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Covering Case Management Across The Entire Care Continuum

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CMs in primary care practices facilitate care for at-risk members

Pilot demonstrated a 20% reduction in hospital readmissions

Geisinger Health Plan's patient-centered medical home pilot project, which placed case managers in primary care practices, reduced hospital admissions for heart failure, pneumonia, chronic obstructive pulmonary disease, and the frail elderly within six months, and ultimately demonstrated a 20% reduction in hospital readmissions.

After the initial success of the pilot, the health plan has expanded the program, called the Geisinger Health Plan Health Navigator and now has 61 embedded case managers at 37 practice sites who coordinate care for 40,000 Medicare beneficiaries and 2,500 commercial members, says **Janet Tomcavage**, RN, MSN, vice president of health services for the Danville, PA-based health plan.

The initiative calls for one case manager for every 700 to 800 Medicare beneficiaries or 5,000 commercial lives.

The program continues to achieve a 15% to 20% reduction in hospital readmissions for the entire practice, and not just for the patients in case management, she adds.

"We believe that the success of the medical home program has been because of the value case managers bring to the highest-risk population. We believe that by managing a small percentage of the Medicare population in a practice, case management can drive unnecessary utilization and medical expenses down for the whole population at that practice," Tomcavage says.

The case managers are hired, trained, and supervised by the health plan and are embedded in the primary care practices and function as a part of the primary care team. They coordinate care for the highest-risk patients and facilitate the transition of every patient from hospital to home or a nursing home.

Geisinger Health Plan began developing the program in 2006 to combat the growing burden of chronic disease, the fragmentation of

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care, exploding health care costs, gaps in quality, and the decline of the work force in primary care, Tomcavage says.

The initiative kicked off in January 2007 at two sites with three case managers who coordinated care for about 3,000 Medicare beneficiaries. (**For a look at what the case managers do, see related article on page 100.**)

"When we started the program, we looked for opportunities to change the way we approach people with complex medical conditions to address gaps in care. Fragmentation, lack of coordination of care, and quality was a real concern. As an insurer, we knew that we could not continue to pay using the work-unit mentality. We wanted to design a payment model to pay for outcomes, rather than individual work units," she says.

Geisinger Health Plan has had a robust disease management and case management program for 15 years, says **Sonia Hoffman**, RN, BSN, case manager in a primary care clinic.

"We had a lot of expertise and had poured a lot of resources into strategies for managing the care of patients with chronic conditions and complex medical needs. We knew that if we pushed some of our disease management and case management strategies into primary care, we could make a difference," Hoffman says.

Geisinger is an integrated system that includes hospitals and outpatient clinics in addition to the health plan.

Geisinger's program combines the strengths of the health care delivery model with the strengths of the health plan to form a partnership that drives outcomes for individual patients as well as improving clinical and financial outcomes, Tomcavage says.

The health plan team collaborated with leadership at the primary care practices to create the model and redefine roles within the health care team to improve efficiency and effectiveness.

"The basis of patient-centered primary care is moving people to the top of their license," Tomcavage says.

This means having physicians do what only physicians can do, nurses doing what only a nurse can do, and moving other tasks to a non-clinical person when appropriate.

"We looked at roles and activities best suited to each discipline and maximized health information technology by designing tools that help a physician practice manage its population," she adds.

Before launching the program, the health plan did a lot of groundwork in forging relationships with providers throughout the continuum, Tomcavage says.

"The primary care office is the foundation for much of the activity involving patients but is just one piece of the health care system. The hospital, the emergency room, specialists, the community pharmacy, home health agencies, and other post-acute providers are all a critical piece of managing patient better and driving better outcomes," Tomcavage says.

For instance, many times when patients came back to see their primary care physician after being in the hospital, the doctor didn't have the discharge summary or had to struggle to read the handwritten notes.

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The team worked with the hospitals to get timely discharge summaries in a readable form. They worked with community pharmacists on getting pill boxes pre-filled and prescriptions delivered.

"We collaborated with home health agencies on managing patients in a different way. If we needed them at a particular time, we wanted them to be available to make the visit and to work with the clinic-based case manager to assure effective transitions," she says.

Recognizing that one in three Medicare patients in nursing homes are readmitted to acute care, the case managers work with the core nursing homes in the community, round with the physicians, and participate in family conferences when needed.

"The case managers work extremely hard when patients transition into nursing homes to make sure they get continuity of care," Tomcavage says.

The case managers coordinate care between the specialist and the primary care physician and help the patients understand their treatment plan.

For instance, a patient with heart failure and declining kidney function may be told to drink a lot of fluids by the nephrologist and to keep their fluid intake down by the cardiologist.

"Sometimes there are conflicting messages. The case manager translates them into something the patient can understand," Tomcavage says.

When the health plan rolls out the Health Navigator program at a primary care site, the practice uses the health plan's predictive modeling tool to profile its population and identify patients who are at low risk, moderate risk, and high risk for health care consumption.

The case managers at the practice sites get a list of patients in the program, sit down with the physicians, and look at the risk stratification of each patient, then develop strategies to manage their care. The higher-risk patients are enrolled in case management.

"This helps us identify patients at risk and those who have preventive care needs. Some patients haven't been in to see their primary care provider in more than a year and have gaps in preventive care. Others have chronic conditions and need education and other resources," she says.

Other patients are identified for the program by their physician or when they have been hospitalized.

Having case managers in a primary care practice helps eliminate the tendency on the part of patients and physicians to think of the health plan as an outsider, not part of the care team, Tomcavage points out.

"The embedded case manager becomes an extension of the primary care practice team, and both patients and providers trust the case manager and realize that he or she knows what is going on and that there are additional resources to help patients and their families navigate through the often complex health care system," she says.

Over the four years she's worked in this model of care, Hoffman has had only two patients refuse to participate.

"If patients are suspicious in the beginning, the physician intervenes and tells them to consider the case manager a direct link to the physician. Once they get involved with the program, they realize they can call my private number and get in to see the doctor whenever they need something," Hoffman says.

The health plan works with each Health Navigator site to pick 10 quality metrics to measure. Examples of the quality metrics include: the percentage of patients who have a follow-up call from a case manager within 48 hours of discharge; the percentage of patients who have a timely post-discharge follow-up visit with their physician; preventive care measures such as mammograms or flu shots; the percentage of heart failure patients who have an action plan documented in their medial record; and the percentage of patients with diabetes who receive the appropriate care.

Part of the physician practices' reimbursement is based on their performance on the core quality measures.

When the health plan began the model, it kept fee-for-service reimbursement and its pay-for-performance initiative in place based on HEDIS data and other measures but added an efficiency target to the payment structure and shares 50% of the cost savings with the practice, based on how many of their quality indicators were met.

For instance, if a practice beat its cost target by $100,000, and met five of its 10 quality measures, it would receive an additional $25,000 in reimbursement.

"We didn't want the practices to be at risk. We wanted to reward them for delivering high-quality care in a more efficient manner. We believe that if you take better care of patients, it makes an impact on the patients' outcomes, improves efficiency, and in the end saves health care dollars," she says.

The program started with case managers who worked only with Medicare patients and has gradually added Geisinger Health Plan's commercial population as well.

"We needed to be able to show outcomes at the initial sites and knew that because of the burden of disease among the Medicare population that we could do so with Medicare patients. The entire initiative is about driving quality. We believe that when quality is improved, cost goes down," Tomcavage says. ■

Close relationship with patients is key to success

Health plan employees part of primary care team

Sonia Hoffman, RN, BSN, a Geisinger Health Plan case manager who works at a primary care clinic, tells the following story of how her interventions kept a woman with severe chronic obstructive disease out of the hospital and avoided unnecessary utilization of health care resources:

As part of the treatment team at the primary care practice, Hoffman had worked with the woman for four years when the woman was diagnosed with aortic stenosis. Because of the severity of her condition, she couldn't have surgery to correct the problem, which intensified her health care needs.

The woman had a stay in a nursing home but wanted to go home so Hoffman developed a transitional care plan to provide home health services in the woman's home.

By talking with the patient and her caregiver three or four times a week and adjusting her medications weekly, Hoffman was able to keep the patient out of the hospital.

"Early on, I started talking with the patient and family about options for care. The physician and I went to the home on two occasions to discuss options, but she wasn't quite ready for hospice care," Hoffman says.

When the patient's condition worsened and she went to the emergency department, Hoffman faxed the woman's living will and power-of-attorney to the hospital and informed the case manager and the emergency department physician about the woman's history and condition.

"There was nothing that could be done for her medically, and she didn't want to be admitted. We were able to get her home and work with the home health nurse and the area agency on aging to get her the care she needs," Hoffman says.

Without an intervention, the patient would have gone into respiratory distress, been admitted, and possibly had additional services that she really didn't want, Hoffman points out.

"That would not have been the best utilization of resources, and it wasn't what the patient or her family wanted," she says.

Since Hoffman works with patients in the doctor's office, the patients and family members don't identify her as part of the health plan, Hoffman says.

By being in the doctor's office, Hoffman develops a rapport with patients and their families when they come to see their physician.

"They identify me as a caregiver who has their best interests at heart, and I see many of them on a regular basis. My office is directly across from the lab and they know where to find me," she says.

When new patients are identified for the program, Hoffman does a chart review and learns as much as possible about the patients before calling them and explaining what her role is.

If patients are admitted to a hospital, Hoffman works with the hospital case management team to develop a plan of care and is alerted when the patient goes home. She follows up with a call within 24 to 48 hour, Monday through Friday. The case managers rotate weekly duty and have on-call services 24-7.

"If a patient I've been working with is going home on Friday, I call them the next day. If it's a new patient going home on Friday or Saturday and I see red flags that may indicate gaps in care, like a patient with a wound who doesn't have home care services, I notify the inpatient home health services or I refer them to the health plan on-call case manager," she says.

Physicians often call Hoffman into the exam room when a patient needs services such as home health. In those instances, she double-checks on the insurance plan and conducts a brief chart review. If the patient does not have Geisinger Health Plan insurance or Medicare, Hoffman will provide directions for the office-based nurse so that all patients have access to the resources they need.

"I talk with the patient, identify their problem, take care of the acute problem, and call them the next day to review the patient's plan of care and social needs and to identify their barriers to adher-

ing to the plan of care," she says.

She follows up as frequently as necessary depending on the patient's needs. Patients who have been discharged from the hospital receive at least one phone call a week for four weeks. If they have a lot of complex needs, Hoffman calls them two or three times a week.

The model also uses an outbound telephone monitoring system that makes phone calls to discharged patients with no comorbidities, such as a younger patient who had a total knee replacement. The interactive voice response system asks patients if they are having problems and gives them a number to call.

"This helps maximize the skills of the nurses. The case managers are taking care of the people who are at highest risk, but we have a way to reach all patients," Tomcavage says.

Some patients are going through a rough period when they enter case management and become an inactive case when their acute needs have been handled. They always have their case manager's telephone number to call in case they have problems.

For instance, if a patient calls in and says he has a cold, he's not likely to get an appointment, but the case manager can intervene if it's a person with lymphoma who has a suppressed immune system and get an immediate appointment for the patient.

Patients with chronic illnesses, such as heart failure or COPD, typically stay in the case management program. If they have tobacco issues, diabetes, osteoporosis, hypertension, or other diagnoses and have their conditions under control, the case manager puts them in touch with a disease management program to provide telephone follow-up.

Hoffman has met almost all of her patients face to face at least once, the exception being patients who are in a nursing home.

"I don't go to the nursing homes often except for a care planning meeting when sensitive issues are being discussed; but I do work with the care team at nursing homes to make sure they have all the information they need for a smooth transition and to make sure the patient's needs are being met."

Home visits are not the norm, but Hoffman visits her patients when she feels that it's needed.

"My job is all about building a relationship with them and earning their trust so they understand that I truly have their best interests at heart," she says. ■

Opportunities for CMs in changing health care arena

Make the public aware of your value

As the Patient Protection and Affordable Care Act makes sweeping changes in the health care environment, case managers have the opportunity to be the critical link between the patients and providers. At the same time, the profession also faces the challenge of educating the public about the role of case managers and the value they bring to the health care arena, says **Teri Treiger**, RN-C, MA, CCM, CCP, new president of the Case Management Society of America (CMSA).

"Making the public aware of case management and how we can help facilitate care is a subject near and dear to my heart. In today's world, where consumer-driven health care is coming to the forefront, case managers should take the opportunity to make the public aware of what case managers do and what case managers can do for them," says Treiger, a case management consultant based in Holbrook, MA.

Despite the efforts of the profession, many people, even those in the health care field, don't understand the case management process and the value that case managers bring to the table, she says.

Treiger tells of recently trying to schedule surgery around the CMSA annual conference.

"The surgeon turned to me and in the most sincere way asked, 'What is a case manager?' This was coming from a surgeon in a hospital with a very strong case management department. He truly had no clue," she says.

As the concept of patient-centered medical homes gains ground, there's a lot of discussion about how the primary care practices will coordinate care and ensure that people who need them receive resources in the community.

"People talk about these functions as if it's a new concept, but it's what case managers have been doing for decades," she says.

Even people who have benefited from case management services may not understand what case managers do, Treiger says.

"Many people don't realize that it's the case managers who are responsible for making sure their tests and procedures in the hospital occur in a timely manner, and that they have the services

they need after discharge," she says.

Before people can have an understanding of case management, they have to know exactly what the job entails, Treiger says.

"The term case manager has been so misused and abused that it really is taking a focused effort to redefine it. If you look at the job descriptions of some people who are called case managers, they're clearly utilization managers or risk managers but they're called case managers," she says.

The public's lack of understanding about case management was brought home to Treiger last year when she worked with an organization that was setting up a case management pilot project.

"The level of mistrust was one of the biggest barriers to getting people involved in the program. Some thought we were bill collectors from the hospital. That demonstrates how misunderstood clinical case management is," she says.

CMSA has been working to educate the public on the definition of case management and is making progress, she says.

"As an organization, CMSA has been asked to present at various conferences to increase consumer awareness of case management. Case management is being invited to work with more and more important organizations. We have representatives on the URAC board of directors and advisory panels and on the National Quality Forum work groups. Last year, CMSA was invited to give input into the health care reform bills under consideration by Congress," she says.

"CMSA is working with educational institution and employers in the development of mentorships, partnering with hospitals and medical associations to define best practices, meeting with legislators and regulators to discuss pressing health care issues, and presenting at international conferences regarding case management and transitions of care," she adds.

As an individual, Treiger has worked on the local level to educate people about case managers and the services they provide and suggests that her fellow case managers do the same.

"I have reached out to elder councils and senior centers in my area and offered to come and speak to seniors. I tell them what case management is, what case managers do, and how they may have been affected by a case management intervention," she says.

Treiger's presentation includes information the seniors can use, such as tools that are available to help them keep track of medication and what they need to know if they are admitted to the hospital.

"This is not a situation where you put up a PowerPoint presentation. You just sit around the table and talk. If one person learns the value of case management or has a better understanding of what goes on when a loved one is admitted to the hospital, I consider the visit a success," she says. There's a grassroots effort to speak to more community groups about case management, she adds.

One of the biggest career opportunities for case managers is the patient-centered primary care home, Treiger points out.

"The direction the guidelines and standards are going make it clear to me that case managers are going to play a critical role if a medical practice wants to take a big leap forward and not just be a primary care provider but really become an advanced medical home," she says.

Case managers are going to be the fulcrum of the health care team in the patient-centered primary care practice, she says.

"The health care system is truly taking a leap forward by putting the patient in the center, rather than having the provider dictate the care. Some of the disciplines on the health care team may vary, but the constants are going to be the patient, the physician, and the case manager," she says.

The wave of new technology in health care offers big opportunities for case managers who want to step away for direct patient contact and are technologically inclined, Treiger says.

"We need people who are knowledgeable about case management to work with vendors and developers to come up with fantastic tools for case managers. We already have case management software, but what we really need is an electronic medical record with a case management component," she says.

Technology also presents a challenge for case managers to learn about and use the new technology in their daily jobs, she says.

"Now that the Centers for Medicare & Medicaid Services has issued the final rule to promote the adoption of electronic health records, there is a flurry of activity in the health care arena around use of technology and electronic communication. If case managers don't keep current with technology, it won't necessarily impact their jobs but it will impact the health care environment in which they work," she says.

One of Treiger's goals as president of CMSA is to keep case managers apprised about what is going on with health care technology and to help them understand how to use it to increase their efficiency and effectiveness.

She urges case managers to make their voice known as their organizations develop or purchase new technology, Treiger says.

"Case managers' input may make a huge difference in the development of technology guidelines and work flow. Case managers' expertise and value will be lost if they sit back and don't say anything," she says.

Treiger challenges all case managers and case management leaders in every practice setting to join together and derive strength from unity within the profession rather than working in silos.

"We will be our own worst enemy if we continue to go down the road with one group doing this and another group doing that. It causes confusion and will water down the message and the strength of case management. We need to respect each other's area of expertise and strength and figure out ways to work in unison, rather than with separate voices,' she says. ■

Case Management Week is your time to shine

Start planning activities to showcase your profession

Case Management Week, Oct. 10-16, offers a great opportunity for case managers to educate members of the public and people within their own organizations about case management, says **Teri Treiger**, RN-C, MA, CCM, CCP, new president of the Case Management Society of America (CMSA).

Case Management Week is a great platform to start educating payers, providers, regulators, and consumers about the tremendous value case managers bring to the successful delivery of health care, she says. "Some organizations that employ case managers have been mindful of Case Management Week but in some large organizations, people aren't aware what case managers do and how much they can help," she adds.

It's important for employers to recognize case managers during their special week and not lump the celebration into Nurses Week or Social Workers Month, adds **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"Case management is neither; but at the same time, case managers are both. We should continue to bring to the forefront that case management is a different area of practice and should be identified separately and celebrated separately."

Treiger suggests that local chapters of CMSA hold significant events during Case Management Week and work with members at the chapter level to increase awareness of the profession.

For instance, the New England chapter hosts a dinner event, usually with a well-known speaker, in honor of Case Management Week, Treiger says.

"It's a networking opportunity but also a chance to celebrate our profession and the difference we make in people's lives, she says.

The Dallas-Fort Worth chapter of CMSA has asked the mayors of Dallas and Fort Worth and the governor of Texas to issue a proclamation in honor of Case Management Week, Kizziar says.

The chapter sends case managers discount coupons for the dinner meeting celebrating Case Management Week and asks the local media to run spots or articles in recognition of the week and the importance of case management, she adds.

The Case Management Society of Alabama is holding its 16th annual conference during case management week, says **Chris Saab**, RN, president of the organization.

The day-long conference includes speakers, breakfast and lunch, and door prizes as well as a celebration of Case Management Week and Breast Cancer Awareness Month, Saab says.

Here are some other suggestions from CMSA on how you can celebrate Case Management Week:

- Offer to speak about case management at community events.
- Ask every CMSA member to wear a "Member Pin" during the week.
- Sponsor health fairs, conduct preventative preventive screenings in underserved areas or organize other services in your community.
- Hold a celebration or reception to honor an outstanding case management in your community. The recognition could honor years of service in the community, exemplary acts of service, or commitment to case management.
- Display Case Management Week posters and banners in prominent places throughout your place of work.
- Profile case managers willing to share their stories in your organizations newsletter.
- Encourage employers to purchase CMSA memberships for their case managers.

(For more information, samples of news releases

and proclamations, and promotional items, see the CMSA website at http://www.cmsa.org/Individual/NewsEvents/NationalCaseManagementWeek/tabid/304/Default.aspx.) ■

Would you like a 96% participation for HRAs?

Offer eye-catching discounts

Do you think that better health is enough of a reward for employees who choose to take a health risk assessment? That may not be sufficient, if you want participation rates to brag about.

Talei Akahoshi, director of occupational health at Piedmont Healthcare in Atlanta, says that her department took the leading role in developing the organization's Your Health Matters program.

The program gave employees discounts on health plan premiums for participating in Health Risk Assessments (HRAs). Employees were offered a discount of $20 per pay period, or $520 per year, if they took a HRA. To receive the discount the following year, they had to participate in both the HRA and biometric screens.

"I presented the incentive campaign to our executive team under the leadership of our corporate VP of human resources, and gained executive approval," she says. "Once approved, I worked with marketing to develop the slogan, and assisted with the communication campaign."

Akahoshi made it her mission to make sure everyone knew what had to be done for the incentive.

"I feel that it was successful because we expressed the need for the screenings, and of course, that they were confidential," she says. "I asked managers for their support, to be sure they delivered the message back to their employees."

The occupational health team did all the screenings on and off-site, plus entered all the lab results. "We did health fairs and were available in the evenings, night shift and weekends," she says. "We even sent out letters to those who completed their screenings."

Providing periodic updates on participation rates spurred competition and increased participation rates. The team also e-mailed or called employees during the ending phase to make sure they were aware of the incentive.

"We really attempted to talk to each employee," says Akahoshi. "We had a 96% participation rate for those in our health plan. Everyone got to know their numbers."

Akahoshi credits the high participation rate to the high dollar amount of the incentive, and "pure determination."

"In hard economic times, we wanted to make sure people had the opportunity to meet the requirement," she says. "It's not about the money. It's about getting the HRA assessment and screenings done, to hopefully help them with their health status."

Health premiums are reduced for employees of the Mars/Wrigley Company in Gainesville, GA who participate in an annual HRA.

"The HRA is designed to help associates understand their health status, and provide tools and resources to improve their well-being," says **Paula Hopkins Clay**, RN, MPH, COHN/CM/SM, the company's health and wellness manager.

This past year, 89% of associates participated in the HRA. "We also offer personalized health coaches that guide and support associates when making changes in their lifestyles," says Clay.

[For more information on incentives for participating in occupational health programs, contact:

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Dig a little deeper after a near-accident

There may be more to the story

If you can discover *why* an employee performed a job incorrectly, which caused a near-miss accident that could have been fatal to other

workers, wouldn't this information be priceless to you?

Employee X was a general production worker performing duties of lifting a full beam of material with a manual overhead hoist, recalls **Kathy Dayvault**, RN, MPH, COHN-S/CM, an occupational health nurse at PureSafety in Franklin, TN. The beam weighed approximately 1200 pounds.

At this manufacturing site, general production workers were to be trained in at least three jobs. Lifting a beam required correct placement of straps on the floor, rolling the full beam off the loom, lowering the hoist and hooking the straps to the hoist, and lifting the roll with the power control.

On this particular day, a co-worker had observed employee X doff the roll onto the straps. He began to lift the roll with the hoist, while holding the hoist cable above the hook, and started raising the beam. The full beam began lifting from the floor with the employee holding onto the cable, who was being lifted as well.

"A different co-worker saw the employee being lifted. He yelled for him to stop the hoist and let go," she says.

The employee let go, but did not stop the hoist. Suddenly the full roll slipped out of the straps and fell to the floor from a height of approximately four feet.

"Fortunately, no one was injured," says Dayvault. "The second co-worker noticed the straps were placed incorrectly, as well as the employee being lifted from the floor."

Underlying reasons

Initially, it was felt the employee failed to perform his job safely, placing himself and others at risk for substantial harm including death. Upon questioning the employee, however, Dayvault learned some additional information.

"I learned that he spoke poor English, had not had training in greater than two years and had not done the job in at least three years," she says.

She also learned that a prior similar incident has occurred about four months earlier to a different worker, resulting in a fracture to his finger. At that time, company officials advised that all workers should be re-trained. However, only the workers who performed maintenance work had been re-trained.

"Employee X had just moved from a night shift position to a day shift position, and had been out of work for a substantial amount of time due to a workers' comp injury to his arm," she says.

A forklift physical completed after the incident revealed that the man suffered from poor vision. He wore glasses, but had not seen a physician for a vision exam in five years.

"We then found that other employees performing the job did not follow a standard procedure for doffing full rolls of material," says Dayvault. There was one loom where the correct procedure could not be used due to lack of physical room. Also, a general production worker might be needed on any job, but was only trained on three.

"All the above issues were addressed. Appropriate workers were trained, and the employee obtained stronger corrective lenses," she says. ■

Tailor education on heart disease to women

Teach prevention, how to advocate for good care

A one-size-fits-all education about heart disease is not a good strategy, according to **Holly Andersen**, MD, director of education and outreach at the Ronald O. Perelman Heart Center at New York-Presbyterian Hospital Weill Cornell Medical Center in New York City.

Lessons for women should be different from those for men, because certain information is unique to females, she explains.

While heart disease is the No. 1 cause of death for both men and women in the United States, every year since 1984, more women have died of cardiovascular health problems than men, according to statistics tracked by the American Heart Association.

Heart disease is more deadly in women, says Andersen. Once a woman is diagnosed, she will be more likely to die from the disease than a man, she adds. Many factors contribute to this. Women are often diagnosed and treated later in the disease process. In addition, treatment methods have been proven in men but may not be as effective in women, she says. Women are treated less aggressively as well, she adds.

To help change the statistics, women need information about prevention; about risk factors that

contribute to the development of heart disease; and about how to advocate for the best medical treatment.

"We are pretty good at treating heart attacks — but pretty bad as a profession about helping patients in our community practice prevention, which is so important," says Andersen.

Women usually go to gynecologists when they are of childbearing age and get their health care from this specialist. Therefore, Andersen, who is a cardiologist, is working to have gynecologists educate women about screening and prevention of cardiac disease. For example, one in two Hispanic girls will develop diabetes, which can lead to heart disease. So, when they reach childbearining age, they need to be taught about physical activity and diet, says Andersen. Learning ways to reduce stress and get enough sleep is also important.

"If you educate a woman about prevention, you educate a family," she adds.

In addition, heart disease can be addressed by pediatricians. Just because some young people look fine in spite of a poor diet doesn't mean their food choices are not doing damage, says Andersen.

She recommends that education go beyond the description of a good diet and teach people how to actually put the recommendations into practice. For example, a busy mother not only finds dinner at a fast food restaurant convenient, but inexpensive as well. Women need a solution to this predicament.

Teach risk factors

There are other factors that increase the risk of heart disease in addition to a poor diet, lack of exercise, and stress. Obesity and being overweight increase risk, as does smoking, high cholesterol, and diabetes.

Genetics can play a role, as well. It's important for women to know their family history and how that impacts their risk for heart disease. For example, risk is increased if there is a history of heart disease at a young age within a family, says Andersen.

Although genetics is important, lifestyle changes can improve risk factors. Those who smoke should stop; good, wholesome food should be consumed at mealtime; and physical activity should become a habit. Andersen says that studies show 20 minutes of exercise, five days a week, reduces premature death rates by 50% in both men and women.

Several risk factors are unique to women. For example, certain complications during pregnancy can be an indicator of future cardiovascular disease. Women who have had preeclampsia or gestational diabetes or hypertension should aggressively manage all risk factors for heart disease, says Andersen.

Smoking greatly increases the risk of heart attack for women under the age of 45. The combination of smoking and birth control pills increases a woman's risk by at least twenty-fold, she adds.

Women must become knowledgeable patients, tracking their cholesterol level, blood pressure, glucose level, sleep, and stress. Also, they must know their waist measurement, because a waistline is a good predictor of cardiovascular risk. The fat around the waist is metabolically active and will make a person more insulin resistant, which leads to diabetes. Ideally, women should have a waistline of 29 inches or less, but 33 or 34 inches is OK, says Andersen.

Some women should test for a "silent heart attack." This is a heart attack without pain, but it can cause permanent damage if it causes a long-term shortage of blood and oxygen flow to the heart. Women who are post-menopausal and have at least three risk factors for heart disease should ask their physician for a cardiac stress test, says Andersen.

It's also important for women to learn the warning signs of a heart attack, as well as symptoms leading up to one. Chest pain is the most common symptom for women, but only about 45% experience it. Other symptoms include jaw pain, back pain, sudden fatigue, perspiration, nausea, and indigestion. "The symptoms aren't really that subtle; you know something is going

on. I would much rather have someone come in thinking they had a heart attack, and they had a bad case of indigestion, than miss a heart attack," says Andersen.

Yet often women do not call 911 right away when they think they are having a heart attack. In a survey conducted by the American Heart Association, 53% of women who think they are experiencing a heart attack call 911, which means that 47% do not make the call. Yet 88% of the women in the survey said they would call 911 if they thought someone else was having a heart attack.

Typically, people experience warning signs prior to their heart attack, such as a little tightness in the chest while climbing stairs, or feeling winded or more fatigued. Symptoms that come with exertion and go away with rest are heart disease until ruled out, says Andersen.

If a woman is taken by ambulance to the emergency department because she thinks she is having a heart attack, she should ask for an EKG test or an enzyme blood test to check for a heart attack if the medical team does not order one.

Women need to be active in their care, says Andersen. Medical professionals can miss heart attacks in women, so it is important that women know they can make their voice heard and get checked out, she says.

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COMING IN FUTURE MONTHS

- Strategies for helping patients avoid rehospitalization
- Helping seniors live safely at home
- Setting up case management in a patient-centered medical home
- Maximizing your clients' health care benefits

CE QUESTIONS

9. In Geisinger Health Plan's patient-centered medical home pilot, pairing case managers with primary care practices, what percent reduction was seen in hospital readmissions?
A. 10%
B. 20%
C. 30%
D. 40%

10. As part of Geisinger Health Plan's patient-centered medical home pilot, pairing case managers with primary care practices, case managers are on call 24-7.
A. True
B. False

11. Which of the following are suggestions from CMSA for Case Management Week?
A. Offer to speak about case management at community events.
B. Sponsor health fairs, conduct preventative preventive screenings in underserved areas or organize other services in your community.
C. A & B
D. none of the above

12. Risk factors for heart disease unique to women include which of the following?
A. Poor diet.
B. Lack of physical activity.
C. Certain complications during pregnancy.
D. Stress.

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

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 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. ■