Patient Education Management™

For Nurse Managers, Education Directors, Case Managers, Discharge Planners

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IN THIS ISSUE

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Multidisciplinary cardiac rehab programs can improve patient health

Education is a key to successful lifestyle change

A comprehensive cardiac rehabilitation program is highly beneficial for people who have experienced a cardiac event, such as a heart attack or bypass surgery, says **Murray Low**, EdD, FAACVPR, FACSM, president-elect of the American Association of Cardiovascular and Pulmonary Rehabilitation.

It can reduce the risk of death after a cardiac event by 20% to 25%.

"The cardiac rehabilitation program is an independent variable in and of itself. Above and beyond everything physicians do to provide patients with optimum medical care, cardiac rehab further reduces mortality from cardiac death," says Low, who is director of cardiac rehabilitation at Stamford (CT) Hospital, The Burke Rehabilitation Hospital in White Plains, NY, Sound Shore Medical Center of Westchester in New Rochelle, NY, and Northern Westchester Cardiac Rehab in Mt. Kisco, NY.

There has been a focus on acute care of patients with coronary artery disease and acute management of their illness and complications. Secondary prevention techniques have been slow to develop, says

EXECUTIVE SUMMARY

A new set of performance measures not only improves cardiac rehab programs, it also helps get patients involved. Thus, education that results in lifestyle change plays an important role in managing heart disease and preventing further problems.

In this article, *Patient Education Management* looks at the benefits of a good cardiac rehab program.

Richard Stein, MD, a spokesperson for the American Heart Association and director of the Urban Community Cardiology Program at New York University School of Medicine in New York City.

Cardiac rehabilitation programs that include finding a lifetime activity for exercise as well as dietary and psychosocial counseling are dramatically effective in helping people make the lifestyle changes that will increase the likelihood of outliving their disease, says Stein.

An important part of successfully managing heart disease is cardiac rehabilitation yet it is not utilized very effectively in the United States, says Stein.

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To remedy the problem, a new set of performance measures aimed at increasing patient enrollment in cardiac rehabilitation programs and setting standards of excellence for program operation were released in 2007 by the American Association of Cardiovascular and Pulmonary Rehabilitation based in Chicago, The American College of Cardiology in Washington D.C., and the Dallas-based American Heart Association.

AACVPR/ACC/AHA 2007 Performance Measures on Cardiac Rehabilitation for Referral to and Delivery of Cardiac Rehabilitation/ Secondary Prevention Services is available on each organization's web site [www.aacvpr.org, www.acc.org, and www.americanheart.org]. **(For a brief overview see article on pp.123.)**

Cardiac rehabilitation requires a multi-disciplinary approach, and the performance measures pull all the pieces together to define a high-performing program that is providing all the necessary services, says **Larry F. Hamm**, PhD, FAACVPR, FACSM, 2007-08 president of AACVPR and visiting professor & director of the Clinical Exercise Physiology Program in the Department of Exercise Science at The George Washington University Medical Center in Washington, D.C.

The document does more than identify the core components of a good cardiac rehab program. It provides information on how they are delivered.

"It would be difficult to take the performance measures paper and unilaterally implement everything in it overnight. Certainly over time and in stages that would be the goal," says Hamm.

Education key element

One of the toughest lessons to teach is the importance of lifestyle change, and that is an important element of cardiac rehab, says Low. Patients must understand that a procedure, such as bypass surgery, and prescribed medications do not protect them completely from the progression of the disease. If it did, then cardiac rehabilitation would not be needed.

"In our health care system, we have put the cart before the horse in that we are focused on providing medication and procedures, not dealing with the most important part, which is altering the lifestyle that led to the disease process," says Low.

The foundation of a good cardiac rehabilitation program is exercise training, says Hamm. An

individualized exercise prescription is developed for each patient that is safe and effective. Then patients perform the exercise prescription in a supervised environment. In addition, patients need education on a wide array of topics, including heart disease, medications used to control symptoms, risk factors, diet related to a heart healthy lifestyle, and the importance of cardiac rehab.

Once patients have the information, they must learn how to apply it in order to reduce their risk for subsequent cardiac problems, says Hamm. For example, if a patient has high cholesterol, a diet plan must be determined in addition to medication to reduce cholesterol.

Patient education improves outcomes for cardiac patients by not only giving them information on lifestyle changes, but also teaching them how to make the changes. It's important to give people the tools to make necessary changes and then coach them or encourage them while they make the changes, adds Hamm.

In addition, greater knowledge about heart disease and how to achieve positive outcomes reduces fear and anxiety, says Stein.

The vast majority of hospitals that have a full range of cardiovascular diagnostic and intervention services offer cardiac rehab programs, says Hamm. The problem isn't so much in the availability of programs but in the referral process, he adds. **(To learn more about the need for better referral methods, see article, below.)**

Yet there is no better way to monitor cardiac patients following discharge. In cardiac rehab, patients are seen two to three times a week in a medical setting for about three months. They are given electrocardigrams, and their blood pressure and heart rate is monitored, says Hamm. If a problem occurs, it can be communicated quickly to the patient's physician.

Patients that go through cardiac rehab and adopt the lifestyle changes afterwards do better medically, says Stein. It is not only a good investment of time and energy, but it is also very enjoyable, he adds. Essentially, the patient gets a personal trainer for three months at a very expensive gym.

"It is a wonderful way to not only lead yourself back into life, but lead yourself into an active life," says Stein. ■

SOURCES/RESOURCES

For more information about cardiac rehab programs and their benefits, contact:

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Referral to cardiac rehab must be improved

Implement systematic approach

Although research shows that cardiac rehabilitation programs, also known as secondary prevention programs, help improve the health and life expectancy of people with heart conditions, the referral rate is low.

Across the United States, about 20% of eligible patients are referred to cardiac rehabilitation, says **Murray Low**, EdD, FAACVPR, FACSM, president-elect of the Chicago-based American Association of Cardiovascular and Pulmonary Rehabilitation and director of four cardiac rehabilitation programs in New York State and

EXECUTIVE SUMMARY

A system for referral to a cardiac rehabilitation program following discharge from the hospital after a cardiac event should be implemented at every institution. With a defined system in place, patients will be less likely to fall through the cracks.

Connecticut.

Low says in a recent study published by a group of researchers at Brandeis University in Waltham, MA, referral among states varies greatly. For example, only about 12% of eligible Medicare patients in New York State were referred to cardiac rehab. In Connecticut, it was slightly higher, with 19% referred.

To improve the numbers, new standards were created by the AACVPR, Dallas-based American Heart Association, and the Washington, DC-based American College of Cardiology. The AACVPR/ACC/AHA 2007 Performance Measures on Cardiac Rehabilitation for Referral to and Delivery of Cardiac Rehabilitation/Secondary Prevention Services give details on referral and enrollment in programs, so no eligible cardiac patients fall through the cracks.

"The referral to cardiac rehabilitation for specific diagnoses or procedures should be automatic and systematic within a hospital," says **Larry F. Hamm**, PhD, FAACVPR, FACSM, the 2007-08 president of AACVPR and visiting professor and director of the Clinical Exercise Physiology Program in the department of Exercise Science at The George Washington University Medical Center in Washington D.C.

All the right boxes can be checked on a hospital discharge form, but if there is no follow-up, the patient may not enroll in a cardiac rehabilitation program. The cardiologist may forget to ask the patient at his or her next office visit.

A good way to make sure patients are encouraged to enroll is to initiate an automatic referral to a cardiac rehabilitation program. Then patients can be scheduled for an informational session and make an informed decision about whether they want to participate.

In addition, physicians must understand they need to directly refer their patients, says **Richard Stein**, MD, a spokesperson for the American Heart Association and director of the Urban Community Cardiology Program at New York University School of Medicine in New York City.

All other strategies, such as providing brochures or having the nurse discuss a program with the patient, have less impact than a physician giving a patient a direct recommendation, he says.

It's important that the recommendation be direct, says Stein. For example, the physician should state "the next important step in your health care is to go to cardiac rehabilitation" rather than making a general statement such as "all my patients go to cardiac rehabilitation."

The AACVPR is currently working on quality indicators for cardiac rehabilitation, says Low. In the future, hospitals would be able to measure what percentage of their eligible patient population is referred to cardiac rehabilitation and which actually go.

The goal is to have as many programs as possible participate so hospital administrators can compare their institution's scores with the average of all participating programs, explains Hamm. ■

Overview of performance for cardiac rehab programs

Details include steps for proper enrollment

A new set of performance measures to increase patient enrollment in cardiac rehabilitation programs and set standards of excellence for program operation were released in 2007.

They are the work of teams from the American Association of Cardiovascular and Pulmonary Rehabilitation in Chicago, The American College of Cardiology in Washington D.C., and the American Heart Association in Dallas.

The AACVPR/ACC/AHA 2007 Performance Measures on Cardiac Rehabilitation for Referral

EXECUTIVE SUMMARY

New standards for cardiac rehabilitation programs can ensure patients receive the best education for lifestyle change and are appropriately referred to a program.

to and Delivery of Cardiac Rehabilitation/ Secondary Prevention Services divide the material into two parts. The first section focuses on referring and enrolling patients to cardiac rehabilitation programs. The second portion addresses outcomes measures.

Included in the document are referral forms for both inpatient and outpatient settings. There are also sample data collection tools.

There are many details included in this paper. Following is an example, which is the list of steps for program referral:

- Discuss with patient the choices of cardiac rehabilitation programs in his/her home area and have the patient select a program.
- Provide patient with information about the selected cardiac rehabilitation program.
- With patient consent, call the receiving cardiac rehabilitation program, chosen by patient, requesting that the program contact the patient at home to arrange the first appointment.
- Document the name of the cardiac rehabilitation program in the hospital discharge summary with copies of the appropriate enclosures.
- With patient consent, send hospital discharge summary and other appropriate information to the cardiac rehabilitation program (could include surgical report, angiogram report, electrocardiogram, inpatient cardiac rehabilitation evaluation).

Full copies of these standards are available online at www.aacvpr.org, www.acc.org, and www.americanheart.org. ■

Cancer program carefully monitored for best results

Tool uses time and complexity to track patient acuity

OhioHealth Cancer Services in Columbus is building a navigator program called CancerConnections. The purpose of the program is to educate and support cancer patients, intervening as close to their diagnosis as possible.

New cancer patients are identified through hospital admission lists, the surgery schedule, or physician referral. Once patients are identified, information about them is gathered through the electronic medical record, diagnostic studies such as a pathology report, and discussions with their physician or the nurse on duty.

CancerConnections staff members, which are currently two RNs and one person without a medical degree, work with the patient to help him or her through the diagnostic and treatment process.

Currently, patients diagnosed with lung, colorectal, or pancreatic cancer take part in the CancerConnections program, says **Mary Szczepanik**, MS, BSN, RN, manager of Cancer Education, Support and Outreach at OhioHealth Cancer Services. The next group of patients who will probably be added are those with head and neck cancer, because most could use a navigator.

"We look for patients that really need us. They have a bad prognosis, and most of the time a complex surgical procedure is their very first treatment. Also, they have a shorter survival rate," explains Szczepanik.

To make sure the program runs well, it is carefully monitored. An acuity measurement tool was implemented so staff in CancerConnections can monitor their workload, based on the complexity of the patients with which they work.

Also, the program manager can monitor the overall acuity of patients in the program during any given month to determine if another staff member is needed to cover workload, or if those on staff should be given more hours. In addition, the manager can determine if the program is at a point to handle patients with another type of cancer.

Szczepanik says a database was created to record all the demographic information about patients, track the number of new patients added each month, and whether they are seen before discharge, which is one of the program's quality measures. The system also tracks whether new radiation therapy patients are contacted within 24 hours of their consultation appointment. It also measures acuity.

EXECUTIVE SUMMARY

CancerConnections is a navigator program for patients with certain types of cancer that often require lots of education and support. To make sure the program runs well — and no one falls through the cracks — certain data are collected and reviewed. Learn how these data help to make CancerConnections a quality program.

Special acuity tool

To gather data on acuity, a tool has been created to track time spent with each patient and factors that determine the complexity of each patient, such as the need to attend appointments with him or her. **(For details on what is measured, see article, below right.)** Acuity equals time plus complexity measured at each interaction with patient.

The acuity measure was implemented to help determine whether certain types of patients required more resources or needed more from staff than other types of patients, explains Szczepanik. The tool helps determine if it is individual need or if a certain type of cancer patient has a higher acuity, such as those with pancreatic cancer.

"It helps us know what types of patients really have the largest need for education, support, resources, financial assistance, and all the things that go into the acuity score itself," says Szczepanik.

Everyone in CancerConnections knows what is measured, so if one navigator nurse says her acuity is high a particular week and she cannot take a new lung cancer patient, then other staff members understand why. In addition, the tracking of the data creates a report that can be submitted to administrators detailing program acuity each month, which indicates the difficulty of the workload.

Every morning CancerConnections staff meet to discuss the patient caseload. The non-nurse navigator assumes a lot of the routine activities that do not require an RN, such as advising the patient as to what resources are available.

CancerConnections is part of the Cancer Education Support and Outreach department.

SOURCE

For more information on the CancerConnections nurse navigator program, contact:

• **Mary Szczepanik**, MS, BSN, RN, Manager, Cancer Education, Support and Outreach, OhioHealth Cancer Services, 3535 Olentangy River Road, Columbus, OH 43214. Telephone: (614) 566-3280. E-mail: szczepm @ohiohealth.com.

Therefore, if a patient's distress score is high, he or she may be referred for a massage or to an oncology counselor. There are many resources and services within the department, including those to help children cope with the diagnosis of a family member.

"In the past, most of our support programs have been used by patients who are done with treatment. Now we see them participating while in treatment shortly after they start chemotherapy. It has been exciting to see that happening," says Szczepanik.

From the patient's perspective, Cancer Connections provides education and support. However, it provides much more. It improves communication with the staff, the physician, and the patient. It helps solidify the relationship between hospital staff and outpatient office staff.

Better communication results because the nurse navigator assists patients with physician communication and provides support during appointments, if needed. Also, the nurse navigator provides the educational information needed by each patient in the program. ■

Determining acuity with CancerConnections

Tracking tool helps determine overall patient need

An important element of the Cancer Connections program at OhioHealth Cancer Services in Columbus is a tool to measure patient acuity.

According to the tool, acuity equals time plus complexity measured at each interaction with patients. It helps staff who are navigating cancer patients through the diagnosis and treatment process to manage workload.

"Basically, what we were looking for was a way to determine what makes one patient take up more time than another," explains **Mary Szczepanik**, MS, BSN, RN, manager of Cancer Education, Support and Outreach at OhioHealth Cancer Services.

Time is measured in 15-minute increments that are counted as one point. In addition, there is a list of activities that make work with the patient more complex, and each is counted as a point. Whenever a patient is contacted, he or she is assessed for distress, fatigue or pain using the

EXECUTIVE SUMMARY

A tool was created at OhioHealth Cancer Services to determine acuity at Cancer Connections, a program that provides personal services to certain types of cancer patients. Acuity is measured by time spent with patients and the complexity of the interventions.

National Comprehensive Network measurement scales. If a patient scores higher than a three on a scale that is measured from zero to 10, one point is documented.

Some of the categories that receive a point if the box is checked include:

- Patient is hospitalized.
- Diagnosis of cancer is unexpected
- Patient suffers from addiction.
- Patient has psychiatric diagnosis.
- Patient required financial assistance.
- Patient has complex family history/lives alone/other.
- Nurse must assist patient with physician communication.
- Nurse attends appointment with patient for support.
- Nurse does chemo teaching.
- Nurse does radiation therapy teaching.
- Nurse makes referral to other member of Connections team.
- Nurse must consult with physician.

Information is entered into a database to track numbers. For example, the average acuity for each month is calculated to determine the workload for staff in CancerConnections. An average acuity of 35% would mean that 3.5 patients out of 10 had acuity higher than three.

Monitoring acuity helps the program run smoothly because problems can be avoided. Szczepanik says she would not let the average acuity get much higher than 50% before asking that staff be given more hours or an additional staff member is hired.

If acuity is high for three months, it would not be long before there is a decline in staff members' ability to see all cancer patients before discharge or contact patients scheduled for radiation therapy 24hours before their consult — all of which are program quality measures. ■

Health plan, medical practice team up on 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.

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 on 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.

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 programs, or helping them get connected with a payment plan for utilities or gas, as well as individual and family therapy," Gomez says. ■

CNE instructions/objectives

Nurses and other patient education professionals 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 activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you.

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- **explain** how those issues impact health care educators and patients;
- **describe** practical ways to solve problems that care providers commonly encounter in their daily activities;
- **develop** patient education programs based on existing programs from other facilities. ■

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COMING IN FUTURE MONTHS

- ■ Health literacy more important than reading level
- ■ Using patient experts to shape programs
- ■ Using technology to improve patient teaching
- ■ Making good staff selections when hiring
- ■ Best practice for selecting vendors

CNE Questions

9. Above and beyond everything physicians do to provide patients with optimum medical care, cardiac rehab further reduces mortality from cardiac death.
   A. True
   B. False

10. Steps for referring cardiac patients to a rehabilitation program might include
   A. Discussing programs with patients.
   B. Giving details on patient's choice.
   C. Contacting rehab program with patient's name.
   D. All of the above.

11. A tool was developed to measure the acuity of CancerConnections, a navigator program at OhioHealth Cancer Services, for which of the following reasons?
   A. To know which patients to drop from program.
   B. To make sure nurses did their job.
   C. To monitor overall acuity of program.
   D. To document patient education.

12. Acuity rises when CancerConnections nurses do which of the following?
   A. Assist with physician communication.
   B. Teaches on chemo or radiation therapy treatment.
   C. Attends an appointment with patient.
   D. All of the above.

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

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