

Case Management

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Guided Care Nurses help chronically ill patients manage their health care

Nurse-physician collaboration is key to program's success

Older patients who are at high risk for health care utilization are staying healthier and out of the hospital thanks to a new primary care enhancement program called "Guided Care."

The Guided Care model, developed by a team of clinical researchers at Johns Hopkins University, is an interdisciplinary model of health care in which patients are supported by a nurse-physician primary care team that provides coordinated, patient-centered care to at-risk patients for the rest of their lives.

In a three-year randomized, controlled trial involving 49 physicians and 904 older patients, researchers at the Johns Hopkins Bloomberg School of Public Health found patients who were treated using the Guided Care model cost health insurers 11% less than patients who received the usual care, according to **Chad Boulton**, MD, MPH, MBA, principal investigator for the study and creator of the Guided Care model.

The Guided Care patients in the study, on average, experienced 24% fewer hospital days, 37% fewer skilled nursing facility days, 15% fewer emergency department visits, and 29% fewer home health care episodes.

"The key to success in the Guided Care model is to create a close relationship with the patient. The interventions of the model rely on evidenced-based guidelines for chronic conditions tailored to each patient. The nurse, the physician, and the patient can work within the model and produce good outcomes," says **Cecelia M. Daub**, RN, BSN, CCM, MA, Guided Care nurse at Kensington Medical Center of Kaiser Permanente's mid-Atlantic states region.

Daub participated in the randomized, controlled trial of Guided Care at Johns Hopkins and now works with four doctors in a primary care practice to managing about 60 patients.

She visits the patients in their homes — involving family members

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and caregivers if possible — sees them when they come for their primary care visits and goes over what the doctor told them, accompanies them to specialist appointments whenever possible, visits them in the hospital, and even meets them in the emergency department.

“We take a holistic approach to care and work with the patients in their home environment, surrounded by their loved ones,” she says.

The Guided Care model uses predictive modeling software to identify patients older than 65 with chronic conditions and who are at high risk for health care utilization. Patients typically have

hypertension, diabetes, congestive heart failure, chronic obstructive pulmonary disorder or coronary artery disease, or a combination of several conditions.

When patients are identified for the program, the nurse visits them in their home and conducts a comprehensive geriatric assessment and home safety evaluation.

“By seeing what they have to manage in the home environment, we get tremendous insight into what is going on. If there is a caregiver, a spouse or a child involved with the patient’s care, we invite them to the initial session,” she says.

The initial evaluation usually takes between an hour and a half and three hours.

“We customize the evaluation to the patient and the caregiver and the complexity of the patient’s medical condition. When I conduct an evaluation, I leave an entire morning or afternoon free so the patient and caregiver will have a chance to get answers to all their questions. It sets up a very nice platform for a close relationship,” she says.

When Daub completes the in-home assessment, she develops a preliminary care guide using evidence-based guidelines, then meets with the primary care physician to collaborate on a care guide.

“We see a lot of things in the home and bring the information back to the physicians. They are very appreciative. The physician may have been treating the patient for many years, but when we go into the home, we may find a situation that he or she wasn’t aware of. By working together, we can develop a plan to address the patient’s issues,” she says.

Working with the physician, the nurse develops an action plan and shares it with the patient. The plan includes a medication list the patient can follow as well as information on physical activity, diet, recommended procedures, and follow up with specialists.

Daub encourages the patients to keep their action plan in a convenient location and bring it with them to specialists appointments or if they go to the emergency department.

“The action plan becomes a point of communication between the different health care providers the patient sees and helps with continuity of care,” she says.

By meeting with patients in their homes, the Guided Care nurses find out information they’d never discover during a telephone conversation, Daub points out.

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Editorial Questions

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

"Medication reconciliation is of tremendous importance with the geriatric population because many patients are on multiple medications and get them mixed up. When we conduct in-home medication reviews, we may see pill bottles that are expired and other combinations of problems that could affect the patient's conditions. When I'm in the home, I can see what's going on and get to the bottom of their problems," she says.

Sometimes Daub knows that a physician has told the patient to use a walker or a cane at home and observes that he or she isn't doing it.

"This becomes an opportunity for a coaching session. Depending on the circumstances, I might discuss it with the patient at the time or follow up later," she says.

She may recommend a fall prevention class or educate the patient on the importance of safety in preventing falls.

"Because I'm in the home and have a good relationship with the patients, I can focus in on what they need to do to stay safe and healthy. Doctors don't have the time to coax their patients into following their advice," she says.

She works with the patients to identify red flags that indicate they should call Daub or their doctor.

For instance, she educates diabetics about safe blood sugar levels and what to do when blood sugar is higher or lower. She encourages them to check their feet regularly and call her if there's an open wound. She tells patients who have coronary artery disease, to call her if they have an increase in chest discomfort or palpitations.

"I educate them on monitoring activities they can do for themselves and give them guidelines for when to call me. I get more information and make a recommendation," she says.

The physicians decide on the frequency of monitoring that is included in the care guide. For instance, if the patient is on Coumadin, the physician indicates how often they need blood tests.

"Our system of technology allows me to put in reminders for myself. I can see the specialty visit notes and know what that physician has in the patient's plan, she says.

Daub reminds the patients to get regular screenings and procedures, such as mammograms or flu shots, and educates them on safety issues.

"I make suggestions such as installing grab bars in the home. If they don't accept the idea right away, I remind them later on. I check the smoke alarms and make sure they get new batter-

ies if needed," she says.

She has contact with each patient a minimum of once a month but sees some patients much more frequently if necessary.

"I follow the patient in the outpatient setting, through any inpatient admissions, and help with the transition in care," she says.

Since she's located in the same office as the primary care physicians, when patients give permission, Daub accompanies them to their doctor visits, and then brings the patients back to her office to go over what the doctor said and make sure they understand it.

If the doctor changes the medication or the treatment plan, Daub can print out an updated action plan for the patient to follow.

"The Kaiser center I work in has primary care physicians with a laboratory, X-ray, and mammography downstairs. There's a same-day surgery and cataract surgery center here, and many of the specialists are next door. This kind of access to care is particularly helpful in providing continuity and cohesiveness of care to the geriatric population or anyone with mobility issues. If one of my patients has an appointment with a neurologist, I can easily walk over and sit in on it," Daub says.

Recently, a woman Daub was following was picking up her medication refill at the pharmacy and asked to see Daub because she wasn't feeling well.

"I took one look at her and knew she was in trouble. She told me her chest felt heavy and she wasn't breathing normally so I was afraid she was on the verge of a cardiac event," she says.

She notified the primary care physician who saw the patient immediately and sent her to the emergency department.

During her conversation with the patient, Daub asked her why she was at the pharmacy and found out the woman had been out of her beta blocker for three days.

"She felt comfortable telling me but didn't mention it to the primary care doctor or the emergency room physician. This was a crucial piece of the emergency room treatment, but nobody would have known it if I hadn't had a close relationship with the patient," Daub says.

Daub informed the emergency department physician of the missed medication and educated the woman about the importance of taking care of her medicine. She got the woman's daughter involved in assuring that her mother gets her medications refilled promptly.

Patients can call Daub on her office phone when they need to within regular business hours, and she encourages them to do so.

“My patients appreciate the fact that when they call, there is a personal connection. It’s the consistency. They aren’t calling in to a call center. They know that they can always get a message directly to me in my voicemail,” she says.

She also asks patients for permission to share private health information with their caregivers so there are no barriers to communication between the patient, the caregivers, and the nurse.

When she gets a call that patients are going to the emergency room, Daub meets them whenever possible.

“Patients often have trouble explaining their situation and their medical history. I can give their background information to the emergency room physicians and they love it. It really helps them treat the patients in an effective and efficient manner,” she says.

Guided Care nurses follow patients for the rest of their lives.

When patients are hospitalized, Daub doesn’t actively manage the care but brings information to the treatment team.

“I’m in a listening role for what will happen after discharge. I find out if the patients will be able to go back to the same living situation, if any home modification will be needed, if the caregiver will have more responsibility than in the past, and work with all parties to achieve the best outcome,” she says.

Her close relationship with her patients often helps with end-of-life issues. She tells of one diabetic patient who had a recurring abdominal infection.

“He’d go to rehab and work hard and something would happen again. One day I visited him in the hospital and he said, ‘Please call them off. I just want to go home.’ The family wasn’t around and he was able to say what he really wanted. He was putting on a good face for his family and doing whatever the doctor asked him to do,” she says.

Daub talked to the man’s doctor, who had a discussion with him, then set up hospice care in the home.

“He was surrounded by his whole family. His wife made his favorite meal. A few days later he went into a coma and died at home. It was a dignified and happy death,” she says.

(More information about Guided Care is available

at <http://www.GuidedCare.org>. The three-year trial of Guided Care was funded by a public-private partnership of the Agency for Healthcare Research and Quality, the National Institute of Aging, the John A. Hartford Foundation, the Jack and Valeria Langeloth Foundation, Kaiser Permanente Mid-Atlantic States Region, Johns Hopkins HealthCare, and the Roger C. Lipitz Center for Integrated Health Care.) ■

Remote monitoring cuts costs for chronically ill

Project extends the reach of health care providers

Following the success of a program that provides remote monitoring of chronically ill patients in poverty-stricken rural areas, Roanoke Chowan Community Health Center in Ahoskie, NC, is replicating the program at six other community health centers in North Carolina.

The program monitors vital signs and other data as determined by the patient’s primary care physician using remote monitoring devices placed in the patients’ homes. Nurses review the data daily and intervene.

In the original pilot project, hospitalizations decreased by 38%, total charges for health care were reduced by 70%, and hospital bed days dropped by 50% among the 65 patients for whom the health center could obtain data, says **Bonnie Perry Britton**, MSN, RN, telehealth clinical network director/development director for the health center.

“We don’t have an affiliation with a hospital so we can’t get emergency department data. We can get data from our local hospital, but if the patient went to another hospital, we had no way to obtain the data,” Britton says.

“We do know that one of the main reasons for the decrease in cost is that if patients went to the emergency room and were hospitalized, their length of stay was shorter,” she says.

The three-year pilot project was conducted with a grant from the North Carolina Health and Wellness Trust Fund Commission, which utilizes the state’s share of the national tobacco settlement to fund programs that promote preventive health.

Medicare beneficiaries represented the largest number of patients in the pilot program, followed by indigent patients and Medicaid

patients.

The health center rotated the monitors every six to seven months.

The new program, which started July 1, will monitor about 400 Medicaid patients with cardiovascular disease over a three-year period, leaving the monitors in place for about six months at a time.

“North Carolina Medicaid is our partner in this program to supply financial data on all health care expenditures, including emergency department visits, hospitalizations, and primary care provider visits,” Britton says.

The program will be replicated at Green County Health Care, Kinston Community Health Center, Tri-County Community Health Center, Rural Health Group, Cabarrus Community Health Center, and Bertie Rural Health Group.

The telehealth program was instrumental in improving the health of residents of three rural counties that are among the poorest in the state, Britton adds.

The center is a federally qualified health center serving four counties in northeast North Carolina, an area that leads the state in heart disease, diabetes, and childhood obesity.

The median family income in the counties served by Roanoke Chowan Community Health Center is \$21,000 a year, and 21% of the population is uninsured.

“We have only a 41% high school completion rate, which means that people grow up and go right into poverty. It’s a vicious cycle,” she says.

“The center provides primary care and mental health services as well as operating a program that provides medication and supplies for indigent patients and conducting outreach into the community to screen residents for hypertension, cardiovascular disease, and HIV,” Britton says.

“One of the obstacles we have to overcome is that patients have difficulty accessing care for a number of reasons. There is only one public transportation system in the area, and many residents have to pay someone to drive them to see the doctor. For the poorest families, that can be a challenge and a problem,” Britton says.

The North Carolina Health and Wellness Trust purchased 25 in-home monitors for the pilot project to monitor patients with cardiovascular disease, diabetes, and hypertension.

Primary care physicians identify patients who are eligible for the telemonitoring program, develop a plan of care, and determine what parameters to use for the biometric data that will

be monitored.

The information is faxed to a nurse case manager, who gets the patient’s consent to participate, goes to the patient’s home, installs the unit, and teaches the patient to use it.

Patients use the device daily Monday through Friday to collect whatever data the physician determines are appropriate and answer a series of questions.

For instance, the machine will ask if the patient is short of breath. If the patient says no, it shifts to another question. If yes, the patient answers a series of questions developed by the primary care physician and the telehealth team.

The telehealth nurse checks the server regularly, and if there is an alert indicating that the patient is having problems, she contacts the patient immediately to verify what is going on. She may ask the patient what he has eaten that day, whether he’s taken his medications, or other questions that will help her determine what interventions the patient needs.

The nurse educates the patients on diet, medication compliance, or whatever else may have triggered the alert and notifies the physician if she feels more interventions are needed or if the physician may need to change the patient’s medication.

The physician reviews the situation and may ask the patient to come in for a visit, or may send a change of medication to the patient’s pharmacy.

“In our experience, this has increased medication compliance because the patients don’t have to come into the office for the doctor to adjust their medication. They don’t have to travel from home, possibly paying as much as \$30 for transportation, then pay for the office visit as well. Many patients will skip their medication when they run out or not see the doctor when they don’t feel well simply because they can’t afford it,” she says.

Britton attributes the success of the pilot to the fact that, unlike the majority of telemonitoring projects, the program is driven by the primary care provider.

“The physicians designed the protocols that the telemonitoring nurses use. They determined which data to track for each patient and which questions to ask. Nobody knows the patient better than their primary care provider,” she says.

Many telehealth projects follow patients for only 60 days, according to Britton.

“Our average is six to seven months, during which time patients receive daily reminders. The

nurses develop a close relationship with their patients, who often say that the nurse is the first person who has cared enough to help them manage their disease," she says.

When patients monitor their vital signs on a daily basis using the telemonitoring equipment, it keeps them aware of their disease and what they need to keep it under control, Britton points out.

"Our program is not just about vital signs. The telemonitoring equipment asks the patients questions designed to give us insight into the patient's daily routine and the social setting. Our nurses have the information they need to help the patient manage their disease and to get them tied into other resources and programs that can assist them," she says.

The first telehealth monitors in the second phase of the program were installed in August and will be redeployed to other patients at the end of January.

The health center is working with East Carolina University and Wake Forest University to analyze data from the program.

The health center chose a different vendor for the telemonitoring equipment for the second phase of the program because it needed equipment that would enable it to quickly manage the volume of data that will be gathered by the new program, Britton says.

"Our new vendor's products seamlessly integrate the information gathered from patients, their electronic medical records, and Medicaid, giving us easy access to data," Britton says.

Roanoke Chowan Community Health Center created a telehealth manual for the new program and is handling the installation and training on the monitors.

Roanoke Chowan nurses are conducting the initial assessment of all patients in the new program and will monitor all of the patients in the new program. When interventions are needed, they will be conducted by nurses and physicians at the individual health centers who are familiar with the patients.

"Based on anecdotal information and the data we were able to access in the pilot project, we expect the program will show significant reduction in charges and total Medicaid expenditures among the patients in the program. Remote monitoring is an extremely cost-effective way to extend the reach of rural health care workers and improve public health," Britton says.

(For more information, contact: Bonnie Perry

Britton, MSN, RN, telehealth clinical network director, Roanoke Chowan Community Health Center. e-mail: bbritton@uhseast.com.) ■

Ready to save a worker's life in of these situations?

Consider every possible hazard

Amputation, anaphylactic shock, asthmatic reaction, cardiac arrest, convulsion, seizure, diabetic emergency, head injury, heat stroke, and pneumothorax.

These are just some of the emergencies that can occur in your workplace at any given moment. "The occupational health nurse needs to be aware of the conditions that can occur as a result of an individual's health status and also work-related issues," says **Bonnie Rogers**, DrPH, COHN-S, LNCC, director of the North Carolina Occupational Safety and Health Education and Research Center, and the Occupational Health Nursing program at the University of North Carolina, both in Chapel Hill.

Every day, you may potentially save an employee's life by encouraging healthy lifestyle changes and safe work practices, and never know it. However, there are occasionally dramatic "saves" made by OHMs that literally save an employee's life or limb.

"You must be familiar with all the jobs that are done at the worksite, in order to put prevention strategies in place," says Rogers. For example, an employee using potentially dangerous equipment could suffer an amputation. In this case, "you will need to provide immediate emergency care to make sure the worker is breathing, stop any bleeding, and arrange for immediate transport of the employee to the hospital, while taking care of the affected part that was amputated," says Rogers.

If an employee has an anaphylactic reaction from an allergy to food or latex, it can trigger respiratory distress, bronchospasm, wheezing, and cardiovascular collapse. "Here, you will need to be sure the airway is open, administer oxygen and epinephrine per written medical standing order, monitor vital signs, and immediately provide for transport to the hospital," says Rogers.

Be ready for cardiac arrest

According to **Bruce Sherman**, MD, medical director of global services at Akron, OH-based Goodyear Tire and Rubber Co., “the most likely setting for an occupational health professional to provide a critical emergency response is a cardiac arrest.” Consider these items:

- **Ensure timely access to an automated external defibrillator (AED).**

“This is essential for improving the likelihood of resuscitation from cardiac arrest,” says Sherman. “My recommendations are to have AEDs available in the workplace so that the device can be transported and used within five minutes of recognition of cardiac arrest.”

To be of any value, AEDs must be readily accessible to trained personnel, says **Patrick Stover**, MD, senior medical director at General Motors Corp. in Detroit. “We have established a guideline that includes a ‘drop to shock’ time of three to four minutes,” says Stover. To meet this goal, he says that AEDs are required to be:

- highly visible, such as in wall mount units;
- near expected responders, such as in security vehicles or first aid stations;
- close to where the largest numbers of people spend their time;
- near hazards or where high-risk activities take place;
- tied into the communications system;
- accessible during all shifts or hours of operation;
- protected from tampering.

Site assessments were done by occupational health staff, with special attention paid to difficult-to-reach areas, such as upper floors in a high-rise building and secured locations. “Each site is required to have a written emergency response plan. The AED protocol must be incorporated into this plan,” says Stover.

- **Develop an emergency response team.**

“This is ideal for most workplace settings, where team members have received training and certification regarding cardiopulmonary resuscitation and AED use,” says Sherman.

- **Consider the need for additional resources.**

For geographically remote areas with significant delays in the arrival of emergency medical services, additional advanced cardiac life support medications, and individuals certified to use them, may be warranted, says Sherman.

“Equipment, including supplemental oxygen and a means for passive and active administra-

tion, should also be available,” says Sherman. ■

If necessary, could you restart a worker’s heart?

A long-term machine operator employee in his 60s was working in the pocketed coil department at an Atlanta, GA-based Simmons Bedding Co. factory, when he suffered a sudden massive heart attack.

“He dropped to the floor without a heartbeat or a pulse, and his breathing had stopped,” says **Jonathan Dawe**, director of safety, health, and workers’ compensation. Two of his co-workers were trained emergency first responders. One immediately began giving cardiopulmonary resuscitation (CPR). The other grabbed the plant’s automated external defibrillator (AED), and another worker called 911.

“The employees were successful in keeping blood flowing to vital organs through a combination of using the AED and providing CPR until paramedics arrived,” says Dawe. “The employee’s life was saved, and there was no brain damage as a result of the event, because Simmons employees had kept circulation going.”

Take leadership role

At each Simmons facility, “first responder” volunteers are trained and certified in first aid, CPR, and AED use. Most are also members of the plant’s safety and health committee. Dawe recommends that all occupational health nurses be trained in the use of AEDs and be prepared to train other workers how to “calmly use the device in an emergency.”

For most organizations, a team of individuals trained in CPR and AED use can meet any anticipated response needs for initial cardiac emergency care, says **Bruce Sherman**, MD, medical director of global services at Akron, OH-based Goodyear Tire and Rubber Company. Consider these items:

- **Formalize the transfer process of patients from the workplace to community emergency services personnel.**

“This may include mutual agreement on a specific location for patient transfer, preparation of medical documentation in advance of emergency services arrival, and a communication process to

ensure that community medical responders have unhindered access to the identified patient pick-up point," says Sherman.

— **Establish protocols for regularly scheduled and functional evaluation and testing of the resuscitation equipment.**

— **Perform periodic drills that provide a functional testing of the entire emergency response process.**

"Proper equipment and training are important; but to me, periodic drills represent an equally important aspect of the emergency response process," says Sherman. "Because cardiorespiratory arrest is a rare occurrence, it is important that trained responders don't lose their skills due to disuse."

As an occupational health professional, you should take a leadership role in this. "Work closely with safety personnel, and accept primary responsibility for the medical aspects of these drills," says Sherman. ■

These actual interventions saved lives of employees

In an organization as large as Detroit, MI-based General Motors Corp., medical emergencies "are encountered with some regularity," according to **Joel R. Bender, MD, PhD, MSPH, FACOEM**, corporate medical director.

In addition to cardiovascular disease, Bender says he routinely sees patients with chest pain, shortness of breath, hypoglycemic episodes, asthma attacks, cardiac rhythm disturbances, stroke symptoms, syncopes, and seizures. "Under most circumstances, urgency of response is critical to a successful medical outcome," says Bender.

Here are some examples of interventions done by General Motors' health services staff:

- At a service parts organization site, a supervisor in his late 20s was returning from work from a sick leave for right lower quadrant pain of unknown origin. A routine check of his pulse revealed a rhythm disturbance.

"The employee did not have any previous cardiac history and was extremely reluctant to permit the nurse to investigate further," says Bender. "Finally, he consented to an EKG, where he was found to be in bigeminy. The nurse activated the emergency response system."

Shortly after the ambulance arrived, the employee went into ventricular tachycardia. He was successfully resuscitated, transported to the hospital, and ultimately had multiple ablation procedures to correct a conduction disturbance.

- An employee complained of back pain and asked an occupational health nurse if he could lie down. The nurse assessed his color and the severity of his complaints, and activated the emergency response system. While waiting for the ambulance to arrive, the employee experienced a sudden cardiac arrest that responded to defibrillation.

"The alert response of the nurse correctly recognized that this was a medical emergency, rather than dismissing it as common back pain that is frequently seen in an occupational setting," says Bender.

- An employee complained of heartburn after eating a hamburger. After the occupational health nurse checked the man's blood pressure, which was 220/110, he was transported to the hospital by ambulance and subsequently had three stents placed.

- An employee came in for a routine truck driver exam with a history of chest pain, but was not symptomatic at the time. An EKG was performed that revealed a rhythm disturbance. The man was transported to the hospital via ambulance and coronary artery bypass grafting was performed.

- A 55-year-old man complained of not feeling well. "After a brief evaluation, the nurse determined that prompt transport to the emergency room was required," says Bender. "He was diagnosed with a dissecting aortic aneurysm that was successfully treated with emergency surgery."

- A 35-year-old employee had an anaphylactic reaction from a bee sting. "The nurse on duty recognized it as such and administered an IM injection of epinephrine, likely saving the employee's life," says Bender.

- A very active 42-year-old employee was exercising at the gym in preparation for a triathlon and became light-headed. He was transported by security personnel to the onsite clinic, where the employee had a sudden cardiac arrest. CPR was initiated, the employee was defibrillated and received drug therapy, and a rhythm and pulse were re-established.

"The patient ultimately had a stent placed and has now returned to his normal active lifestyle," says Bender. "Of special note is that the employee initially did not wish to seek medical attention."

Security personnel correctly identified this as a potential life-threatening emergency and convinced him to be evaluated in the clinic." ■

Make the case to pay workers for better health

Despite the recession, incentives paid to employees for participation in health and wellness programs show no signs of slowing down. Of 372 small, medium and large companies surveyed by Vienna, VA-based Health2 Resources, 64% said they use incentives for some type of employee health, wellness, or disease management program. An average of \$329 is spent per employee annually. Of those who measured their return on investment, 83% said it was better than 1:1.

Premium reductions were the most common incentive, but employers also used gift cards and cash. According to Health2Resources president **Katherine Capps**, incentive programs are becoming "more sophisticated." "They are not just giving the employee \$10 or \$15 to lose weight and telling them to come back in six weeks and step on a scale," says Capps. "People are saying, 'We know that incentives can work, but now, let's put a little science behind them.'"

According to **Mary Jane Rink**, RN, FNP-C, CWWC, assistant vice president of the LiveWELL Carolinas! program at Carolinas HealthCare System in Charlotte, if you want to implement an incentive program and can obtain any information on the health risk stratification of your employee population, "the business case can be more easily made. Better still, compare risk stratification info to benefits utilization. If there is a correlation, such as high levels of stress-related risks along with high pharmacy claims for psychotropic drugs, it becomes much easier to make the case."

Here are key trends identified in the report:

— **Varied incentives are used.**

"You don't need to use only one approach," says Capps. "Employers are using a combination of different incentives. You may need to experiment with a variety of types of incentives to elicit the best possible response."

— **Instead of a single incentive, workers are given incentives on an ongoing basis.**

"There is a recognition that you really need to have an evolving program," says Capps. "In

other words, incentives work at key points during the program." For example, an employee may get \$300 to participate in a health risk assessment. The following year he or she also have to sign up for a wellness program to get that same incentive, and the third year, the employee's spouse also has to take the health risk assessment to qualify.

— **Spouses and family members are being included.**

The survey measured the percentage of companies that offer incentives not only to employees, but also their spouses and children. "Employers have always known that spouse and family members impact total health costs. Now some of the early adopters are trying to engage them," says Capps.

This makes sense for two reasons. "First, they have the liability of the spouse and the family member from a business standpoint," says Capps. "Secondly, lifestyle changes are really a family issue. If you want to change an employee's dietary and exercise habits, you need to consider the family." ■

Using support groups in the continuum of patient

Members learn from experts and one another

Support groups are a way of providing continuing education, according to health care professionals who facilitate groups with an educational format.

At Mount Carmel East Hospital in Columbus, OH, the diabetes support group is promoted to people who enroll in the diabetes classes when first diagnosed as a way to continue learning about the chronic disease once they finish their basic education.

"I explain to patients that the classes are just a start. They need to continue learning about diabetes, whether it is through the support group or another way," says **Julie Hitch**, RN, BSN, CDE, an educator in diabetes self-management education at Mount Carmel and facilitator of the support group.

Hitch adds that the treatments for the disease and the modalities used to live with it are changing all the time. With the way she conducts the support group, people attending have an opportunity to be updated on new products, medica-

tion, and information. The patient's physician may not have all the latest information if he or she is not a specialist in diabetes, says Hitch.

A topic is offered each month and presented by an expert in that area, or Hitch provides the education. There is always a lot of time left for questions. Also, the group has time to discuss issues among themselves.

People newly diagnosed are encouraged to find others who have managed diabetes for a long time, and it gives them hope, says Hitch. During group time, they bounce ideas off each other, so often the newly diagnosed will learn a lot from the knowledgeable people who have had diabetes for a while have gained in areas such as eating healthy in a restaurant or traveling with diabetes.

A support group designed for ovarian cancer survivors at The University of Texas MD Anderson Cancer Center in Houston gives people who attend access to experts. People in the group listen to a presentation and ask questions of people they normally would not have easy access to, says **Mary A. Fitzgerald**, MA, a co-facilitator of the group and research manager for the department of behavioral science.

"Women and their family members don't interact a lot in the meeting itself, but hearing other people's questions is often very helpful," says Fitzgerald.

Originally, the group allowed time for the ovarian cancer survivors to meet in one room and their family members to meet in another following the presentation, so they could discuss various issues. However, feedback from the group indicated they wanted information, so Fitzgerald and her colleague, **Alycia Hughes**, LMSW, adopted an educated forum.

Topic titles have included: "Coping with Fear of Recurrence," "Making the Most of Your Doctor's Appointment," "Can Foods Heal?," "Emerging Therapies for Ovarian Cancer," "Spirituality and Cancer," "The Effect of Stress on Cancer," "Legal Issues Affecting Cancer Patients," and "Acupuncture Treatment for Cancer Patients."

"The reason our group exists is because patients are hungry for information. They want information about their disease, aspects of treatment, how to deal with the financial or legal aspects of cancer, and about their spirituality. There are a lot of things patients want to know, and they don't want to just read about it," explains Fitzgerald.

The best way to provide education may depend upon the type of diagnosis of those attending the group. The Head and Neck Cancer Support Group

at James Cancer Hospital in Columbus, OH, has formal presenters, but those attending find that sharing information about how to get through the treatment, various issues pertaining to it, and the phases of survivorship are invaluable, says **Cheryl A. Huang**, MS, RN, AOCN, a clinical nurse specialist and group co-facilitator.

Huang says the Head and Neck Cancer Support Group is one of the largest at the cancer hospital, and many have attended since the beginning. These cancer survivors are probably one of the most challenging groups of people, because they have tremendous needs, she explains. Treatment often impacts their physical appearance, their ability to communicate, and their ability to eat and swallow. All have quality of life issues, says Huang.

Regaining quality of life

Learning how to live with a disease is part of the education process. Support groups can help people learn how to get back that quality of life they often feel they have lost, says Huang. One year, in addition to querying the group about their educational needs, the facilitators asked what else the group members would like to do. The answer was to educate medical staff on what it is like to be a head and neck cancer survivor.

Eventually, members of the group presented to resident physicians discussing what it was like being diagnosed, going through the treatment, and what their present challenges were. Their hope was that the residents would be able to better prepare patients for the implications of head and neck cancer surgery, says Huang. Group members also have done a nursing grand rounds presentation and addressed dentists at a convention.

"One of the presenters has now done several presentations and gone from a person who was angry and depressed to an advocate for cancer survivorship and patients in the health care arena," says Huang.

The group also wanted to reach head and neck cancer patients who did not have a local support group, so the facilitators put together a half-day conference funded with grant money. Head and neck cancer survivors across the state of Ohio were invited to the conference to hear presentations by a physician who treats patients with this cancer, a speech and swallowing therapist, two social workers who discussed coping and resources, a presentation by a dentist on oral care, and a nutritionist who discussed the importance of good nutrition. ■

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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 the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management 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. ■

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COMING IN FUTURE MONTHS

■ A look at some new career paths for case managers

■ How to combat the obesity epidemic

■ Disease management in the home health setting

■ Using incentives to keep members healthy

■ Extending case management beyond hospital walls

17. How long was the randomized, controlled trial by Johns Hopkins researchers?
 A. one year
 B. two years
 C. three years
 D. four years
18. In the remote monitoring pilot project, hospitalizations decreased by how much?
 A. 38%
 B. 42%
 C. 54%
 D. 64%
19. Which is recommended regarding access to an automated external defibrillator (AED)?
 A. Guidelines should not specify "drop to shock" timeframes.
 B. AEDs should never be placed in wall mount units.
 C. AEDs should not be placed near high-risk activities or large groups of people.
 D. AEDs should be placed near expected responders, such as security vehicles or first aid stations.
20. Which is recommended for occupational health professionals to improve their emergency response to a cardiac arrest?
 A. All occupational health nurses should not be trained in the use of automated external defibrillators.
 B. Protocols should be established for regularly scheduled functional evaluation and testing of resuscitation equipment.
 C. The transfer process of patients from the workplace to community emergency services personnel should not be formalized.
 D. The occupational health professional should not accept primary responsibility for the medical aspects of periodic drills.

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

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