CMA Salary Survey included in this issue.

Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

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To improve care of patients, become culturally competent

Work around beliefs to solve treatment problems

As our society becomes increasingly diverse, case managers need to be aware of the cultural beliefs and practices of the people they serve to effectively coordinate their care and help them adhere to their treatment plan.

"Healthcare providers have been emphasizing patient-centered care in recent years, but care can't be patient centered unless the patient's cultural beliefs and practices are taken into account." **Josepha Campinha-Bacote**, PhD, MAR, PMHCNS-BC, CTN-A, FAAN, president of Transcultural C.A.R.E. Associates, a Cincinnati-based cultural competency consulting firm says,

Patient-centered care and cultural competency are two sides of the same coin, Campinha-Bacote says. "Both aim to improve healthcare quality, but each emphasizes different aspects of quality. It has to do with individualizing patient care," she says.

Culture and language may influence health; healing and wellness belief systems; the perception of illness, disease and their causes by patients; attitudes toward providers; and the delivery of services by providers who tend to view the world through their own experiences and values, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, presi-

EXECUTIVE SUMMARY
To serve an increasingly diverse population, case managers must become aware of the cultural beliefs and practices of the people they serve.
- Develop open-ended culturally sensitive questions to determine a person's beliefs, and ask them in a respectful manner.
- Incorporate their beliefs as you negotiate a treatment plan.
- Avoid stereotyping people because they look a certain way or have a certain ethnic background.
- Remember that cultural also involves age, gender, educational level, socioeconomic status, and other factors.

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dent and founder of Mullahy and Associates, a case management consulting firm based in Huntington, NY. "We as case managers need to be prepared to meet the needs of all our patients and family members, not just those who look like us, speak like us, and share our beliefs, values, and customs," she says.

The United States is becoming increasingly multicultural, Mullahy points out. Some individuals immerse themselves in American culture and language and decide to embrace all this country has to offer, including healthcare. Others do not have a comfort level with the healthcare system, but they still need care.

Bria Chakofsky-Lewy, RN, nurse supervisor for the House Calls program at Harborview Medical Center in Seattle says: "The problem is not the culture of some patients. The issue is that there are different lenses with which people look at the same situation. Providers have to be able to understand the other person's viewpoint in order to negotiate a successful outcome." *(For details on the program, see related article on p. 100.)*

Understanding the cultural beliefs and practices of your patients or clients is important because it impacts health outcomes, Mullahy adds. If case managers don't understand the person's cultural background, they will have difficulty engaging with that person, whether it's on the telephone or face-to-face, and they might not be able to help the person modify his or her behavior or adhere to the treatment plan. *(For tips on avoiding stereotyping when you work with multicultural populations, see related article on p. 99.)*

How do you provide patient-centered care when the patient's health beliefs, practices, and values are in direct conflict with medical guidelines? Chakofsky-Lewy says: "Establishing a respectful relationship is the first step toward providing culturally competent care." Develop questions that are culturally sensitive, she suggests. "Listen to what the patient is telling you, then share your suggestions. Acknowledge where there are differences and where there are similarities with your recommended plan of care, then work with your patient to come up with a plan that he or she can and will follow," she says.

Campinha-Bacote suggests asking leading questions rather than direct questions. "People's cultural beliefs are so ingrained they can't articulate them," she says. Ask open-ended questions such as: "Tell me what brought you here." "Tell me what you do to stay healthy." "What treatments do you think you should be having here?" "Some people may go to a doctor or a nurse when they are sick. Others may call their pastor or their mother for advice. What do you do when you are sick?" Identify treatments that the patient has used, including herbs and home remedies.

"Even though you may know what needs to be done for the patient, let the patient tell you. Find out his goals, and integrate what they say into the treatment plan," Campinha-Bacote says.

For example, the case manager might ask the

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EDITORIAL QUESTIONS

Questions or comments? Call Mary Booth Thomas at (770) 939-8738.

member to name their favorite foods, and then they keep asking about what is in their diet to isolate and understand where to begin working with the member on healthy eating habits. Chakofsky-Lewy says, "When they work with multicultural patients, clinicians may know what will improve the patient's condition, but they also need to determine what is getting in the way of the patient adhering to the treatment plan. If the patient's views can be elicited and heard respectfully, the case manager will establish a basis for working with the patient to come up with a plan that will work."

Incorporating a patient's cultural beliefs into a treatment plan often is a win-lose/win-lose situation, Campinha-Bacote says. The case manager wins a little and loses a little, and so does the patient. "When a patient's beliefs and practices conflict with standards of care, we have to look for the bridge between what they believe and what we believe needs to be done for the patient," she says.

For example, some Southeast Asian cultures practice "coining" a treatment for a variety of illnesses that involves rubbing coins on the skin, which sometimes leaves an abrasion. Suppose you are coordinating care for a sick child and see marks on his back. You question the mother, who tells you that it is coining and that she has done this healing practice to bring down her child's fever.

Campinha-Bacote suggests that you tell the mother, "I respect this treatment to heal your child and would like to add that when you leave a scrape on your child's skin, there is a chance that bacteria or germs can enter into that cut and cause an infection. Also, if we as healthcare providers notice any marks or scrapes on a child's body that were caused by a parent, we must consider child abuse."

Tell the mother that you realize that in her case it is not child abuse but rather a treatment to help the child. "Add, 'We must consider everyone's concerns as we make a plan to treat your child.' Then discuss with the mother alternative ways to coin on the child's back that do not leave a mark or abrasion," Campinha-Bacote advises.

Achieving cultural competency is not easy. While your organization provides information, individual case managers should assume some of the responsibility for learning about and understanding the populations they serve, Mullahy says. "It may be difficult to give culturally competent care when the beliefs of the case manager are very different from the beliefs of the patient," she points out.

Make it a point to know a little about the cultural beliefs and practices of your patients' cultures. Be patient and keep the lines of communication open, she says.

(For links to information about achieving cultural competency, see resource box, below.)

SOURCES/RESOURCES

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- **Cultural Competence Project.** Web: www.cultural-competence-project.org.
- **DiversityRX.** Web: www.diversityrx.org.
- **Harborview Medical Center's ethnic medicine website.** Web: http://ethnomed.org.
- **Health Research and Educational Trust Health Disparities Tool Kit.** Web: www.hretdisparities.org.
- **Transcultural C.A.R.E. Associates.** Web: http://www.transculturalcare.
- **Transcultural Nursing Society.** Web: www.tcns.org.
- **University of Washington Medical Center's Culture Clues.** Web: http://depts.washington.edu/pfes/CultureClues.htm.
- **Department of Health and Human Services resources.** Web: http://thinkculturalhealth.hhs.gov. ■

Avoid stereotypes in treatment plans

Culture extends beyond ethnicity, country

As soon as you make an assumption about a particular culture, you are likely to find that many people from that culture don't fit into that particular stereotype, says **Josepha Campinha-Bacote**, PhD, MAR, PMHCNS-BC, CTN-A, FAAN, president of Transcultural C.A.R.E. Associates, a Cincinnati-based cultural competency consulting firm.

"You may have two different people from the same culture with the same condition or disease and come up with different strategies for manag-

ing it," Campinha-Bacote says.

For example, Campinha-Bacote's family came to America from the Republic of Cape Verde three generations ago. "While I'm Cape Verdean, I am much different from a Cape Verdean who immigrated this year. We would have different ways of looking at disease and managing it," she says.

Cultural groups extend beyond ethnicity or country of origin, Campinha-Bacote says. "You can't just say something is true for Hispanics. Someone from Colombia could be very different from someone from Ecuador or Peru," she says.

Bria Chakofsky-Lewy, RN, nurse supervisor for the House Calls program at Harborview Medical Center in Seattle, cautions case managers to avoid stereotyping their patients because they look a certain way or belong to a certain ethnic group. "As a clinician, it's very important to remember that the person you're working with may or may not ascribe to the beliefs that you have learned about that culture. There is a tremendous amount of intra-cultural variation. People vary as much within cultural groups as they do across cultural groups," Chakofsky-Lewy says.

A comprehensive cultural assessment should involve more than just the person's ethnic background. Culture is more than just ethnicity. It also involves age, gender, sexual orientation, religious beliefs, disability, socio-economic status, occupational status, geographical location, and other factors, Campinha-Bacote says.

If you work in an area where there are ethnic communities, it's your obligation to have information about that community, Chakofsky-Lewy says. Research the literature to learn about the cultures of the patients you encounter, but don't stop there, she suggests.

There are a plethora of cultural assessment tools available in the literature, Campinha-Bacote points out. "My advice for case managers would be to become familiar with some of these tools and incorporate them into the patient history and case management assessment," she says.

"It's the encounters that help us with cultural competency. The more encounters you have with a patient, the more you can learn about that culture. However, case managers may be at a disadvantage if they see someone only once or twice and some healthcare providers get just one shot. The bottom line is that you just do the best you can in making the patient feel respected, supported, and understood," she says. ■

Program helps navigate healthcare system

Cultural mediators visit in communities

When immigrants and refugees living in Seattle's diverse multicultural communities seek care at Harborview Medical Center, the hospital's Community House Calls program helps them navigate the healthcare system and overcome linguistic and cultural barriers to care.

Called caseworkers/cultural mediators, the staff members are bilingual and bicultural. They have had the experience of being immigrants and refugees themselves. They all have connections with the communities they serve, and they visit their clients in their homes and in their communities.

A key portion of their jobs is to help clinicians understand patients by providing them with information about their cultural backgrounds, current living situations, and healthcare practices and beliefs, as well as accompanying them into the community to talk with residents, says **Bria Chakofsky-Lewy**, RN, nurse supervisor for the program.

Patients who come to Harborview Medical Center speak more than 90 languages.

English, then Spanish are the most common languages, followed by Somali and Vietnamese. The hospital has a staff of 50 interpreters, who with telephonic back-up for languages they don't speak, provide interpretation for more than 100,000 patient visits each year.

The House Calls program began 17 years ago by two physicians who thought that to practice good medicine, they needed information about the populations they were serving "They wanted to know the experiences and the expectations of their patients, and what they were doing at home to get well, such as herbal medicine or other practices," Chakofsky-Lewy says. "This allows knowledge of their patient's beliefs and practices and allows providers to negotiate with patients to develop an effective care plan."

The caseworker/cultural mediator's duties include case management services such as advocacy and coordination of care, interpretation, cultural mediation, health education, and assistance in accessing English and citizenship classes.

Patients are referred by physicians and other healthcare providers. Depending on the situation, the caseworker/cultural mediator might visit the

patient in the hospital or set up an appointment the next time the patient has an outpatient visit. In some cases, the cultural mediators set up a home visit and might ask a nurse or physician to accompany them. For example, a provider might refer a patient who has repeatedly been scheduled for a mammogram and hasn't had the procedure. "The reason may be transportation, she might have heard misinformation in the community, or it may be that the patient is afraid to have an unfamiliar procedure and needs someone to go with her," Chakofsky-Lewy says. "The case worker/cultural mediator addresses the problem and finds a solution."

The focus for the House Calls program has expanded through the years, she says. When the program started, most of the patients were new immigrants with acute healthcare problems. Now that they are seeing a physician when they have acute problems, the treatment team at Harborview is working with patients on chronic illnesses. "These illnesses are not unique to these populations, but the idea of taking medication every day when you don't feel bad makes no sense to many of our patients," she says.

A common scenario is for the patient to thank the physician for his prescription for hypertension. "Many of our patients have respect for the authority of a provider that precludes them saying anything but 'thank you' for the medication, but then they don't take it," Chakofsky-Lewy says.

During the next visit, seeing no improvement, the physician increases the dosage. If the patient abruptly decided to take the medication, he could have a medical emergency.

Sometimes, the caseworker/cultural mediators take on the role of a health coach to help patients learn to manage their chronic diseases. For example, they might find out what is important to the patient and help them change their behavior by taking their medication or otherwise adhering to their treatment plan so they can meet their goals. "There are a lot of myths about insulin in some communities," she says. "The caseworker/cultural mediators know about these myths and can talk to the patient and the provider to help overcome the patient's misconceptions."

Some of the caseworker/cultural mediators have been with the program since it started 17 years ago. Others have used the position as a career springboard. One is now a nurse in the hospital system. Another is a social worker.

Some patients learn to navigate the healthcare system in a short time. Others have stayed in the program since it began. For instance, one of the first patients referred to the program came to physician appointments many hours early because she couldn't read a clock. When the cultural mediator looked into the situation, she discovered that the patient had cognitive problems that resulted from being tortured in her native country. The caseworker/cultural mediator reminds her of her appointments, makes sure she has transportation, and arranges to be with her during her appointment. As a result, the woman sees her physician regularly and receives the recommended preventive care.

"Our goal is to give people the tools to manage for themselves, but in this case, the person will never be able to be totally self-sufficient, so we continue to support her," she says. ■

Case Management Week puts you in the spotlight

Celebrate your role in healthcare

For a long time, case managers have been the unsung heroes of healthcare, but that's all changing.

"We're entering the Golden Age of Case Management. The Affordable Care Act, the Accountable Care Organization initiatives, and other patient-centered, value-based models of care all recognize the value of case management. This year, we truly have something to celebrate during National Case Management Week," says **Mary Beth Newman**, MSN, RN-BC, CMAC, CCP, MEP, CCM, program manager, case management, WellPoint Centers of Medical Excellent, based in Mason, OH, and the new president of the Case Management Society of America.

National Case Management Week, Oct. 9-15, is an industry-wide event to recognize the contributions that case managers bring to the healthcare arena and to educate the public about the significant work they perform, Newman points out. "This is a chance for case managers in all settings to raise awareness of our role and the value of case management with colleagues within their own organization, with government officials, and with consumers who may benefit from case management interventions," she says.

Case managers can gain recognition in their workplace by organizing celebrations in their workplace, put up posters celebrating case management

EXECUTIVE SUMMARY

Case Management Week, Oct. 9-15, is a chance for case managers to toot their own horns.
- Educate your colleagues on the value that case managers bring to the healthcare arena.
- Organize events in public areas to education consumers about case management.
- Ask your government officials to recognize the week.

week, and arranging for articles about case managers in the company newsletter or online. Many local case management chapters organize educational events, luncheons, or other celebrations for members. The Case Management Society of America (CMSA) has produced a guide to planning and promoting National Case Management Week. The guide is available free to the public on the Internet at www.cmsa.org/CMWeek.

But don't stop there, Newman suggests. Develop events in public areas, such as hospital lobbies, community centers, or nursing homes to educate the public about case management. Set up displays that explain case management. "There are so many ways that consumers can benefit from case management, but many of them don't know what kind of services we provide. This week gives us a wonderful opportunity to bring case management to the forefront by educating our patients, our clients, and members of the public about how we can help them manage their health and spend their healthcare dollars effectively. People need to know their options so they can make informed choices," she says.

Newman suggest getting your governor, mayor, county executive, or another local government official to sign a proclamation recognizing National Case Management Week, then send out a press release to your local news media. "When you have a proclamation in hand, it gives you a lot of leverage with the media. It validates the profession and shows that we're really being recognized," she says. ■

Geriatric Program addresses seniors

Do PCPs have time for a full exam?

Senior citizens and their families are getting help in identifying and coping with the medical and social needs of the elderly through a Geriatric Assessment Program offered by Geisinger Health System, with headquarters in Danville, PA.

Robb McIlvried, MD, director of the Geriatric Assessment Program, says, "The Geriatric Assessment Program addresses some of the geriatric issues that the primary care provider doesn't have the time or the resources to focus on. Our multidisciplinary team is experienced in geriatric care and conducts a thorough assessment to identify the specific needs of the patient and develops a customized plan to help the patient and family member manage those needs."

The team includes a board-certified geriatric physician, a registered nurse experienced in geriatrics, a social worker, and a pharmacist.

About half of the patients who go through the program are referred by their primary care physician. The rest are self-referred or are brought to Geisinger by their family members who have recognized that there are problems and heard about the program from an acquaintance or found it by searching the Internet.

At the beginning of the assessment, the entire team meets with the patient and family, then the patient and family members meet individually with each discipline. Members of the team review the patient's medical history and medication regimen. They conduct a thorough physical examination of the patient and a social assessment with the patient's family. Then the entire team meets with the family again, discusses the outcomes of the evaluation, including any diagnoses, explains the treatment options, and makes recommendations. They forward their findings to the patient's primary care physician, and they emphasize the importance of follow up care.

Many times the assessment uncovers mental health issues, either longstanding, unrecognized, or never addressed. Cognitive impairment or

EXECUTIVE SUMMARY

The Geriatric Assessment Program at Geisinger Health System addresses seniors' issues and develops a customized plan.
- Multidisciplinary team performs a thorough physical and cognitive assessment.
- Mental health issues, such as dementia, are often uncovered for the first time.
- The team members make recommendations on keeping the senior safe at home or help the family identify appropriate facilities.

dementia is the No. 1 issue that the geriatric assessment uncovers, a diagnosis that often surprises the family, McIlvried says. "Dementia is very common," he says. "It's striking how many times the family has no idea that there is a problem or just thinks the patient is a little forgetful but have no idea how impaired he or she is."

Unless patients are accompanied by family members, primary care physicians often overlook the possibility of dementia, McIlvried says. "A cognitive assessment takes a minimum of 20 to 30 minutes," he says. "Primary care physicians don't have time to conduct the assessment, then explain the diagnosis and treatment option or to further evaluate the patient to address safety issues such as driving and conditions in the home."

When tests show that a senior has cognitive issues, the social worker and the rest of the team help family members deal with changes that are going to occur as the patient's cognitive problems progress. They support the family in making arrangement as the condition worsens. "We talk to the family about how to address safety issues with patients who have cognitive impairments," he says. For example, the team might recommend that a family member remove all the medication from the patient's home and bring it over on a daily basis to make sure the senior isn't making mistakes in medication. They might recommend disconnecting the stove or taking away the car keys.

In all cases, the team evaluates whether the patient is able to live safely at home alone or whether they should move to an assisted living center or a skilled nursing facility. They inform the family of options for services in the home, such as home health visits or meals on wheels, which can enable the senior to continue to live alone. "Often we uncover issues that require additional support from the family or a caregiver," he says.

Patients and family members are asked to bring in all of the medications, including over-the-counter products and herbal remedies the patient is taking for the pharmacist on the team to review. "We want them to bring the bottles and not just a list. Many times, we find out that they are taking duplicates or a medication they don't really need," he says.

When appropriate, the social worker on the team helps the family identify a skilled facility or personal care home for the patient. The social workers helps families pursue guardianships, powers of attorney, and advance directives, and they intervene when the team discovers that a senior is being exploited by a family member or scammed by someone outside the family.

In most cases, the patients and family members make just one visit to the program.

"It depends on what we find and what recommendations we make," McIlvried says. "If we are making a lot of recommendations, we may bring the family back in a couple of months for another assessment. Most of the time, they just need to follow up with the primary care physician." ■

Giving advice on clear communication

Lead health literacy improvements

To address the issues of health literacy, St. Vincent Charity Medical Center in Cleveland, OH, made a radical move. It abolished its patient education committee and formed the Health Literacy Institute that consists of an interdisciplinary team of caregivers who are dedicated to improving health literacy through better communication.

Karen Komondor, RN, director of patient and staff education, heads up the team. All team members developed a passion for improving health literacy through education on that subject, which gave them a different perspective, Komondor says. "We saw that although many of us had been in healthcare a long time, we didn't realize that maybe our patients didn't understand what was being taught, and it wasn't about noncompliance," she explains.

Their tutors were staff members from Project Learn, an adult learning center in Cleveland. The partnership was formed in 2007 when the adult learning center received a grant from Sisters of Charity Foundation of Cleveland to form a partnership with St. Vincent Charity Medical Center to address low health literacy.

Project Learn remains a partner of the Health Literacy Institute, which made its overall goal the institutionalization of health literacy across the continuum of patient care. The first step to reach this goal was to conduct health literacy awareness training, beginning with senior leadership. *(For more information about guiding proj-*

ects, see story, p. 105)

Senior leader buy-in and support is critical when addressing health literacy, says **Mary Ann Abrams**, MD, MPH, health literacy medical advisor at Iowa Health System Center for Clinical Transformation in Des Moines. "The health literacy focus at this institution began about 2005. Administrators can raise the visibility of the issues and dedicate time, space, and resources for staff to work on them, and they can change policies and procedures," Abrams explains.

One way to engage them is by providing data compiled in national reports, she says. To use national data in making a case for a focus on health literacy within an institution, make it personal by adding state statistics and data from your location, Abrams advises. "People are inclined to say the problem exists somewhere else, but indeed the problem does exist locally," she says.

Another powerful way to engage leadership, as well as colleagues, is by involving patients, family members, and adult learners. Let them share their stories about struggling to understand information. Healthcare providers will see that these people are the same as those patients in their clinic waiting rooms or those admitted to the hospital, Abrams explains.

Komondor says that health literacy education must encompass all staff. It begins with health literacy awareness training, and then it becomes more specific by providing guidance on the use of plain language or teaching techniques.

Members of the health literacy team attend staff meetings in different departments to provide health literacy training. The topic of health literacy is included in general hospital orientation and annual competencies. Administrative policy related to patient education requires the use of plain language and the teach-back method in all provider communication.

Create areas of focus

Health literacy teams within the Iowa Health System are similar to those at St. Vincent Charity Medical Center, with patient education coordinators or managers heading up the teams. However, direction is given to the hospitals within the system by providing three areas of focus for health literacy projects. Abrams says that these include the care environment, interpersonal verbal communication, and written materials.

Under the heading of care environment, teams might implement a program to enhance understanding, such as "Ask Me 3," a patient education program designed to promote communication between healthcare provider and patient. *(For more information, see Resource, below.)*

Interpersonal verbal communication might entail training on the use of plain language. Work on written materials involves making sure instructional handouts and forms are user- and reader-friendly. Abrams says teams are providing guidelines and training for staff about user-friendly handouts, which encompasses layout, word choice, and organization of content. Although the health literacy teams at the hospitals within the system review written materials, as they teach staff to write in plain language, fewer and fewer revisions are required.

Komondor says that The Health Literacy Institute made rewriting patient education documents to an average sixth-grade reading level its second major focus and has revised more than 100 handouts. Staff members at Project Learn do the major revisions, and team members and experts review content before the document is posted on the Intranet for distribution. Adult learners at Project Learn are sometimes used to gain a patient perspective on written materials and videos.

According to Abrams, gaining the patient perspective is important. Health literacy teams at all the institutions are encouraged to include one or more patients or an adult learner on the team. Adult learners at New Readers of Iowa have helped with documents at the system level, says Abrams. For example, they helped with the development of reader-friendly informed consent documents.

Patient input also can be spontaneous, says Abrams. When creating a new form or handout, ask patients on the hospital floor or in the clinic waiting room to provide feedback. "It helps to make sure we are communicating accurately," says Abrams.

SOURCE/RESOURCE

For more information on creating a system-wide focus to address issues of health literacy, contact:

- **Mary Ann Abrams**, MD, MPH, Health Literacy Medical Advisor, Iowa Health System Center for Clinical Transformation, 1200 Pleasant St. ERC-2, Des Moines, IA 50309. E-mail: abramsma@ihs.org.
- **Karen Komondor**, RN, Director, Education St. Vincent

Charity Medical Center, 2351 E. 22nd St., Cleveland, OH 44115. E-mail: Karen.komondor@stvincentcharity.com.

• Ask Me 3: These brochures encourage patients to understand the answers to three questions: "What is my main problem?" "What do I need to do?" and "Why is it important for me to do this?" They are available in English and Spanish from the National Patient Safety Foundation. They come in packages of 100 at a cost of $100 plus shipping and handling. Order online at www.npsf.org/askme3. Click on links to downloadable materials at the bottom of the homepage to find resource page. Click on ordering brochures. ■

7 goals to help guide projects

HHS guides health literacy

Many healthcare institutions are using the seven goals stated in the "National Action Plan to Improve Health Literacy" developed by the Department of Health and Human Services to guide health literacy initiatives. The goals each have specific strategies for different sectors of the health system. The goals include:

• Develop and disseminate health and safety information that is accurate, accessible, and actionable.

• Promote changes in the health care system that improve health information, communication, informed decision making, and access to health services.

• Incorporate accurate, standards-based, and developmentally appropriate health and science information and curriculum in child care and education through the university level.

• Support and expand local efforts to provide adult education, English language instruction, and culturally and linguistically appropriate health information services in the community.

• Build partnerships, develop guidance, and change policies.

• Increase basic research and the development, implementation, and evaluation of practices and interventions to improve health literacy.

• Increase the dissemination and use of evidence-based health literacy practices and interventions.

Source: "National action plan to improve health literacy." Web: www.health.gov/communication/HLActionPlan. ■

Motivate change: Use a few key questions

Simple technique good for busy settings

How do you get patients to put into practice the steps for better disease management, prevention techniques, or adherence to a medication regimen?

Try motivational interviewing (MI), advises **Steven Cole**, MD, professor of psychiatry at Stony Brook (NY) University Medical Center and president and CEO of Comprehensive Motivational Interventions, a trademarked application of MI based in Stony Brook.

While education improves patients' knowledge and skills, it does not necessarily move them into effective behavior change, Cole explains. MI addresses behavior change. Cole describes MI as: "a collaborative, goal-oriented method of communication with particular attention to the language of change. It is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own arguments for change."

This intervention technique was developed by **William R. Miller**, PhD, an emeritus distinguished professor of psychology and psychiatry at the University of New Mexico in Albuquerque, and **Stephen Rollnick**, PhD, professor of Health Care Communication in the Department of General Practice, Cardiff University in Wales. Cole developed a particular application of motivational interviewing called Comprehensive Motivational Interventions. He and three colleagues give workshops on these interventions and are developing an e-learning platform.

One motivational tool, called Brief Action Planning (BAP), is designed to be used by clinicians in a busy facility. BAP is organized around three core questions:

• Is there anything you would like to do for your health in the next week or two (what, when, where, how often, etc.)?

• On a 0-10 scale of confidence, where 0 means no confidence and 10 means a lot of confidence, about how confident are you that you will be able to carry out your plan? (If confidence is less than 7, initiate collaborative problem-solving.)

• When would you like to meet again to

review how you've been able to do with your plan?

According to Cole, BAP is a short way to begin making a specific and concrete action plan for health. The tool has improved the way she educates patients, says **Christine Stamatos**, RNP, MSN, a rheumatology nurse practitioner working at L.I. regional Arthritis and Osteoporosis Care in Babylon, NY. "I have always tailored my education to readiness to learn, but this whole process is more collaborative and invites the patient to participate at a greater level," says Stamatos. She is working on her doctoral degree, and Stamatos' advisor suggested she attend a class on BAP presented by Cole. It is designed to be used in an acute setting.

In her practice, she sees 20 to 30 patients a day with about 15 minutes allotted per patient. The patients she sees have complicated disease issues and suffer from such chronic ailments as osteoarthritis, rheumatoid arthritis, fibromyalgia, osteoporosis, and lupus. Stamatos says she performs a significant amount of one-on-one patient education.

Practicing BAP

Putting BAP into practice requires a significant number of open-ended questions, Stamatos says.

She says it is easy to learn, but she is in the process of perfecting it. When patients are on a set of medications and she is monitoring them, it is not hard to ask what they would like to do for their health. When the visit is complicated, for example, she is prescribing several new medications, it is more difficult to find time to ask the basic questions and create an action plan.

Because Stamatos sees her patients on a regular basis, any time from every two weeks to every three months, she can set measurable, concrete goals with patients and see if they achieved them.

One patient with bad osteoarthritis in her knees needed some exercise to feel better. The patient came up with a plan to walk 10 minutes a day for five days a week. Her confidence was at 7 on the scale. Four weeks in a row, she made slight changes in her plan until she was walking 30 minutes a day for five days a week. At the end of that time, her depression, energy, aches, and pains were dramatically improved.

"I think the most important factor that is different is that it is more collaborative. Though I always thought I was good at assessing exactly where someone was and what their needs were, I think I am probably getting better," says Stamatos.

According to Cole, there are three elements in the attitudinal approach, or spirit of motivational interviewing. The first is collaboration between the provider and the patient as equals. The second is evocation, or eliciting ideas for change from the patient. The third element is respect for autonomy, which is communicating clearly that the patient has the right to change or not to change, explains Cole.

SOURCES

For more information about Brief Action Planning (BAP) and how to implement it, contact:

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Studies evaluate transition care

Programs designed to help transition care for hospitalized older patients to outside healthcare clinicians and settings are associated with reduced rates of hospital readmissions, according to two reports in the July 25 issue of Archives of Internal Medicine.[1]

"In the United States, 30-day all-cause readmission rates for patients 65 years or older generally range from 20 to 25%, depending on clinical condition and geographic region, indicating much room for improvement," the authors write. "Interventions addressing patient- and systems-level factors show promise for reducing hospital readmissions."

In the first article, **Rachel Voss**, MPH, program coordinator, Quality Partners of Rhode Island, Providence, and colleagues examined the effects of the Care Transitions Intervention randomized controlled trial in a real-world setting to test its effectiveness in reducing hospital readmissions. The intervention occurred over 30 days and included a coach who completed a hospital visit, a home visit, and two follow-up

telephone calls with the patient.

Between January 2009 and June 2010, the authors recruited patients at six Rhode Island acute care hospitals for participation in the intervention. Patients were separated into three groups: intervention group, internal control group (patients were approached but declined the intervention or did not complete the home visit), and external control group (patients not approached but eligible for participation based on study criteria).

Of the 1,888 patients approached for the study, 1,042 (55.2%) agreed to participate and of those, 257 (24.7%; 13.6% of the eligible participation group) completed the full intervention with home visit. The odds of hospital readmission within 30 days of discharge were significantly lower for patients participating in the intervention compared with those who were never approached for participation (12.8% readmission rate vs. 20% readmission rate). Individuals in the internal control group had readmission rates similar to those of the external control group (18.6%).

The authors conclude that, "the Care Transitions Intervention appears to be effective in this real-world implementation. This finding underscores the opportunity to improve health outcomes beginning at the time of discharge in open health care settings."

In a second article, **Brett D. Stauffer**, MD, MHS, internist, the Institute for Health Care Research and Improvement, Baylor Health Care System, Dallas, evaluated an advanced practice nurse-led transitional care program for patients 65 years and older with heart failure who were discharged from Baylor Medical Center Garland (BMCG) from August 2009 through April 2010. The program included a pre-discharge intervention by the advanced practice nurse and at least eight post-discharge house calls per patient.

The study examined the association between the transitional program and 30-day (from discharge) all-cause readmission rate, length of stay, and 60-day (from admission) direct cost for BMCG with that of other hospitals within the Baylor Health Care System.

During the study period, 140 Medicare patients with heart failure were eligible for the intervention and of these, 56 (40%) enrolled in the study. The adjusted 30-day readmission rate was 48% lower at BMCG after the intervention than before, however the intervention had little effect on hospital length of stay or total 60-day direct costs for the center compared to other hospitals in the Baylor system.

"Preliminary results suggest that transitional care programs reduce 30-day readmission rates for patients with heart failure," the authors conclude. "This underscores the potential of the intervention to be effective in a real-world setting, but payment reform may be required for the intervention to be financially sustainable by hospitals."

REFERENCE

1. Archives of Internal Medicine. Voss R, Stauffer B. *Arch Intern Med* 2011; 171:1,232-1,237; 171:1,238-1,243. ■

COMING IN FUTURE MONTHS

- Integrating medical, behavioral case management
- Engaging the Medicaid population in self-care
- How your peers are reducing readmissions
- Improving transitions across the continuum

CNE QUESTIONS

9. How do you incorporate a patient's beliefs and practices into the treatment plan?
   A. Establish a respectful relationship.
   B. Ask open-ended questions about their beliefs.
   C. Work with the patient to come up with a plan he or she will follow.
   D. All of the above.

10. True or False: If you learn about the beliefs and practices in one person from a particular ethnic groups, you can assume that they are the same for all patient in that same ethnic group.
   A. True
   B. False

11. According to Bria Chakofsky-Lewy, RN, nurse supervisor for Harborview Medical Center's Community House Calls program, some chronically ill immigrants fail to take the medication prescribed to keep their condition under control. Why?
   A. They don't have enough money to fill the prescription.
   B. They don't understand the label.
   C. They prefer herbal medicines.
   D. They don't believe in taking medicine when you don't feel sick.

12. What is the number one diagnosis uncovered by Geisinger Health System's Geriatric Assessment program?
   A. Dementia
   B. Osteoporosis
   C. Coronary artery disease
   D. Congestive heart failure

CNE 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.

CNE INSTRUCTIONS

Nurses participate in this continuing education program and earn credit for this activity by following these instructions.
1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■