Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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AUGUST 2007
VOL. 18, NO. 8 • (pages 73-84)

Health coaches help participants follow their personalized health plan

Patient-centered approach focuses on behavioral change

Duke Integrative Medicine takes health coaching to a new level, providing coaching by highly trained health care personnel who work closely with their clients to help them follow their personal health plan.

"What we do is more than just motivate people to change. It's helping connect their behavior to their values and to what matters most to them," says **Julie Kosey**, MS, CPCC, ACC, integrative health coaching manager at Duke Integrative Medicine.

It is the first major academic medical center to develop a specified role for the health coach on the clinical team. And the program's success was demonstrated in a study of 154 outpatients with one or more known cardiovascular risk factors who received a personalized health plan and worked with a health coach to set and achieve goals.

At the end of the 10-month study, participants experienced a reduction in risk for coronary heart disease as measured by the Framingham risk score.

A health coaching program tailored for a subset of high-risk Duke employees and their dependents resulted in fewer hospitalizations and lower emergency department costs for those who would have qualified for the program but did not participate, says **Ruth Wolever**, PhD, director of research at Duke Integrative Medicine and assistant professor of psychiatry at Duke Medical Center.

Health coaching meet personal coaching

"Health care has long been about treating disease to return a person's body and mind to an acceptable state of health, and separately, people have sought the support and guidance of coaches to help them move to new levels. Health coaching brings these two worlds — health coaching and personal coaching — together," Kosey adds.

Integrative medicine combines state-of-the art medical treatments and evidence-based complementary therapies and focuses on the whole person, rather than a disease or condition to help the patient achieve optimal health. In addition to traditional Western medicine therapies, such as treatment by physicians and prescription medicine, participants in integrative medicine programs may receive services including physical therapy, nutritional therapy, movement and exercise, health psychology, stress reduction and mind-body inter ventions, botanicals, and acupuncture.

"Our mission at Duke Integrative Medicine is to be a catalyst to shift the way that health care is practiced, to move to a more patient-centered approach," Wolever says.

During what is called an "immersion experience," each patient collaborates with physicians and other health care professionals and develops a plan tailored to his or her needs, then works with the health coach to reach the goals set out in the plan.

The depth of the program is what distinguishes Duke Integrative Medicine's health coaching from those offered by other entities, Wolever says.

"I presented at a teleconference with several disease management entities. At the end, someone asked the typical caseload of each program. One said 250, another said 500. Our health coaches work with no more than 30 people at a time," she adds.

"Often people have a lot that they need to do to become healthy. They want to work on some of [those things] and they don't want to work on others. One thing the integrative health coaches do better than traditional health care providers is stay focused on what is important to the client," she says.

The multidisciplinary team at Duke Integrative Medicine includes physicians, nutritionists, exercise physiologists, and health coaches as well as ancillary services such as psycho-social services, acupuncture, and massage therapy.

Participants in the integrative health coaching program become involved in a number of ways.

During the immersion experience, participants work with a variety of disciplines over a three-day period, then work closely with a health coach to follow the personalized health plan the multidisciplinary team recommends.

"There are multiple pages of suggestions. This is overwhelming for most people. Together we create a plan that helps them choose what is most important to them out of the whole big picture. The plan shifts and changes as they try out different things," she says. The integrative medicine center offers enrollment programs that include consultations with the health care team, coaching sessions, and personal health plans as well as personalized group programs for businesses, families, and groups as well as day and half-day programs.

"The concept of this program is to empower the patient through education and skill building. It's a holistic program that gives patients access to providers with different views who can help them create a health plan," Wolever says.

When participants enroll in the health coaching program, the coaches help the participants

Case Management Advisor™ (ISSN# 1053-5500), is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Case Management Advisor**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $9.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, $449. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

Editorial Questions

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

This activity is valid 12 months from the date of publication.

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identify what they want to work on and to be specific and look at how the changes they want to make would influence their life as a whole, Kosey says.

In most situations, the participant and the health coach develop specific goals in each session and discuss what worked and what didn't the next time they talk.

It's not all or nothing

"Health coaching is all about helping people identify what is important to them and how they can go about it. The most critical piece of the process is whether the person is ready to make the changes. So many people see their physician who may say that the most important thing they can do is quit smoking. They're not ready to do that, so they don't do anything," Kosey says.

For instance, when a health coach meets with a smoker, if that person says they want to start walking for exercise, the health coach helps them get started in the process.

"There's often a ripple effect. They start walking and find they are short of breath and this encourages them to stop smoking," she adds.

The participants may want to have the energy to play with their grandchildren, or to be around for their daughter's wedding, or to be able to climb a mountain. Whatever their goal, the health coach helps them reach it.

"A lot of health coaching through occupational health or health insurance has a disease-management focus, such as encouraging patients to manage their blood sugar and report the results the next week. What we are doing is to help the person understand what differences it would make in their life if they got their diabetes under control. Integrative health coaching is not just about accountability but helping the person learn about themselves. We help them engage in personal reflection in addition to, or instead of, a specific action," Kosey says.

Individual coaching sessions are typically 30 to 40 minutes in length. Group coaching sessions are an hour in length and may take place in person or over the telephone via conference calls.

The integrative health coaches have master's degrees in health promotion or behavioral change, such as health psychology and are trained in how to help people change the way they relate to the world and how they behave.

Duke Integrative Medicine provides training for the coaches on motivational interviewing, assessing readiness to change, and on mindfulness along with clinical training that gives them the knowledge to work with members of the interdisciplinary team.

The coaches are trained to recognize symptoms that indicate that people need to seek medical care. ■

Health program saves $1.70 for every dollar

Inpatient admissions down, member satisfaction up

A health management plan for members with chronic conditions has generated a 1.7-to-1 return on investment and glowing responses to member satisfaction surveys for Health Alliance Plan (HAP).

Health Alliance Plan began the HAP HealthTrack program in August 2004 with a program for members with heart failure and expanded it to include other chronic conditions after the heart failure component showed a decrease in hospitalization and an increase in recommended care. For instance, from 2003 to 2005, the number of inpatient admissions among HAP members with congestive heart failure declined by 65%. Use of ACE inhibitors among members with heart failure increased from 38% prior to the program's implementation to 78% in 2005. The percentage of members with LDL cholesterol levels below 100 mg/dt increased from 61% in 2003 to 70% in 2005.

"In addition to the financial gains and improvement in member health, this program has enhanced member satisfaction. This year, we've had about close to a 70% return rate on our surveys. We have evaluated the first 117 surveys returned and 100% of members who talked to a case manager reported being satisfied or very satisfied," says **Richard Precord**, MSW, director of clinical care management for the Detroit-based health plan.

Members at high risk for hospitalization or complications from the disease work with an RN case manager, and, if indicated, a behavioral specialist or pharmacist, who helps them learn to self-manage their conditions.

"We have developed a member-centric chronic care registry rather than a disease-specific registry. We approach our members holistically, rather than from the standpoint of a disease," Precord says.

The case managers are cross-trained to work with members with all of the conditions in the program and attend regular in-services on the various conditions. They can call on a certified diabetic educator if needed when they work with members with diabetes.

"We have a high prevalence of comorbidities. For instance, many of our members with heart failure also have diabetes. There aren't very many members who have just one condition. We look at all the members' needs and work with them on all conditions," Precord says.

Members are identified for the program by a variety of methods. The health plan automatically analyzes medical claims, pharmacy claims, and laboratory claims and values every month to identify members with chronic conditions. The computerized system also looks for gaps in care that may indicate that a member's disease is not being well-managed. For instance, the program flags members with diabetes who have not had regular hemoglobin A1c tests as well as those whose test results are outside the normal range.

The enrollment packet sent to new members includes information about the program along with the insurer's web site and a telephone number to call for more information. If the data show that new members are not managing their chronic disease well or have not had the recommended tests and procedures, they are referred to the program for appropriate intervention.

"Our data system also identifies members who were admitted to the hospital with a chronic disease or who have had a coronary event and been hospitalized as soon as they are discharged so that a case manager can call them. We also get referrals from physicians and other providers," Precord says.

The names of members who are identified with chronic illnesses and gaps are forwarded to an enrollment center where the staff make outbound calls to members to discuss the program and schedule them for a telephone appointment with a case manager.

"There are health risk indicators for each condition that prompts a telephone call," Precord says. For instance, a member who has a high LDL cholesterol level or someone who has made a visit to the emergency room is referred to case management.

The case managers have the member's health profile, medication, labs, and utilization data at their fingertips when they call the members. The case manager completes an extensive assessment over the telephone and, based on the assessment and other information, the case manager identifies goals and works with members to set priorities, Precord says.

"In the past, the case managers would get a member's name and number and then call the doctor's office to obtain clinical information. We have put together a methodology we use to prioritize members. They are risk stratified before the nurse calls them and the relevant clinical data are readily available to the nurse. It's a much more efficient way of doing things," he says.

Case managers frequently contact members over the first three months, then taper off the calls when the members begin to better manager their condition. Members work with the same case managers on managing their conditions.

"Many of these members are trying to manage multiple conditions, which can be very overwhelming. The case managers work with them on getting the conditions under control and eliminating barriers to appropriate care," he says.

HAP's case managers go through training on motivational interviewing and behavioral changes so they can more effectively engage members and facilitate healthy behavioral changes.

"Helping members manage chronic diseases is not as simple as just calling them and telling them what to do. Case managers need to find out what motivates people to change," he says.

Since there is a high prevelance of depression among people with chronic conditions, the disease management case managers may co-manage members with the behavioral health team when appropriate.

Promoting self-management

HAP's program promotes self-management of chronic diseases. During the early weeks members are in the program, case managers work with them to develop action plans and to set health goals.

The case managers call on HAP's clinical pharmacists for a consultation if a member isn't taking their medication or has questions about the medication.

For instance, the case manager can refer a member to the pharmacist if the member with asthma is using his rescue medicine too much or if a diabetic has questions about getting his LDL cholesterol under control.

The clinical pharmacists talk with the members and educate them on how and when to take their medication. They may contact the members' physi-

cians to discuss medication or dosage changes.

Members with chronic obstructive pulmonary disease, heart failure, and diabetes who are at high risk for hospitalization are eligible for HAP's telemonitoring program.

Members in the program receive a small appliance that plugs into the telephone line. The appliance beeps every morning to remind members that they need to answer a series of questions. For instance, members with heart failure are asked to weigh themselves and answer a series of questions that assess their symptom knowledge and behavior patterns.

The system automatically flags members whose answers indicate health problems.

"The system helps us identify people early when they have difficulties and gives us the opportunity to intervene. The member may be scheduled for the next phone call from a case manager next week but if there are signs of a deteriorating condition today, the case manager can take action to help them get needed care or avoid a potential visit to the emergency room or a hospitalization," he says.

Case managers in the program work hand-in-hand with physicians to help the members learn to manage their condition.

"We emphasize to the members that we are helping them follow the treatment plan from their physician," Precord says.

The health plan sends provider bulletins and newsletters to physicians to let them know that the program is available to support their plan of care.

When a member is identified for case management, HAP sends a letter to the physician with details about the member's condition and the goals the member and case manager have set.

The plan sends physicians regular updates as the members work toward meeting the goals. "If something urgent arises, the nurses alert the members' physicians by telephone and work with them to get the condition under control," he says. ■

Multi-pronged plan helps members with chronic illness

Interventions depend on the severity of disease

Health Plan of Nevada Inc. takes a multi-pronged approach to managing the care and services of its chronically ill members throughout the continuum of care.

Depending on the severity of their condition, members' care and services may be coordinated by an RN health coach or a case manager. A home health nurse at one of Health Plan of Nevada's sister companies, Family Health Care Services, may become involved when the member requires regular monitoring of his or her condition using an in-home telemonitoring device.

Health Plan of Nevada is a wholly owned subsidiary of Sierra Health Services, a Las Vegas-based diversified health services company. Other Sierra Health subsidiaries include Southwest Medical Associates, the largest multi-specialty medical group in Nevada with a staff of 250 staff doctors who work in 14 clinical locations.

Health Plan of Nevada's health management program focuses on four chronic conditions — chronic obstructive pulmonary disease, congestive heart failure, diabetes, and pediatric asthma.

The program was developed in partnership with Southwest Medical Associates, which many members choose for primary care providers.

The health management program has resulted in an increased number of members who receive the recommended tests and procedures for their chronic diseases, reports **Deborah Wheeler**, MSPH, director of quality improvement.

For instance, the percentage of members with diabetes who had hemoglobin A1c tests increased from 72.8% in 2003 to 83.5% in 2006. During the same time period, the proportion of individuals with diabetes who received LDL cholesterol tests rose from 75.2% to 91.5% and those who received screenings for kidney disease increased from 49% to 62%.

When members are identified for the program, they are stratified into low, moderate, and high-risk groups, based on their history of inpatient hospitalizations, emergency department and outpatient visits, and/or laboratory test results, according to Wheeler.

Depending on their level of risk, the members receive interventions designed to help them get their condition under control and avoid developing complications or being hospitalized.

All members receive disease-specific materials when they are identified for the program and receive follow-up postcards reminding them of recommended tests or procedures such as eye examinations for members with diabetes and flu shots for all members in the program.

Members at high and moderate risk work with health coaches who educate the members on their

disease, make sure they receive recommended tests and procedures, and work with them to help them follow their physician's treatment plan.

The RN health coaches are supported by non-clinical staff who make initial contact with the members and schedule them for a phone call from the health coach, helping maximize the time of the health coaches, Wheeler says.

When the health coaches make their first telephone calls to the members, they conduct a health assessment and review the member's health issues. They encourage the members to see their primary care physician if they have not had the recommended disease-specific tests and examinations, she adds.

The role of the health coaches is to support the treatment plan of the providers, to make sure the members remain compliant with their medication regimen, and to schedule appointments for recommended care. The frequency of the telephone calls depends on the member's risk level.

The health coaches work to develop a relationship on an ongoing basis and typically work with the same member as long as he or she is in the program.

"The health coaches work with the primary care physician to encourage the member to self-manage his or her condition. They help the physician identify other issues with the members and contact the physician if they feel a member may be experiencing an acute problem," Wheeler adds.

The health plan's electronic case management software application allows the health coaches to communicate instantly with the home health agency, Southwest Medical Associates, Health Plan of Nevada's case management department, and other services, and to transfer members seamlessly between various components of the program.

"This helps coordinate care between the services and the departments. Our system allows for referrals to go back and forth. Members who are in case management may be referred back to a health coach when they become stable or refer them to the home health program if they need to be closely managed," says **Dana Zuckerman**, RN, BSN, MA, CCM, assistant vice president for utilization management and case management.

For instance, if the health coaches determine that members have complex issues, acute issues, and/or needs beyond monitoring their condition, they are referred electronically to case management. This includes members who need durable medical equipment or help getting access to social services.

Once the acute issues are stabilized and the member has been set up with equipment or linked to community social services, the case manager transfers him or her back to the health coach.

The case managers coordinate the care for members with major trauma after an accident — from acute care through rehabilitation and outpatient rehabilitation. They manage the care of premature infants, high-risk obstetric patients, members with cancers, and those who are receiving care outside the service area.

"The case managers coordinate care for people who need a lot of services including those with complex conditions who see multiple physicians. Members in case management represent about 1% of the population and they are the ones at highest risk," Wheeler says.

When a member is referred to case management, the case manager conducts a complete assessment.

"We are not just looking at diabetes or heart failure. We take a holistic approach and look at the entire person and everything that is happening with them," Zuckerman says.

The case managers develop a plan of care and take care of what the member needs right then.

If their plan of care is related to a specific disease and the member requires no other interventions, he or she is referred to health management and a health coach.

If the member has comorbidities or other issues or is going outside the service area for care, the case manager coordinates the care.

Most members of Health Plan of Nevada who need organ transplants must go out of state for the service.

For instance, if a member with diabetes needs a kidney transplant, the health plan case manager coordinates the appointments for laboratory procedures, X-rays, and treatment at the hospital where the transplant will take place and follows the members after the surgery to make sure they get everything they need.

Some members with congestive heart failure are eligible for a telemonitoring program offered by the health plan's affiliated home health company.

When a member is eligible, a home health nurse makes a home visit, evaluates the home environment for safety, and determines if the member would be a good candidate for telemonitoring.

If so, they receive a device in their home that they use to input their weight, vital signs, and health status. The home health nurses monitor the

results and call in the member's physicians if they see a decline in health status.

Sierra Health Services' computer system is set up so that components that receive a referral can instantly tell if a member's care is already being managed by another component.

For instance, if a health coach receives a referral of a member who is at high risk for hospitalization for congestive heart failure, he or she can immediately determine if the member is already enrolled in another program, such as the home health remote telemonitoring program or Southwest Medical Associates' congestive heart failure clinic.

"If members are already being managed by other services, the health coaches don't duplicate the services," Wheeler says.

The health plan sends a quarterly profile to the members' primary care physicians showing which of their patients have or have not had disease-specific examinations, along with information on the frequency of hospital, outpatient, and emergency room visits for the condition.

The pediatric asthma program works much the same as the health coaching programs for other chronic diseases. The RN health coaches work with the parents of children less than 18 who have asthma and help them learn to manage their children's disease.

The parents receive educational materials and information about how to participate in Sierra's health education and wellness classes on childhood asthma. ■

Knowledge of normal development key in diagnosis

Deviations signal need for exam and intervention

Early intervention is important for children with autism. To make sure this early diagnosis occurs, every pregnant woman should be given a chart on childhood development so she knows what is considered typical behavior.

"It is important for all families to know what the typical developmental patterns of a child is, so if things are starting to go wrong, they can start asking questions early," says **Sheila Wagner**, MEd, assistant director of the Emory Autism Center, Emory University School of Medicine in Atlanta.

It is impossible for parents to learn the warning signs of all the various disabilities including autism, but if they know what is normal they can seek medical attention when there are deviations, she explains.

If children are diagnosed at an early age, they can be taught normal patterns for play, communication, and language, which brings them more in line with typical development patterns.

"It doesn't mean you are getting rid of autism, but you are starting to shape those behaviors. If that child was not identified and traveled along this atypical pathway for years and years, those learned behaviors become cemented and it becomes much more difficult to retrain learned behaviors," says Wagner.

According to the Autism Society of America based in Bethesda, MD, this developmental disability is a neurological disorder that interferes with the normal functioning of the brain and typically appears during the first three years of life. People with autism usually have difficulty with verbal and non-verbal communication, social interaction, and leisure or play activities.

Some of the traits often exhibited include the use of gestures or pointing to express needs, not responding to verbal cues, a preference for being alone, little or no eye contact, odd play, tantrums, and resistance to change.

While people with autism may exhibit certain traits, each is unique. According to the ASA, autism is a "spectrum disorder" and, therefore, affects each child differently and in varying degrees.

With early diagnosis and intervention, the cost of lifelong care for adults with autism can be reduced by two-thirds, according to ASA.

For a successful intervention what do parents need to know? Education should start even if a toddler has not had a firm diagnosis but is only considered at risk, says Wagner. At the Emory Autism Center, children can be placed in the early childhood program at the age of one. The majority of children who graduate from this program are placed in a regular kindergarten classroom.

Include parents in intervention

It is a good idea to include parents in the intervention, training them to do what the therapist does with the child. Children with autism have difficulty generalizing information, so parents can transfer what has been learned from setting to setting and person to person, says Wagner.

Without parental involvement, the child will only be learning in a school setting. Education

needs to be on a 24-hour basis so he or she can learn to use the skills in different environments.

There is a broad spectrum in the disability range for people with autism. While some may need support and supervision all their lives, others, with mild characteristics and behavior, are fully independent. Many are professionals and have full-time jobs, some earn a PhD degree, and others get married and have children.

While the cause of autism is not yet known, researchers believe there is often a genetic link but something in the environment triggers it. "It is a mystery in many areas and all that we know about autism at this point is nothing compared to what we don't know about the disability," says Wagner.

A child may be developing language and starting to babble, saying a few words and then for some reason stop all progress.

"Developmentally, it is like they are going along a pattern of development and for some reason they hit a pothole and they can't jump over it to progress. What makes that pothole nobody knows; research has not been able to discover the reasons why some children with this disability seem to appear to be doing fine in language and in social skills and then for some reason that stops," says Wagner.

Some children never go through a regression in language or social skills but show delays and deviance in language and social development all along.

What is known is that families need a lot of support when they have a child with autism. Physicians need to provide families with a resource packet when a child is diagnosed that has the names of agencies that can help as well as web sites and books that provide good information.

The divorce rate is high in families who have a child with autism so couples must build a support system. Children with autism are extremely vulnerable — families must find people they trust fully to care for their child.

"It is important for families to have outside interests beyond autism. I often tell couples they need a date night once a week to have dinner and go to a movie," says Wagner.

On date nights she gives parents two rules to follow. One is not to talk about autism and the second is to avoid conversations about their children.

It is also a good idea to spend time alone with other siblings who do not have the disability. "Many times siblings feel left out because all the focus is on the child with autism so they need some care and attention, and loving and nurturing as well," explains Wagner. There are support groups in which siblings of autistic children can participate as well.

"Autism is a very complicated thing and our families get pulled in a lot of directions. These kids tend to be very challenging for families and finding that balance is very difficult," says Wagner. ■

Techniques for educating with the aid of an interpreter

Interpreters can improve understanding

There are many basic practices that improve teaching encounters between health care practitioners and patients with limited English proficiency (LEP). These are applicable in all interactions within a medical center when the use of an interpreter is required.

In addition to the basics, patient education requires a little more preparation and work with the interpreter to make sure the session is effective, according to some experts.

What are some of the basics that must be mastered? Learning to speak directly to the patient rather than to the interpreter is one. According to **Molly K. Smith**, manager of Language Services at Clarian Health in Indianapolis, IN, people have a tendency to speak to the interpreter rather than the patient. They will say, "Ask the patient if he has pain" rather than "Do you have pain?"

"The goal of health care practitioners is to make the patient feel they are the focus of the communication and act as though the interpreter is not there," explains Smith.

The person teaching should be positioned so that he or she can see the patient. It is important to make eye contact so that non-verbal communication can be observed.

"If a provider is not looking at the patient he or she won't see the facial expressions that might indicate confusion," explains Smith.

Before the education session begins, the health care practitioner should introduce the interpreter and make sure the patient is clear on the perspective roles of everyone in the room. It is important to remember that everything said in the room will

be interpreted so nothing should be said that the patient shouldn't hear.

It is best for anyone using an interpreter to pause after finishing a complete thought. This gives the interpreter time to interpret what was said.

When using an interpreter for patient education, the best way to capitalize on his or her medical interpreting skills is to plan ahead and be organized about the teaching session, says **Susan Scritchfield**, MA, MSW, LISW, coordinator of consumer health education at the James Cancer Hospital, which is part of the Ohio State University Medical Center.

"You have to plan ahead to allow time to get an interpreter on sight and to make sure the caregivers or family members the patient wants to be present for the teaching are also available," she explains.

The interpreter needs to know the nature of the teaching in advance so he or she can prepare, says **Jose Sanchez**, coordinator of Interpreting and Translating Services at Children's Healthcare of Atlanta. If teaching protocols are to be used interpreters should be given a copy in advance.

"Make sure the interpreter understands what the training is about so he or she is familiar with the terminology," says Sanchez.

When teaching patients with communication barriers use the teach back method, having the patient demonstrate the skill or repeat back what was taught, advises **Mursal Khaliif**, RN, director of Community Health & Language Services at the University of Minnesota Medical Center, Fairview in Minneapolis.

The use of the teach back method will give the practitioner confidence the patient fully understands. It will also help uncover misunderstandings so the information can be rephrased, explains Khaliif.

Relying on interpreter's observations

Sometimes it is the interpreter that observes that the medical terminology used is not clear to the patient and can ask the practitioner to use more family friendly terms, says Sanchez.

According to Smith the interpreter can serve as a "cultural broker," meaning if there are cultural practices or norms in either culture that might impede effective communication or lead to misunderstandings the interpreter will explain the differences.

For example, some Hispanic parents might rub a tomato on a baby who has a fever, leaving tomato seeds on the child's body. If staff in the emergency department are concerned that the baby has been abused the interpreter could tell the practitioner about the cultural practice and ask if they should find out if this is what the parents did, explains Smith.

Stephanie MacPhail, a Spanish interpreter and LEP patient advocate in the Hematology and Oncology Clinic at Children's Hospitals and Clinics of Minnesota in Minneapolis, says there are two schools of thoughts on interpreting. One is that interpreters only interpret what was said, not actively participating in any education other than repeating what the other party said.

With the second model, the interpreter is more of an integral part of the health care team and given an expanded role in terms of the input they can give the provider in a situation. This role is strictly for staff interpreters who have built a relationship with the health care practitioners, says MacPhail.

Interpreters can be instrumental in bringing the barriers out front but it is up to the provider to initiate the practices, she adds.

For example, in collaboration with the nurses at the clinic where she works, MacPhail came up with a system of calendars to help families with limited English proficiency manage confusing medication regimens during the course of their child's treatment.

The project was initiated because of a misunderstanding on dosage. A child's chemotherapy regimen was one half of a pill, yet instead of using numbers on the label the pharmacy had written the dosage in words.

The family members, who could read a little English, saw the word "one" but did not understand the "half" therefore, they had been giving their child a whole pill until the error was discovered.

Now families are given calendars to help with dosage and if the child is taking a pill, there is a picture of the dosage whether a half pill or whole pill.

Liquid medicines are color coded and a sun and moon indicate whether or not the dosage is to be taken in the morning or at night.

"When I am in an encounter with a provider and patient, I play a strict interpreting role, "outside that role I do a lot of advocating and case coordinating working together with the nurses for purposes of education," explains MacPhail. ■

Costly errors are common in same-day surgery arena

Preadmission coordinator a must, consultant says

Mistakes involving patient classification and preauthorization of procedures are among a lengthy list of common errors made in the same-day surgery arena, says **Bob Whipple,** RNC, CCM, CCS, MHA, a Boston-based senior management consultant with ACS Healthcare Solutions, who specializes in all areas of the revenue cycle.

Those errors, Whipple adds, can cost hospitals thousands of dollars in denied claims, as well as cause them to lose business to a growing number of freestanding surgical centers.

With regard to obtaining authorization for the surgery, Whipple says, "sometimes the hospital gets it, and sometimes the physician's office gets it. If they precerted for an inpatient, and you did it for an outpatient, the bill is denied.

"People who schedule for physician offices don't know the first thing about coding," he points out. "They will send a sheet that says 'possible kidney transplant,' and that's not a diagnosis."

When those orders get to bed placement, Whipple says, it's crucial that someone with clinical case management skills — preferably a registered nurse — is on hand to make sure everyone who's going into a bed is at the right level of care.

The designation should be "inpatient" or "outpatient," but not "observation," he says. His experience, adds Whipple, is that a lot of hospitals make the mistake of precerting a same-day surgery patient under the observation designation.

"It's a big compliance issue," he notes. "How do you know they will have to observe somebody after surgery? You don't have a crystal ball."

A patient cannot be put in observation status preoperatively, Whipple emphasizes. "Post-operatively you could think about it, but I wouldn't recommend it. Same-day surgery comes with an implied 24-hour length of stay [LOS], so the designation either should stay 'same day,' and the person should be discharged and go home, or if necessary, the patient should be converted to inpatient status."

These mistakes happen with the observation designation because people don't understand what it really means, he says. "The physician thinks, 'I want to observe the patient,' [so that must be the right classification]."

With Medicare, there are many CPT (common procedural terminology) codes that are for inpatient-only procedures, Whipple adds. "If a procedure happens to be on the inpatient-only list and the patient receiving that procedure doesn't have inpatient status," he says, "[Medicare] will deny the claim and you can't even appeal it. It's a technical denial."

There are hospitals doing mastectomies, laminectomies, and thyroidectomies — all inpatient procedures under Medicare — on an outpatient basis, and when the bills for those surgeries are denied, there is no recourse, Whipple points out. "What Medicare is trying to say is, 'We want our patients to be [admitted to the hospital] for these kinds of procedures.'" This kind of occurrence is "very common," he adds. "I find it everywhere I go."

Again, the take-home message is that there needs to be a clinically trained person — within the access department — who literally reviews every patient before he or she is placed in a bed for outpatient surgery, he emphasizes. "You can't expect office staff to do it. They will put patients in a bed with wrong orders or no orders."

One of the other costly errors that hospitals are prone to make in their same-day surgery operations has to do with cardiac interventions, such as cardiac catheterizations, Whipple says. The Medicare reimbursement rate for cardiac caths is about $5,000, he adds, but if the physician ends up putting in a stint as well, the procedure — known as angioplasty — goes in the inpatient category, and reimbursement is about $19,000.

Therefore, if the change in patient classification is not made and the surgery is billed as an outpatient procedure, Whipple notes, the hospital loses $14,000. "When I'm doing revenue cycle assessments, these are areas where [hospitals] fall down all the time," he says. "I almost always find it with angioplasties."

Other mistakes that are frequently made in same-day surgery settings include the following, Whipple says:

- Developing a process that is organized around the hospital staff and not the patient, specifically as it relates to same-day workup and surgery.
- Not gaining cooperation from ancillary departments to facilitate and support same-day services.
- Not changing surgical scheduling processes

to support same-day services.

• Not ensuring preregistration for all same-day patients, including preauthorization/precertification and estimation of copays for collection at time of service.

Coordinator 'should report to access'

The clinically trained individual — sometimes called a preadmission coordinator — charged with making sure patients and procedures are properly designated should report to patient access leadership and should serve as the clinical liaison for the entire department, Whipple contends. "If you don't have that position filled, you are losing a lot of money."

In fact, all areas that perform functions that are part of the revenue cycle ultimately should report to the CFO, he says. "Sometimes hospitals have the bed board report to nursing, or have some sort of precert department or a transfer center that works on its own in another location. [Access leadership] needs to understand all points of entry and make sure to have control over all of those areas."

Whipple recommends that access management work with marketing to create a patient satisfaction survey for the same-day surgery area, and use the results to make improvements and to provide feedback to staff.

General satisfaction surveys, such as those conducted by Press Ganey, aren't specific enough to meet that need, says Whipple, who suggests asking questions geared toward the outpatient experience: "Was it easy to get an appointment? Was the phone answered promptly? Do you feel you were given answers in a timely manner?"

Leverage as much technology as possible to keep customers satisfied, he advises, including providing on-line registration and implementing kiosks to allow service area check-in with electronic signature and payment of copays and deductibles.

Whipple suggests these benchmarks for the same-day surgery operation:

• Wait times for outpatient registration — less than 10 minutes.

• Registration data accuracy — greater than 98%.

• Abandon call rate in scheduling — less than 2%.

• Scheduling calls per day — greater than 95.

• Scheduling quality — greater than 98%.

• Average time to place in a bed — less than 10 minutes.

• Registrations/preregistrations per hour by representative — greater than six.

• Quick check-ins per hour by representative — greater than 12.

• Precertification at 100%.

• Point of service collections — greater than (your hospital's numbers).

• Patient satisfaction score — greater than 95% per reporting period.

• 100% auditing of Medicare Secondary Payer questionnaire.

• Operating room cancellations — zero cases.

Freestanding centers an issue

One of the challenges hospitals face in regard to their same-day surgery operation is the competition posed by freestanding surgical centers, which tend to cherry-pick the easiest and most lucrative cases, Whipple notes.

If you're a patient access manager and a freestanding surgical center has opened down the street from your hospital, he advises collecting data to determine if your operation is being affected.

"Look to see if your volume is down and at the referral patterns of your physicians," he says. "Then you are prepared to go to senior management and say, 'We've got a problem. Dr. Smith is referring patients [to the freestanding center].'"

To address this issue, it takes a lot of support from senior management, Whipple adds. "You need a chief medical officer who understands the problem — why that is a bad thing. It's happening more and more places."

(Editor's note: Bob Whipple can be reached at Bob.Whipple@acs-hcs.com.) ■

COMING IN FUTURE MONTHS

- Making workplace wellness work for you
- Closing gaps in care for members with chronic diseases
- Next generation programs in chronic care
- Keeping Medicare members safe at home

CE questions

5. Duke Integrative Medicine's multidisciplinary team includes which of the following?
   A. Nutritionists
   B. Exercise physiologists
   C. Acupuncture
   D. All of the above

6. For which of the following populations did Health Alliance Plan begin its HAP HealthTrack program?
   A. Members with heart failure
   B. Members with diabetes
   C. Members with depression
   D. None of the above

7. To make sure children with autism are diagnosed early, every pregnant woman should be given a developmental milestone chart.
   A. True
   B. False

8. Which of these basic practices improve teaching encounters between health care practitioners and patients with limited English proficiency?
   A. Speak directly to the patient.
   B. Pause after finishing a complete thought.
   C. Explain role of interpreter to the patient.
   D. All of the above

Answers: 5. D; 6. A; 7. A; 8. D.

CE objectives

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

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

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. ■