Case Management ADVISOR™
Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Health plan, medical practice team up on patient-centered medical home pilot

Nurses coordinate care through the continuum

CIGNA and Dartmouth-Hitchcock have joined forces to improve care coordination and quality of care for patients through a "patient-centered medical home" pilot project.

The pilot, which was launched on June 1, is one of the first collaborations between primary care providers and a private-sector health company.

The patient-centered medical home model of care aims to provide patients with primary care through coordination of care, timely access to physician visits, enhanced communication between patients and providers, and education to help patients navigate the health care system.

A key component of the model is personal contact by nurse care coordinators located in the physician offices, who are trained on health coaching, motivational interviewing, and assessing patients' readiness to change and provide care coordination, follow-up telephone calls, and health coaching to patients with chronic diseases and complex needs, says **Barbara Walters**, DO, senior medical director for Dartmouth-Hitchcock in Lebanon, NH. **(For details on how the program works, see related article on p. 99.)**

Participants in the pilot program are patients who receive care from Dartmouth-Hitchcock primary care physicians practicing in family medicine, internal medicine, and pediatrics who are insured by CIGNA. About 19,000 CIGNA members receive care from a Dartmouth-Hitchcock primary care physician.

"The patient-centered medical home is an effort to revitalize the concept of primary care physicians and their affiliated clinical teams working collaboratively with patients to coordinate and assure appropriate health care for all the patient's needs," says **Dick Salmon**, MD, national medical director for CIGNA.

Before beginning the program, CIGNA increased its compensation

to the physicians so they could hire nurse care coordinators to the staff.

"The financial pressures of the last 10 years resulted in many primary care physicians hiring medical assistants instead of nurses and hiring fewer of those. What this initiative is trying to do is reverse that trend and make it affordable for physicians to add nurses back to the office staff to help coordinate care of complex patients," Salmon says.

In addition, CIGNA created a reward system for the physician practices. Dartmouth-Hitchcock qualifies for additional compensation if it meets quality goals, based on HEDIS measures, and goals for total medical cost.

CIGNA and Dartmouth-Hitchcock have worked together to promote better communications between case managers in both organizations.

"Traditionally, our case managers haven't had a lot of [interaction] with treating physician practices. We have built lines of communications so the case managers who service the area in which Dartmouth-Hitchcock is located know who to call if they are trying to help a patient who is being treated by a Dartmouth physician," Salmon says.

The collaboration will also help the physician office case managers because they know who to contact if they need to coordinate patient benefits or want to get the patient into a disease management program, he adds.

"We have set up communication interfaces with Dartmouth-Hitchcock and our case management, disease management, and behavioral health programs. We want to create real collaboration between the clinical resources of the health plan and the physician practices," he says.

The patient-centered medical home program aims to provide coordinated care for patients and to develop a method to make doing the right thing clinically also a reasonable thing from a business point of view, Salmon says.

Where fee for service falls short

The current fee-for-service system doesn't compensate physicians for extraordinary skills or going to extraordinary lengths to treat their patients, Salmon points out, citing two examples:

- A patient calls a physician office at 4:30 p.m. on a Friday and needs to be seen by a doctor.

"The physician has to make a decision about staying late or sending the patient for emergency care. If the physician is really trying to provide comprehensive service, he might stay late, but if he's being reimbursed on a fee-for-service basis, he's not going to get paid enough to justify missing his son's baseball game," Salmon says.

- A patient is traveling and becomes ill with an exacerbation of a condition for which his primary care physician has been treating him. He calls his physician's office and is advised to go to the emergency department.

"If the physician takes the time to call the emergency room and discuss the patient's condition with the emergency room doctor, there's no way in our current system to reward him for taking that time and being behind with his other patients for the rest of the day," Salmon says.

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Editorial Questions

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Before it launched the collaboration with CIGNA, Dartmouth Hitchcock was one of 10 medical groups participating in the Centers for Medicare and Medicaid Services (CMS) Physician Group Practice Demonstration Project, now in its fourth year. CMS has assigned Medicare beneficiaries who receive the majority of their care from Dartmouth-Hitchcock to the project.

At the time the CMS program began, the physician practice didn't use the words "medical home" to describe what they did, but that was essentially what they were doing, Walters says.

Nurses who receive training on health coaching, motivational interviewing, and assessing patients' readiness to change serve as care managers for patients with chronic diseases.

They identify gaps in care and conduct outreach calls rather than waiting for the patients to come into the office or the emergency room with an acute care need, she says.

"We began looking for a commercial partner to expand the model of care we were using in the Medicare program and CIGNA stepped up to the plate," Walters says.

The CMS project allowed Dartmouth-Hitchcock to continue to use its infrastructure and care processes with the Medicare population that had originated when managed care was prevalent in the Northeast.

"We had participated in managed care in a true sense of the word until eight or nine years ago when all of the managed care products and reimbursement changed to fee-for-service reimbursement. Being a multi-care practice, we believe that providing both primary care and specialty care provides quality and coordinated care," Walters says.

"We still had the infrastructure from the days of managed care when we had accepted delegated care management and care coordination as part of our managed care agreements. We were practicing in what we believe is a coordinated and efficient way," she says. ■

Program identifies patients who need extra help

Gaps in care, hospitalizations targeted for outreach

The collaboration between a commercial health plan and a physician group practice will be able to promote optimal care for patients because the partners have a different focus and outlook, says **Barbara Walters**, DO, senior medical director for Dartmouth-Hitchcock.

"The commercial health plan will use claims information to identify patients who need extra care. We look at the patients in a clinical contact context to identify patients who we think need extra care. Using the two methods, we can better identify patients who can benefit from extra care and adopt them into a medical home," she says.

The health plan and physician practices are collaborating to identify patients who are eligible for the care coordination part of the program, Walters says.

The physician office maintains an electronic registry for people with chronic diseases and mines the data looking for lab tests or gaps in care to identify patients who need a call from a nurse. In addition, physicians can suggest individual patients who would benefit from care coordination.

"There are certain patients who are fragile and/or who have complicated conditions and complex need. They need a little more attention than they can get in the random or sick visit access of the health care system. Our program aims to find patients who fit this profile and give them the extra attention they need," she says.

When a patient is identified as needing extra help, a nurse makes an outbound call and talks to the patient about his or her health care issues.

When targeted patients have an appointment with a Dartmouth-Hitchcock physician, a nurse case manager examines the patient record the day before the visit and makes sure that all laboratory tests results and other pertinent information is available to the doctor. The day after the visit, the nurse calls the patient, discusses the visit, and answers any questions.

"We all know it's very difficult for a patient to absorb everything that happens during a pressurized patient visit scenario. That's why the nurse follow up is important," says **Dick Salmon**, MD, national medical director for CIGNA.

When patients are discharged from the hospital, a Dartmouth-Hitchcock nurse care coordinator calls them to review their hospitalization, their treatment plan and medication regimen, and to ensure the patient has a follow-up visit.

"Patients are stressed when they are in the hospital and they can't remember everything they are told. When they make an acute care visit, they may think of questions or concerns after they get

home. Our nurses follow up and help them understand what's going on and help them follow their treatment plan," Walters says.

The nurses work with patients to help them come up with common objectives and strategies to meet those goals.

"Patients adore the program. They like getting a call from a nurse. Our nurses were trained to become expert health coaches and advocates on behalf of the patients, either in person or on the telephone," Walters says.

Patient portal facilitates communication

To further facilitate communication, the physician practice has developed a secure electronic patient portal that patients can use to access their medical records and communicate with their physicians.

"Patients are encouraged to look into the medical record and see what the doctor wrote so they can confirm what they thought they heard or didn't hear," she says.

They can send an e-mail with questions and clarifications to their health care team.

"This helps get the patient the information they need more quickly and eliminates telephone tag," she says.

Patients who use the electronic patient portals tend to open up more than they do on telephone calls, Walters says.

"They have time to collect their thoughts and feel more comfortable asking things in writing that they may be embarrassed to ask in person," she says. ■

Home visits work for behavioral health patients

Care coordinators offer psychotherapy

When behavioral health patients who have been hospitalized receive interventions in their home, their compliance with treatment recommendations increases and hospital readmission drops, a study by PsycHealth Ltd.'s Home Intervention Program has found.

An analysis of 52 Medicaid managed care patients in the home intervention pilot project showed 100% participation and compliance with the treatment recommendations and an 86% drop in overall hospital readmission rates within six months compared to their hospital admissions six months before the program was instituted.

Participants in the study had a history of two or more hospitalizations within the six months prior to enrollment and were noncompliant with the traditional outpatient aftercare.

The study was so successful that PsycHealth offers the program to appropriate patients including those who have had multiple hospitalizations without follow-up outpatient therapy, those who dropped in and out of therapy, and patients with barriers to compliance, such as lack of transportation or child care issues, says **Madeleine Y. Gomez**, PhD, president of the Evanston, IL, managed behavioral health care organization.

PsycHealth coordinates mental health care for group and private insurance companies, providing everything from 24-hour clinical services and crisis management to case management, utilization management, and quality improvement.

PsycHealth typically begins managing the care of its patients while they are still in the hospital.

"All of our patients leave the hospital with a therapy referral and/or a medical referral. We use our data system to create a comprehensive picture of the patient's status and incorporate that information to coordinate the appropriate follow-up care," she says.

The home intervention program received a Gold Award for Healthcare Management from URAC.

The Home Intervention Program provides services to patients who might not otherwise have received mental health treatment and follow-up, Gomez says.

The goal of the program is to increase compliance with post-hospital outpatient follow-up therapy and reduce rehospitalizations.

"Patients achieve better results and less recidivism if they have follow-up after leaving the hospital, but today it is reported that many people are basically being discharged with solely medication management referrals. Medication is one piece of the picture, but it doesn't change some of the habits or choices that have complicated the person's mental status. Psychotherapy can address those issues," she adds.

Faced with the challenge of overcoming patients' barriers to receiving follow-up therapy, Gomez decided to try an approach that was frequently used when she began her practice.

"It was once very common to do home visits. It was part of the arsenal of intervention. Some

patients never go for their follow-up therapy visits. We have tried phone calls, letters, and all types of interventions. When that didn't work, we decided to pilot the home intervention program," she says.

People who have severe mental disorders often have problems dealing with day-to-day life and need a lot of support, Gomez points out.

"If they don't have a family or the family is unable to help, a therapist can help them comply with their treatment plan as well as reporting back to the psychiatrist if there are areas of concern or the patients are experiencing side effects," she says.

All patients whose care is being managed by PsycHealth receive a transition care visit from a care coordinator who is a social worker, a psychologist, or a licensed therapist.

When the firm's clinical care coordinator receives notification of a member's inpatient behavioral health admission, the case is referred to a therapist, who contacts the hospital case manager or patient before discharge whenever possible to set up the in-home appointment. The goal is for the therapist to see the patient for an in-home session within seven days of discharge from the inpatient level of care.

"The transitional care visit is the entry point into the home intervention program for many patients. If patients have a history of continuing their regular outpatient care or have a past relationship that has been effective, we would recommend that they continue, but there are other patients who would be appropriate for home interventions," Gomez says.

The therapist works to get informed consent releases signed in order to coordinate care with the patients' primary care physicians, she adds.

Ideally, the same therapist makes the assessment and conducts the home interventions.

In some cases, the transitional care therapist makes an assessment and recommends assignment of the case to a home intervention therapist.

The therapists are assigned by geographic area and by specialty. They come into their patient's home and work with the patient and whatever part of the family may need adjunctive treatment.

"During the home interventions, we focus on everything the patients need, including basic needs such as food, helping them fill out paperwork for assistance program, or helping them get connected with a payment plan for utilities or gas, as well as individual and family therapy," Gomez says.

The program is individualized and depends on what each patient needs at that time.

"We're not just providing therapy. We're helping support and manage that patient. If a patient is suffering from not having enough food or has no utilities, those issues have to come first," she says.

Seeing patients face-to-face is an effective way to get the full picture of how the patient functions at home, how family members interact, and to determine the patient's needs, Gomez points out.

"We've had to make reports of abuse or violence when we observed that in the home. You could work with someone for years and not get that wealth of data you get when you step into their home," she adds.

If a patient begins to show signs of improvement and the therapist feels he or she could be served in a traditional office setting, the therapist helps the patient make the transition.

Some receive ongoing home interventions if it works and keeps the patients stable.

Some of the therapists are employees of PsycHealth; others are independent providers who see patients under contract with the firm.

The therapists meet regularly to discuss their cases and to brainstorm strategies for helping their patients.

Patients and their families have responded positively to the program, Gomez says.

"Patients have embraced the idea and welcome the therapists into their homes. They feel cared about and that having someone come to their home streamlines time for them, giving them more time to work on themselves," she says. ■

Case managers: It's your time to shine

Showcase your profession during CM Week

Case Management Week, Oct. 12-18, is a great opportunity for case managers in all settings to educate their co-workers and the public about what case managers do and the value they bring to the health care system, says **Peter Moran**, RN, C, BSN, MS, CCM, emergency department case manager at Massachusetts General Hospital and immediate past president of the Case Management Society of America (CMSA).

He urges case managers to celebrate their special week in two ways: by recognizing their peers for a job well done and by seizing the opportunity to increase the visibility of case managers among

other staff at their organizations and the public.

"Case Management Week is a good time to spread the word about what makes us special. It gives us a chance to tell the people we work with and the public what special skills we have and the role we play," says **Margaret Leonard,** MS, RN, C, FNP, CM, vice president for clinical services at Hudson Health Plan in Tarrytown, NY.

Use the week as an opportunity to step back and reflect on case management as a profession and to commemorate the achievements of case managers in your organization, Moran suggests.

"All of us are very busy taking care of the needs of the people for whom we advocate. As soon as we've solved one problem, two more have cropped up. We need to take a moment and celebrate the progress we've made and what we've accomplished despite our challenges and obstacles," he says.

For the individual case manager, the week is a good time for self reflection about the job you are doing and to think about professional development, Leonard adds.

Join your local case management organization and volunteer to serve on committees.

Consider pursuing case management certification, she suggests.

"People understand that there is value to certification. Case Management Week is a good time to take the next step," she says.

Approach the leadership at your hospital or managed care facility and enlist their help in celebrating. Work to make sure case managers at your organization have celebrations during their own week and not just during National Nurses Week in the spring, Commander says.

Develop a case management award at your own organization, whether it's a hospital or a health plan, Moran suggests.

"A Case Manager of the Year award is a great way to recognize staff for a job well done and to create awareness of what case managers do," he says.

Many chapters throughout the country are planning a luncheon or a dinner to recognize the week, he adds.

"A lot of them have contacted local governments to get a proclamation issued. It's a way of trying to increase legislative visibility and to let people out there know who case managers are and what they do," he adds.

Some of the events marking Case Management Week at Massachusetts General Hospital include a presentation by case managers during nursing grand rounds, a dinner for case managers, and a guest lecture on case management.

Each year, the case management staff set up an information table in the main hallway, offering people advance directive forms to sign and passing out brochures about case management. They use the opportunity to educate staff and visitors about the role of case management at Massachusetts General.

When Leonard goes to the Case Management Society of America's conference in June each year, she purchases gifts, such as a CMSA pin, for the case management staff.

"Everyone in our department, the case managers and the case management assistants, celebrate the week," Leonard says.

The staff put up signs about Case Management Week throughout the company and have a special celebration, such as a breakfast or lunch, every day.

"What I like best is that every day somebody bakes a special treat and brings it in to share. Everybody in the department feels like it's a time to celebrate," Leonard says.

Try to get articles into your organization's newsletters or other publications, Moran adds.

"We need to tell our stories and tell it to people who are not case managers," he says.

Moran suggests contacting your local newspapers or television stations about an article on case managers.

Contact your local public broadcasting stations or cable stations. Cable stations have to devote a certain number of hours to community service. Tap into that, he says.

"Go beyond Case Management Week and reach out to various populations of different audiences," he says.

Volunteer to speak at local professional organizations or civic clubs. Participate in career days in your local schools.

When you talk to people about case management, tell them your success stories, Moran suggests.

"Our stories will leave a lasting impression on individuals, even those who are not in the business of health care. I made more than 50 presentations last year but I never stood in front of any audience without talking about a case," he says.

The Case Management Society of American compiled a list of activities held in honor of Case Management Week in past years. Here are a few of them:

The CMSA of St. Louis chapter held a Case

Managers Appreciation Day reception at a local restaurant with festivities that included special recognition for committee volunteers and awards recognizing outstanding case managers. The event was sponsored by local vendors. The chapter obtained proclamations from the mayor of St. Louis and the governor of Missouri.

• Case managers in the Green Mountain, VT, chapter enjoyed a dinner cruise along the shores of Lake Champlain. Sponsorship by a group of vendors and contribution by the chapter allowed members to receive reduced payment for the event.

• The Tennessee Valley Chapter brought in six local non-profit organizations to educate case managers on the services they provide and the chapter gave donations to two charities. The all-day meeting included door prizes donated by vendors and community physicians and gifts for members. During the week, some local companies provided meals for their case managers.

• The Case Management Society of Alabama provided posters to all hospitals and major health agencies proclaiming Case Management Week and delivered small gift baskets to the case managers at five major health care facilities in Tuscaloosa, AL. The organization received a proclamation from the governor and sponsored a lunch and learn meeting for members and prospective members as well as an evening meeting for case managers who couldn't attend during the day.

• The Case Management Society of American offers a comprehensive guide for celebrating Case Management Week. It's available at the organization's web site: www.cmsa.org. ■

Educate about safe sleep practices to prevent SIDS

Repetitive messages could help lower death rate

Recently, **Laura L. Reno**, vice president of public affairs for the Baltimore-based nonprofit health organization First Candle, spoke with parents who were grieving the loss of their 4-month-old baby, who had died while sleeping in a crib.

Although the baby was put to bed on her back, which is the sleeping position recommended by the American Academy of Pediatrics in Elk Grove, IL, the parents were using a memory foam pad to keep her from getting a flat spot on the back of her head. When the baby rolled over, the pad conformed to her face and she died, reports Reno.

The parents knew the correct sleep position for infants, but they did not know that the use of the pad to position the baby was not safe. Currently, about 85% of parents put babies down to sleep on their backs, says Reno. Yet other safe sleep practices also must be followed, and education on these must be as vigilant as that provided regarding putting babies to bed on their backs, she adds.

For many years now parents have been taught to place babies on their backs when putting them down to sleep. The practice was shown by research to reduce the risk for Sudden Infant Death Syndrome (SIDS). A big educational campaign was initiated in 1994 under the leadership of the National Institute of Child Health and Human Development called "Back to Sleep."

Education regarding placing babies on their backs for sleeping began around 1992. According to the American Academy of Pediatrics, by 2001 there was a 53% decrease in the cases of SIDS.

Reno says her organization is tracking the child death reports from each state and finds it is rare for a baby to die while sleeping in a safe crib on his or her back. She says that while the numbers for SIDS have dropped tremendously, everyone needs to learn the definition of a safe sleep environment, including grandparents, child care providers, and babysitters.

First Candle is dedicated to helping babies survive and thrive, and it works to increase public participation and support in the fight against infant mortality. It was formerly called the National SIDS Foundation. Reno says SIDS is a catchall term for unexpected infant death; however, medical examiners now often assign other reasons for death, such as accidental suffocation.

The definition of SIDS is the sudden, unexpected death of an infant younger than 1 year old that after an autopsy, review of medical history, and death scene investigation, no other cause of death can be found, says Reno.

While the exact cause of SIDS has not yet been determined, many physicians and researchers think it is caused by several different factors, according to the National Institutes of Health in Bethesda, MD. "These factors may include problems with sleep arousal or an inability to sense a build-up of carbon dioxide in the blood. Almost all SIDS deaths occur without any warning or symptoms when the infant is thought to be sleeping," reports the NIH.

According to the NIH, babies between 2 and 4 months of age are more likely to die of SIDS, and about 90% of all cases occur by the time a baby is 6 months old. Also SIDS is more likely to occur in winter months. Babies born to Native American and African-American families are at a greater risk for SIDS.

Education on safe sleep practices

Research has uncovered certain practices parents and other caregivers can follow to create a safe sleep environment and reduce the risk of SIDS. Reno says it is important to educate every parent on best practices.

With more than 4 million families having babies each year in the United States, it is education that must be ongoing.

"While we have made progress in saving lives, it is still the leading cause of death for babies 1 month to 1 year of age. Safe sleep messages are not something that can ever go away," says Reno.

To lower the risk of SIDS, babies should be placed on their backs rather than on their stomachs or sides to sleep. Reno said First Candle is working nationwide to have nurses at hospitals demonstrate safe sleep practices, because these health care professionals play an influential role. Some nurses swaddle babies and put them on their sides, and many new moms will follow the example, she adds.

Babies need to sleep on a firm mattress and never on soft surfaces, including soft mattresses, sofa cushions, or waterbeds. There should be no loose bedding, such as blankets or pillows in the crib, or stuffed toys, bumper pads, or things to position the baby, says Reno.

"If babies are on a very firm surface in an empty crib and on their backs, once they wiggle around and start rolling over, they will still be as safe as possible, because there is nothing they can get their face next to," explains Reno.

To keep the baby warm during cold weather, Reno suggests the use of infant sleep sacks rather than loose blankets.

Overheating has been associated with SIDS, so the baby should not be bundled up for warmth but should be lightly clothed. The bedroom temperature should feel comfortable to an adult in light clothing.

While babies should not sleep with an adult, research shows that the risk of SIDS is reduced when the infant sleeps in the same room with the mother, according to the American Academy of Pediatrics.

"We promote room sharing — not bed sharing," says Reno. Mothers should have the crib or bassinette next to their bed, so after breastfeeding they can place the baby on his or her back in a safe area, she adds.

The American Academy of Pediatrics suggests the crib, bassinet or cradle conform to the safety standards set by the Consumer Product Safety Commission. Reno says First Candle realizes that part of the problem with compliance is that many parents cannot afford to purchase a good bed for their baby.

With the aid of an $11 million grant from the Bill & Melinda Gates Foundation, the organization will combine a crib distribution program with widespread public and professional education in Indiana, Washington, and the District of Columbia. The outcome of the safe sleep campaign will be evaluated, and First Candle will publish the results.

Getting the message out to all types of people is important, because infants are not always in the care of their parents, says Reno. The organization tells parents to tell everyone what their rules are for caring for the baby — that includes grandparents, babysitters, and child care providers.

First Candle has a program to train child care providers, because at one time 15% of all SIDS deaths occurred in child care. While the number is lower, there is still a way to go, says Reno. The most difficult audience to reach are in-home providers.

"We do the best we can to reach who we can, but it is up to the parents to make sure they trust the person caring for their child," says Reno.

Many times grandparents think they know what is best for the baby because they have already raised children, but they are not up-to-date on the best sleep practices. That is why parents must educate the baby's caregivers.

In addition to teaching good sleep practices, women need to know that good prenatal care helps prevent SIDS. Also, they need to be aware that smoking during pregnancy or exposing the baby to secondhand smoke after birth will increase the risk of SIDS.

A pregnancy timeline on the First Candle web site provides information on steps to take to reduce the risk of SIDS. "There are three things we want them to do while they are pregnant: get good and early prenatal care; don't smoke; and learn about how important safe sleep is," says Reno.

(Editor's note: October is Sudden Infant Death Syndrome Awareness Month.) ■

Incorporating end-of-life issues into education

Introduce hospice as a resource for the terminally ill

End-of-life issues should be discussed while people are in good health. Just as people prepare for birth, it is important to prepare for death. The topic needs to be part of the health care discussion, says **Christin (Coco) Regas**, MSW, the consumer programs and services director for the National Hospice and Palliative Care Organization in Alexandria, VA.

There are many details to consider. Advance directives help take the guesswork out of medical decisions by providing such information as whether a person wants to be dependent on breathing machines or tube feeding. It would address whether a person wanted to be cared for at home — if possible when seriously ill — or move in with a family member.

Planning should cover all end-of-life issues from financial considerations to burial arrangements, says Regas. It is important to educate people about planning for end-of-life care because most have not addressed it or articulated their wishes.

"Most people don't like to talk about it until they need to, but it can save a lot of heartache for everyone involved from the health care professionals to loved ones if people make their wishes known," says Regas.

The uncertainty can be avoided — even if people recognize they don't want to deal with end-of-life issues — and giving power of attorney for health care decisions to a family member or friend, she adds.

Preparing for end of life also should include familiarity with the services available in the community in which a person lives. For example, people should know what type of home health care is available, whether or not a meal delivery service in their area provides hot lunches, and what type of long-term care facilities are available.

Hospices are a good source for such information, says Regas. These organizations often have a lot of information about the local resources, and they can offer guidance on the best way to select services. For example, they might suggest questions to ask when evaluating long-term care facilities.

Make hospice familiar

Hospice should be one of the resources people are informed about before they need to use it to help care for a terminally ill family member, says Regas. The criteria for admission are usually a life-limiting diagnosis with a prognosis of six months or less.

Yet, often education about hospice services takes place when care is required. Before families sign the informed consent paperwork to start services, an interview team meets with family members to go over the services provided. In the first meeting, many of the end-of-life issues are discussed or at least touched upon unless the team doesn't think the family is ready for such a discussion.

"If it is a new diagnosis and a new referral to hospice and the family is in somewhat of a state of shock or upset, the evaluation team may not go in depth about end-of-life issues," says Regas.

In such cases, the discussion on how hospice can assist the patient and family in determining their wishes for the end-of-life experience would be postponed until a later date.

Families should know that hospice provides extra support for terminally ill patients and caregivers. A medical team helps manage the patient's pain and symptoms, volunteers provide respite for caregivers, and social workers and chaplains provide emotional support. "Hospice is a holistic model of care that can provide extra support at a time when patients and their families need it most," says Regas.

Families can have as much or as little help as they want when they become involved with hospice. They may not want a lot of unfamiliar faces in their home at the end stage of life, but knowing there is someone to answer questions 24-hours a day — or assist if needed — provides a sense of relief and comfort, says Regas.

Hospice also offers bereavement or grief counselors. Often, patients and families go through the grieving process before death actually happens, and trained counselors help them sort out their feelings and emotions about their circumstances.

While hospice services are often solicited for terminally ill patients, many now offer palliative care programs for people who have a serious illness but will not necessarily die in the next six months.

The subject of end-of-life services can be difficult for people; therefore, it is best to bring up such matters well in advance of the need. "We encour-

age physicians and health care professionals to start talking about end-of-life care long before it is needed. They should introduce the concept and talk about it little by little, visit by visit, so it is not such a shock if it is needed in the future," explains Regas.

(Editor's Note: November has been designated as National Hospice Palliative Care Month.) ■

Class provides insight into caregiving pros and cons

Teach family by family to address individual needs

A class for caregivers was established at the University of Minnesota, Fairview in Minneapolis, because caring for an ill family member is becoming common practice as more people are treated as outpatients.

The class is taught at the Patient Learning Center one family at a time.

The need for the class became evident as more and more people requested information on how to take care of very ill family members at home, explains **Alexa Umbreit**, MS, RN, C, a Patient Learning Center nurse.

Family members who enroll in the class are usually caring for loved ones with end-stage illnesses such as cancer, pulmonary disease, and amyotrophic lateral sclerosis (ALS).

"The class is really appropriate for most end-stage illnesses, because the content is flexible depending on the priority issues of the patient and the needs that the family expresses," says Umbreit.

The class begins by using a flip chart format to convey the program objectives, which are to help caregivers acquire the support, knowledge, and skills they need to provide care to a loved one at home. They are told they may need to learn about symptom management, how to find support services and help for their loved one and themselves, time management, as well as how to develop better communication skills. They also are told that caregivers can live in the home with the patient, outside the home, or even be long distance caregivers.

Class content includes an overview of the common symptoms that end-stage illness can present, the causes, the signs, and how to manage them. These symptoms include fatigue, pain, depression, changes in eating, bowel changes, fever, bleeding problems, shortness of breath, skin problems, hair loss if related to chemotherapy, anxiety, sleep disturbances, changes in mental state, and mobility problems.

"We really focus on the expressed needs of the family. We don't always cover every single topic," says Umbreit.

Every participant has a unique story, and their concerns vary, she explains. For example, an older man wanted to know how to respectfully care for a female loved one who was dependent upon him for her physical care. Another family, who was determined to care for a very ill loved one at home, realized they were not able to do so. During the class, they decided to talk to the medical team about care options, because they couldn't manage the patient's intense health care needs at home. Some families need to learn how to move immobile patients safely. The Patient Learning Center has a video on the topic that caregivers watch, and then they practice the techniques with the bedside nurse before their loved one is discharged.

At the Patient Learning Center, away from the bedside, family members are able to share their concerns and have their questions answered. Caregivers are often exhausted from the patient's illness and hospital experience. Often, they are experiencing emotions of grief, helplessness and uncertainty, but they want to do their best to support their loved one, says Umbreit.

"We find that our family members' worries are eased during the class, and they can become more realistic about all that caregiving involves. They can make a decision on whether or not they can do the job, or if they need to ask for extra help," she explains.

During the class, families learn about the various options they have for help such as hospice, the palliative care program at the medical center, and home care. Organizations for certain diseases such as ALS and multiple sclerosis often offer help as well.

The families can take the class if their loved one is an inpatient or outpatient at the University of Minnesota Medical Center, Fairview. Often the health care team or a bedside nurse suggests the class. Families can ask to take the class as well.

Umbreit says the curriculum was developed from conversations with patients and family members, along with input from the palliative care expert and oncology social worker. In addition, they looked at available course content.

"In the class, we are very candid about the rewards and stressors of caregiving," says Umbreit. ■

An apple a day: Workers eat healthy to stay healthy

Say goodbye to fast food, trans fats

In an example other employers may want to strongly consider, hospitals around the country are re-creating their cafeterias as they strive to become healthier places to work. Kaiser Permanente in Oakland, CA, opened farmers' markets at hospitals to provide fresh fruits and vegetables for employees and visitors and added healthy selections to vending machines.

"Kaiser Permanente is about health care, not just sick care. We try to focus on prevention," says **Preston Maring**, MD, associate physician in chief at Kaiser Permanente Medical Center in Oakland, who set up the hospital-based farmers' markets. "What better place to focus prevention than on your own employees? Without healthy employees here at work every day, my patients don't get taken care of." Fast-food restaurants are not permitted on Kaiser campuses.

As a physician specializing in obstetrics and gynecology, Maring had spent much of his career counseling patients about diet and nutrition. In his spare time, he enjoyed cooking and he shopped at farmers' markets. So, about six years ago, he came up with the idea of hosting a farmers' market at the hospital. He started with seven vendors, who sold organic produce in front of the hospital. Today, there are 30 farmers' markets in Kaiser facilities in five states. The markets have three guiding principles: They provide certified organic food; they don't sell food that requires refrigeration, such as meat or dairy; and they are designed as a complement not a competition to on-site cafeteria food. Maring posts a recipe every week on a Kaiser blog. "It's something that I personally have cooked," he says. "I'm not a trained chef. If I can cook this, anybody can cook this."

With all the talk about healthy eating, some employees dubbed Maring "Dr. Broccoli." They stop him in the hallway to tell him about the new recipe they tried or a new salad they made. "I think I've had much, much more impact with this than I ever would have had in my entire life as a doctor," he says. In a survey of 1,200 shoppers at the farmers' markets, 71% of respondents said the markets have influenced them to eat more fruits and vegetables. "Having the market there puts the fruits and vegetables right in front of the employees when they came to work," says Maring. "It's awful hard to walk past a fresh peach in the middle of summer." Maring's mission is "making good fresh food easily accessible to people." That includes patients' menus, which now include fresh foods from pesticide-free local farmers.

If you want to help employees make healthy food choices, you need to give them information about nutritional content. That is the concept behind a new "healthy picks" program at Kaiser facilities. Fifty percent of the items in vending machines must be healthy — juice instead of soda, an apple instead of chips. The vending companies

COMING IN FUTURE MONTHS

- How assistants can help optimize the time of your case managers
- Taking a proactive approach to managing Medicare beneficiaries
- Recruiting and retaining case management staff
- Ways that community-based case management fulfills a need

CE questions

9. How many CIGNA members receive care from a Dartmouth-Hitchcock primary care physician?
   A. 5,000
   B. 10,000
   C. 19,000
   D. 24,000

10. In the study by PsycHealth of a home intervention pilot project, what was the percentage drop in overall hospital readmission rates within six months?
   A. 45%
   B. 65%
   C. 73%
   D. 86%

11. Which of the following are considered safe sleep practices for infants to reduce the likelihood of SIDS?
   A. Place baby on back.
   B. Place baby on firm mattress.
   C. Remove loose bedding.
   D. All of the above.

12. It is best to teach about end-of-life issues while people are in good health.
   A. True
   B. False

Answers: 9. C; 10. D; 11. D; 12. A.

were skeptical at first, and worried that vending sales would drop, says **Jan Sanders**, RD, director, national nutrition services in procurement and supply at Kaiser Permanente. Kaiser created a task force and pilot tests of vending machines with 100%, 75%, and 50% healthy items. The 50% mark seemed best, she says.

When the switch was made, vending sales actually went up. "We feel we need to be a leader in supporting the health of our members as well as our staff — and even beyond that, trying to support the health of the communities that surround our facilities," Sanders says. Kaiser cafeterias also offer "healthy picks" and are eliminating items with trans fats. ■

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. ■