, and other health care professionals can use the data to make referral decisions.

CalHospitalCompare will be updated regularly with new measures. Future enhancements will include a Spanish-language version and an expanding set of performance measures; specifically, pediatric and intensive care measures will be added later this year. ■

COMING IN FUTURE MONTHS

- How prenatal case management can improve infant health
- Strategies for managing the care of the frail elderly
- Improving the life of chronically ill members
- How diversity affects the case management process

CE questions

17. In Horizon NJ Health's pilot project, social workers see all patients in the emergency department.
A. True
B. False

18. Blue Cross Blue Shield of Flordia consolidated utilization management and case management functions, and added which of the following?
A. member outreach
B. discharge planning
C. cross-training RNs
D. all of the above

19. Which of the following is true about Blue Shield of California's patient-centered management program?
A. The average utilization cost for patients increased compared to the control group.
B. Hospital admissions were reduced 39%.
C. ED visits decreased 30%.
D. B & C

20. To narrow the communication gap between patients and health care practitioners, The Joint Commission recommends which of the following strategies?
A. Use of established methods like "teach back."
B. Improved informed consent process.
C. Development of patient self-management skills.
D. All of the above.

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

CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

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. ■