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Covering Case Management Across The Entire Care Continuum

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AHC Media

Get up-close and personal with your patients

Face-to-face contact helps CMs build trust

When **Catherine M. Mullahy** was a practicing case manager, she received a referral to manage the care of a patient who was recuperating at home on short-term disability, after being hospitalized with a severe case of cellulitis.

When Mullahy visited the man in his fourth-floor walk-up apartment, she discovered that he was morbidly obese and living in a filthy apartment, strewn with open cans of beef stew. His leg was reddish purple and was propped on a dirty pillow. While Mullahy was assessing the man, his cat jumped onto his leg and started licking the wound. She ended up using numerous community agencies and providers as she coordinated care for the patient.

"My care plan for this man would have been so vastly different if I had just been talking to him on the telephone because I wouldn't have known about the all of the psycho-social issues," says Mullahy, RN, CRRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm. "Coordinating care, especially for complex patients, is like putting band aids on a gaping wound if you don't find out the back story, and you can't find that out except when you see patients face-to-face."

EXECUTIVE SUMMARY

Face-to-face contact with patients helps case managers identify social issues and other roadblocks to compliance, and develop a more effective care plan.
- In-person case management is gaining popularity and is being required for some state and federal grants, as well as patient-centered medical homes.
- Personal contact creates a bond of trust and assists case managers in helping patients make lifestyle changes and follow their treatment plan.
- Case managers can't identify patients' deficits, home situation, or family dynamics over the telephone.

Face-to-face case management is gaining recognition as an effective way to manage the care of patients with complex medical and psycho-social needs, says **Margaret Leonard**, MS, RN-BC, FNP, senior vice president for clinical services at Hudson Health Plan, with headquarters in Tarrytown, NY. Many federal and state grants require face-to-face case management interventions, she points out. "In addition, patient-centered medical homes and the new Medicaid health homes also utilize case managers who see their clients in person. Medicare and Medicaid have started to recognize that people who present with certain risk factors are difficult to assess over the telephone," she says.

When case managers meet their clients face to face, they create a bond. "We have a lot of anecdotes about how meeting with case managers and building trust helps people turn their lives around. Getting to know patients personally is more satisfying to the staff as well," Leonard says.

By meeting with the family and patient in person, you pick up on family dynamics, says **Sharon Gauthier**, RN, MSN, iRNPA, owner of Patient Advocate for You, a Hartford, CT, patient advocacy firm. "When the family sits together and talks, I see how the patient and spouse react to the other family members, and I get a sense of what's going on from the body language they use. I find out things I never would know if we didn't meet face-to-face. I couldn't get what I need to know to manage my patients if I relied on talking to them on the telephone," she says. *(For details on patient advocacy, see related article on p. 29.)*

Seeing patients in their home gives care managers in the organization's community care management program a lot of information they couldn't get over the telephone, says **Sherry Marcantonio**, MSW, ACSW, senior vice president for Health Quality Partners, a Doylestown, PA, nonprofit healthcare quality research and development organization. *(For details on HQP's community care management model, see related article on p. 27.)* "In order to develop a long-term, person-centered relationship, the care managers need to see their patients in person, develop relationships with them, and build trust. When we see patients in their homes, we get a much better picture of how they are managing from visit to visit," she says.

While it's more expensive to send a case manager into a person's home, it makes a big difference, particularly with patients who have complex needs, when the case managers sees them in person, Mullahy adds. "Because case management is a relationship-based model of care, this, too, is enhanced when on-site visits can occur," she says.

Case managers can't accurately assess a patient's hearing or vision deficits over the telephone, Mullahy points out. They can't be sure what the patient is eating, if they can manage their daily housekeeping and grooming chores, whether there are safety hazards in the home, or whether the patient is taking his or her medica-

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tion correctly. "In the long run, seeing patients in person at least once winds up being more cost effective than trying to figure out their problems over the telephone," she says. Everyone benefits. the physician, the case manager, the social worker, the patient and family members, and payers, Mullahy says.

To effectively manage the care of patients with complex needs, case managers need to see the home situation, the interaction between patients and family members or caregivers, and understand how the person functions. "It's hard to understand a person's situation and needs over the telephone, particularly if you live in a high-rise apartment in the city, and the client lives in a rural area, a trailer park, or a homeless shelter," Mullahy says.

Hudson Health plan has incorporated face-to-face case management for the most difficult to manage, and highest cost patients throughout the health plan, Leonard says. Case managers and social workers work with their clients face-to-face as well as over the telephone. The case manager or social worker who conducts the face-to-face assessment continues to follow the patient, mostly by telephone, and consults with his or her counterpart in the other discipline to get the information needed to manage the person's care.

"When someone has met the patient face-to-face, they begin to build a relationship, and having the same clinician follow up over the telephone creates continuity in care," Leonard says.

When safety is an issue, case managers and social workers conduct assessments in pairs, in the home or in a public place such as a fast-food restaurant or laundromat. They pay for clients to take a bus or taxi to the health plan headquarters if it's more convenient.

"Seeing patients face-to-face allows us to meet the people where they are and determine if they are ready for change. They may not feel comfortable talking with someone they never met over the telephone," Leonard says. "When our case managers and social workers see clients in person, they start building a relationship and can find out the psycho-social needs that have to be addressed before the patients can start changing their lifestyle and health habits."

Face-to-face case management represents a return to the way case management was conducted in the early days of the profession, Mullahy points out. In the past, workers compensation companies hired nurses and rehabilitation counselors from each state to manage the care of injured workers in their community because they were familiar with the rules and regulations governing that kind of coverage in their states. Later, as commercial insurers began case management programs, they found that telephonic case management was a cost effective option because benefits didn't vary from state-to-state and they no longer needed to hire local nurses.

"The healthcare system is beginning to recognize that in many situations clinicians need to get out and find out what is going on in order to effectively manage a patient's care. Factors like dilapidated housing, financial issues, dysfunctional families, and problems with activities of daily living are difficult to identify over the telephone but all can make it challenging to manage a patient's care."

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In-home case management cuts cost of care

Chronically ill experience fewer hospitalizations

Medicare patients with chronic illnesses experience fewer inpatient hospital admissions and lower medical costs when they participate in Doylestown, PA-based Health Quality Partners' (HQP) community-based care management program. That program provides individually focused assessments and interventions in the patients' homes, as well as in their doctor's office, hospitals, skilled nursing facilities, and other community settings.

The program was one of 15 sites chosen by the Centers for Medicare and Medicaid Services (CMS) in 2002 to participate in the national

Medicare Coordinated Care Demonstration, and is the only one of the 15 sites that continues to be funded. Based on the success of the demonstration program, Aetna contracted with HQP to develop a similar program for its high-risk Medicare Advantage members. The program designs are slightly different but both result in reduced hospitalizations and costs, according to **Sherry Marcantonio**, MSW, ACSW, senior vice president for Health Quality Partners.

Among higher risk patients in the Medicare demonstration program, hospitalizations dropped by 39% and emergency department visits by 37%. Medicare Part A and B medical expenditures were $6,132 per person, per year lower than those of a control group with similar diagnoses who received the usual care. Net savings to Medicare, after HQP's payment, totaled $4,764 per person per year. Participants were Medicare fee-for-service beneficiaries with a diagnosis of coronary heart disease, heart failure, or chronic obstructive pulmonary disease, and a hospitalization in the year prior.

In the first year of the Aetna program, hospitalizations were reduced by a relative 20% and medical costs were 18% lower when patients in the program were compared to members with similar conditions who did not participate.

In the current demonstration extension, CMS has identified a target group of people who have chronic obstructive pulmonary disorder, heart failure, diabetes, and/or coronary artery disease who have been hospitalized in the past year and who live in eastern Pennsylvania.

Aetna identified 942 members with one or more chronic conditions who were being treated by primary care providers with whom HQP was already working. In the first year, HQP identified and outreached to 200 of the 942 patients as being at highest risk.

When patients are identified for the program, HQP sends them an introductory letter explaining the program and alerting them that an HQP nurse care manager will be in touch. If they are interested in participating, the nurses meet them in their home, discuss the program in detail, and enroll them with their consent.

Building a rapport with the patient is a key factor in the success of the program, Marcantonio says. "In order to teach patients the skills they need to manage their own care, care managers need to spend time in person, develop relationships with them, and build trust. These patients have many unmet needs, issues, and concerns. We try to begin with what is the most important to them," she says.

The care managers use a multi-dimensional geriatric assessment and screening that may take as many as three visits initially to complete.

Reviewing medication is a major part of the care manager's job. "When we see the pill bottles in the home and compare them with a list from the hospital and the doctors, we typically find redundant medications. Every time we visit, we go over the list. These patients' conditions are so complex that the medication list often needs updating," she says.

Maryellen Keller, RN, BSN, director of care management, adds that on every visit, care managers get the patients to demonstrate step-by-step how they are taking their medication. If they aren't taking it, the care managers ask them why. "If patients can't afford their medications, the care managers help them sign up for programs to help them pay for the drugs. If they say they don't like the way the drugs make them feel, they work with the physician to modify or change the medications" says Keller, who also carries a patient caseload.

The care managers educate patients about their disease, how to prevent complications, and what to do when symptoms indicate an exacerbation that calls for early intervention. They teach patients how to read food labels, and establish action plans for losing weight, exercising, and weighing themselves.

The care managers conduct a physical assessment on each visit and report abnormal findings and new or worsening symptoms or problems to the patient's physician. They identify fall risks and social needs and work with community agencies to help them access additional services to help them remain in their homes.

For example, one of the care managers visited a patient recently discharged from the hospital and saw that she was unsteady on her feet, and that her husband was hard of hearing and couldn't hear her call for help. She helped them set up an emergency response system and followed up with the inpatient case managers and primary care physician to get home care physical therapy and occupational therapy set up. She arranged for a medical social worker to assess the couple's financial assets to determine if they were eligible for assistance programs.

The care managers build a relationship with the physician office staff and collaborate with the physicians around medical management,

medicine reconciliation, and strategies for helping patients manage their conditions.

Marcantonio adds that the organization also provides best-in-class, structured, interactive group programs for weight loss, gait and balance training, self-management education and skill building for chronic diseases, and seated exercises.

Once patients are enrolled in the community-based care management program, they stay in the program until they move outside the area, or die. "One of the unique things about the role is that we have long-term relationships with patients, rather than providing episodic care," she says. ■

Person-centered care appeals to nurses

They like face-to-face contact

Care managers who work in Health Quality Partners' community case management program often tell **Sherry Marcantonio**, MSW, ACSW, senior vice president for the Doylestown, PA-based healthcare quality research and development organization, that working face-to-face with patients "is why I went into nursing."

"Our nurses love the opportunity to spend time with patients and family members and focus in a person-centered way. They tell me it's the best nursing job in the world," she says.

Nurses in the program have a minimum of 10 years of clinical experience but most have more than 20 years of clinical experience. Many have backgrounds in home care, hospice, oncology, or cardiac care.

The care managers go through intensive six- to nine-month training and have work space in the HQP headquarters, but they do most of their work in the community, coming to the office for meetings with supervisors and weekly team meetings.

Case managers are assigned by geographic area and carry a target caseload of 75 patients at a time. They spend most of their time in the community and use notebook and laptop computers for documentation and to access patient education videos, curriculum and patient education hand-outs.

The care managers provide an average of 13 home visits, per person, per year, see them in the doctor's office for two visits a year, and make follow-up phone calls to monitor progress between visits an average of 12 times a year, according to Marcantonio. "These patients have multiple chronic diseases and a lot of complicated care needs. Our care managers see them a number of times face-to-face," she says.

Maryellen Keller, RN, BSN, director of care management, reports that the frequency of the home visits and telephone contacts depends on the issues the patients are having, and changes according to the patient needs. "They always have us as a resource. Some nurses visit the patients once a week to fill their pill box. These are patients who can stay well if someone organizes their medication and reorders it when needed," she says.

To have a successful community case management program, case managers have to be flexible, be able to understand their patients' concerns, and work with them on their priorities, Keller says. "People who just want to tell people what to do won't be successful in this role. We have to be supportive and help our patients modify behaviors or overcome barriers to adherence," she says.

The case managers are creative in the way they approach people and try different ways to help them reach their goals, rather than being judgmental, she says. For example, if a patient needs to exercise, the care managers help them find something they enjoy doing that will help them become more active.

"We look for little things, like getting smokers to start quitting by cutting out one or two cigarettes a day, or encouraging patients who overuse alcohol to have one less drink a day," Keller says. ■

Patient advocate helps with transitions

Contracting with elderly patients, families

When **Sharon Gauthier**, RN, MSN, iRNPA, was a hospital case manager, she saw people return to the hospital over and over, with issues that might have been avoided if someone had better coordinated care in the community.

"After I left the hospital environment and

EXECUTIVE SUMMARY

Sharon Gauthier, RN, MSN, iRNPA, owner of Patient Advocate for You, in Hartford, CT, contracts with patients and their families to manage the care of mostly elderly patients as they transition between levels of care.

- She meets patients and family members in the hospital, accompanies patients when they leave the hospital, sets up medication boxes, and makes sure home health and other services are in place.
- She collaborates with the patients' physicians and often accompanies them when they visit the doctor.
- When patients need post-acute care, she advises them on their options and visits them in post-acute facilities to ensure that there are getting what they need to move through the continuum safely and quickly.

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finished my master's degree, I looked for ways I could support patients and their families and help connect the dots in the healthcare system," she says. As a result, Gauthier started Patient Advocate for You, an advocacy company based in Hartford, CT, that contracts privately with patients and family members. Her goals are to help patients transition from a hospital, rehab facility, or skilled nursing facility back to their home environment, and stay safe and healthy in the community. The majority of her clients are elderly, and many have family members who live out of state or work full time. She also has managed the care of clients in their 30s and 40s who have profound events that require hospitalization and complex care.

"It's very difficult to navigate the healthcare system. Most people think that everything will be done correctly and accurately in a medical setting. In reality, you need someone there to ensure that the information you are getting is correct and all parties involved in the care are talking," she says.

When patients transition from one level of care to another, it's extremely important for them to have an advocate to help bring all the pieces together, Gauthier says. "Having a clinical person by their side while they get acclimated to being back at home, or to a post-acute facility, is a huge advantage for patients and their families," she says.

Gauthier has assembled a 24-member advisory board that includes pharmacists, gerontologists, social workers, physicians with multiple specialties, and a caterer who provides meals for shut-ins. She calls on them for advice in managing the care of patients.

When Gauthier is hired, she meets with the patient and family to get a handle on what they want her to do. "I usually hit on an immediate issue and come up with a plan," she says. If the patient is in the hospital, she obtains a HIPAA release and talks with the case manager about the case. If appropriate, she brings together the entire treatment team for a conference with the patient and family members to discuss the patient's condition, test results, and the treatment plan. "Once the family hires me, I become the contact person for the nursing staff and physicians. They like dealing with me instead of having to coordinate with several family members. I help coordinate care and education, and provide information for everyone," she says.

When patients are approaching discharge, Gauthier gives the family options for post-discharge placement, and she checks the discharge paperwork to make sure it's readable and complete. "Patients in the hospital often have different hospitalists every week and different nurses every shift. Case managers are really pushed, and they often don't have the time to make sure everything is in place after discharge. I make sure that everything is taken care of and that the patient's primary care physician is informed," she says.

When patients are about to go home, Gauthier conducts an assessment in the home and ensures that home care and other services the patient needs are in place. She checks the medication schedule to make sure that the patient can follow it at home. Gauthier goes home with the patient and puts together their medication box for the week. She compiles a list of the medication the patient was prescribed in the hospital and faxes it to the primary care physician.

She makes sure the patient has a follow-up appointment and accompanies them when they see the doctor. She fills in the doctor on what has been happening with the patient. "Most doctor visits last less than 15 minutes. I am able to identify situations that might otherwise be overlooked or unaddressed," she says.

When patients need post-acute care, she educates patients and family members about what is available and helps them choose the provider. "I'm not working for anyone but the patient and family. When I walk into the case, I'm looking

from the point of view of what is right for the patient. Unlike the hospital case managers who are required to be neutral, I can advise them on which facilities to avoid, based on my experiences working in a nursing pool and supervising nurses in convalescent homes," she says.

Once patients are placed in a post-acute facility, Gauthier monitors the situation to make sure the patient receives the required therapy and moves through the continuum of care quickly and safety. "When patients are transferred, many times, there are medication errors and pain management issues. I stay with them throughout the transition and visit them multiple times to make sure they are getting the services they need," she says.

If a patient is in the emergency department, Gauthier visits and takes the information the emergency department staff needs to initiate treatment. "The staff loves it because I have information they never would get from somebody who just presents to the emergency department. I know the staff, I know how busy emergency departments function, and I know how to get things done so the patient is either admitted or discharged in a timely manner," she says.

Gauthier charges an hourly rate of $100 for actively managing the care of patients. When the patient is stabilized, she charges a flat rate of $400 a month, plus the Internal Revenue Service's rate for mileage, that covers four hours of time she may spend filling the medicine box or taking the patient to doctor's appointments.

"The family knows me, the patient and spouse know me, so if there is an emergency, they call 911 and then call me," Gauthier says. ■

Experts offer tips for substance use

The goal is to prevent hospitalization

Hospital systems and care transition teams should take a close look at their practices regarding patients for substance use problems, with a goal of improving screening and discharge planning to prevent readmission of these patients, experts say.

"This group requires substantial attention; they re-utilize at high rates," says **Alexander Walley**, MD, MSc, assistant professor of medicine at the Boston University School of Medicine.

Hospitals could include questions about substance use in any general hospital admission or high risk patient's screening.

Tom Sedgwick, LCSW, CCM, director of social work at New York University Langone Medical Center in New York City, says, "Most places do a high-risk screen on admission to see if the patient requires further psychosocial intervention, and substance use is just one more thing they could put on the screen."

Also, hospitals that have targeted quality improvement programs, such as Project RED – Re-Engineered Discharge program, could include interventions for substance use. Programs such as Project RED have demonstrated success in lowering hospital readmissions, lowering emergency department use, and lowering costs, says **Brian Jack**, MD, professor and vice chair in the Department of Family Medicine at Boston University School of Medicine/Boston Medical Center. Jack is the principal investigator for Project RED.

"There are now important policy implications for hospitals," Jack adds. "They will need to meet certain quality benchmarks in order to receive payments on an incentive program from insurers and others."

Since programs such as Project RED are expensive, hospitals look for ways to focus and target them to specific patient populations that will benefit most, he notes. "There is a lot of interest in developing risk models using administrative and clinical data that will accurately predict who is likely to come back for the purpose of identifying and targeting those individuals," Jack says.

As hospitals develop and use risk assessment tools, they should keep in mind recent research findings that substance use, like depression and low health literacy, is an important and independent factor associated with rehospitalizations. *(For strategies for incorporating substance use assessment, see related story, p. 32.)* "Project RED wasn't targeted at substance users, but we think substance users would benefit from Project RED just as non-substance users would," Walley says.

Walley and Jack were among the researchers who found that rehospitalizations are more common among patients with substance use disorders than among patients who did not have

that diagnosis.

"If you discharged 100 substance users, there would be 63 utilizations at 60 days," Walley says. "Discharge 100 non-substance users and you have only 32 utilizations at 60 days."

Hospitals should follow best practice measures and look for trends in patient readmissions, suggests **Mirean Coleman**, MSW, LICSW, CT, senior practice associate with the National Association of Social Workers in Washington, DC.

"When patients are readmitted for the same type of problem, it's important to assess what is really going on here," Coleman says. "Screening tools could be administered to patients admitted through the emergency room to the hospital, and that would be one way to find out if there's a need."

Substance use screening for trauma admissions are routine at some hospitals, says **Steven M. Vincent**, PhD, LP, Care Center director, behavioral health services, at St. Cloud (MN) Hospital. The hospital is part of the CentraCare Health System.

"Our functional health assessment that is done at intake involves asking a few questions about substance use, but it doesn't really go in depth unless there's something in the patient's history or current presentation, or trauma indications that triggers us to do a more complete assessment throughout the general hospital," Vincent says. ■

Tactics for including substance use assessment

While hospital systems and care transition teams are looking closely at best practices as it pertains to patients with substance use problems, the goal is improving screening and discharge planning to prevent readmission. **Steven M. Vincent**, PhD, LP, Care Center director, behavioral health services at St. Cloud (MN) Hospital, and other experts provide these strategies for incorporating substance use assessment and interventions in the hospital discharge process:

• **Screen patients for substance use problems.** Screening tools could be administered to patients who are admitted through the emergency department or are in general hospital populations. Social workers who have a certified clinical alcohol, tobacco and other drugs credential are well trained to identify this problem, Coleman says.

"The social worker can administer the screening tool and provide initial counseling regarding substance use during the hospital admission," Coleman says.

A depression screening probably should be automatic, and the patient also could be asked about alcohol use at that time, Coleman says. Screening also could include looking at previous medical records to see if there are any patterns, Sedgwick notes.

"It's almost intuitive when you've been doing it a while," Sedgwick says. "You know the signs when you see them. If someone keeps coming back because they are falling or if an older person has a changed mental status and frequent falls, then these are things we have to consider as possibly related to alcohol use."

• **Arrange for a case management consultation.** A known substance use history might result in a case management consultation.

"A case manager can talk with the patient, and sometimes the family when there's a substance use concern that the patient doesn't acknowledge, but the family is willing to discuss," Vincent says. "Out of that discussion, a determination is made whether we need to put the patient on an observation protocol to see if there are withdrawal signs during hospitalization."

Subsequently, based on the case manager's assessment, the hospital's team will determine whether there should be a full chemical dependency evaluation, he adds.

This assessment also can guide referrals and patient education, such as providing overdose counseling and referring patients to chemical dependency treatment, as needed.

"If that's done, then it will produce recommendations about what level of treatment, if any, is needed," Vincent says. "It's included in the patient's medical record and is included in discharge findings."

• **Educate patients and their families.** At the minimum, discharge teams can educate patients and their families about risk factors for substance use disorders, Vincent says.

Discharge teams also can provide follow-up interventions, Sedgwick says.

"After discharge, we make phone calls to all of our patients within 48 hours," Sedgwick

says. "We check on the patient at home and see if there are any problems."

Nurses making these calls discuss the discharge plan with patients and check on any potential problems, including substance use issues. When a problem is identified, they make a referral or recommendation with the goal of reducing the patient's risk of rehospitalization, he adds. ■

Beneficial screenings could be lacking

More than 20% of U.S. adults receive periodic health examinations (PHE) each year, yet new research shows that patients who have an annual routine visit to their doctor might not receive recommended preventive screening tests and counseling services that could benefit their health.

A paper recently published in the *American Journal of Preventive Medicine* found that 46% of eligible and due services were missed during PHEs. The results came from audio recordings of 484 PHE visits to 64 general internal medicine and family physicians in southeast Michigan. The research was performed by a team led by **Jennifer Elston Lafata**, PhD, co-leader of the Cancer Prevention and Control program at Virginia Commonwealth University (VCU) Massey Cancer Center and professor of social and behavioral health at VCU, in Richmond.

"While the percentage of services delivered may appear low, when you account for the lack of incentives to physicians for screenings and preventive counseling and the limited amount of time during visits to address all recommended services, the numbers are not surprising," says Elston Lafata.

By analyzing the audio recordings to determine if physicians suggested or delivered 19 guideline-recommended preventive services, the researchers discovered that the services most likely to be delivered were screenings for colorectal cancer, hypertension, and breast cancer. Patients were least likely to receive counseling about aspirin use and vision screening, and they also were unlikely to have an influenza immunization recommended or delivered.

The team also evaluated the factors contributing to service delivery. Service delivery decreased with patient age and increased with the patient's body mass index (BMI), an indicator of body fatness based on height and weight. While about half of the 19 preventive services studied were prompted in the patient's electronic medical record (EMR), the researchers were surprised to find that services were less likely to be delivered during visits where the physician accessed the EMR in the exam room. Interestingly, the patients whose doctors ran behind in their appointments seemed to receive more preventive services.

"It appears that while some preventive services are likely to be received by some patients, several services which are known to reduce disease go undelivered during routine PHEs," says Elston Lafata. "Relying on face-to-face interactions between physicians and patients will likely continue to result in less-than-optimal service delivery. However, technological advances that provide patients with easy access to their personal health records coupled with automated reminders may be one way patients can work with physicians to increase delivery of preventive services and subsequently lower overall healthcare costs."

RESOURCE

• The full research manuscript is available online. Web: http://bit.ly/w9A8lf. ■

Educating women about heart attacks

Heart attacks in women go largely unrecognized 30 to 55% of the time, and those who miss the warning signs and fail or delay getting help, run the risk of death or grave disability. But researchers at Binghamton University and SUNY Upstate Medical University in Binghamton, NY, have developed an educational program they believe will shorten the time to treatment and ultimately, save lives.

Women often don't have the same kind of chest pains that men generally experience during a heart attack. They also might have a range of other symptoms, not all of them easy for the typical sufferer to identify. Subsequently, in many cases, they tend to just ignore the warning signs.

In hopes of shortening women's time to treatment, **Pamela Stewart Fahs**, RN, DSN, professor and Decker Chair in Rural Nursing at Binghamton University's Decker School of Nursing, is collaborating with **Melanie Kalman**, RN, PhD, associate professor and director of research, and **Margaret Wells**, PhD, RN, NP, assistant professor, in the College of Nursing at SUNY Upstate Medical University, on a project named "Matters of Your Heart." The goal is to develop an effective program to educate women about heart attack symptoms and also to teach about the early warning signs that a heart attack might be on the way.

Stewart Fahs, Kalman and Wells conducted the first phase of their project under an intramural research grant from SUNY Upstate. Their first task was to develop a questionnaire to measure a woman's knowledge of heart attack symptoms and warning signs. They then created a pilot version of an educational presentation.

Working with 141 post-menopausal women, Stewart Fahs and Kalman held small-group sessions to administer the questionnaire, present the program and then give the questionnaire again. "We did find that the educational program increased knowledge," Stewart Fahs says.

The researchers based the presentation in part on a program that Stewart Fahs developed several years ago to teach rural residents about symptoms of a stroke. That program employed an acronym created by the American Heart Association: FAST, for Face, Arm, Speech, and Time.

The new program uses a similar mnemonic device, and Stewart Fahs says the method seems to help, especially when women practice putting it to use. The next phase of the project will focus on testing whether using acronyms for female heart attack and its warning symptoms improve knowledge as compared to using an educational program without them. The work will begin this spring, thanks to a grant from the Rural Nurse Organization. Stewart Fahs will administer the questionnaire and program to women in rural areas, while Kalman and Wells concentrate on urban Syracuse, NY. The population they have studied so far is too small to reveal whether the program works better for one demographic or the other, Stewart Fahs says.

In a second phase of their research, Kalman and Stewart Fahs plan to give the presentation to many more women over a broader geographical area. Eventually, they hope to do a longitudinal study to discover whether their program improves the way women respond when they experience signs of a possible heart attack. "Having knowledge doesn't necessarily change your behavior," Stewart Fahs says. "But if you don't have the knowledge, you're unlikely to change."

Once they've perfected the program, the researchers will share it with hospitals, community health agencies, and other healthcare organizations. In addition to offering the computerized graphic slides for classroom use, they might someday use communication technologies to give the presentation a broader reach, Stewart Fahs says. "There should be a way, through cell phone apps or some kind of Internet application, to get this message out to women once it's fully developed and tested."

Stewart Fahs, Kalman and Wells hope that the results of their latest research will include better outcomes for more female victims of heart attack.

"The more aware you are of the signs and symptoms," Stewart Fahs says, "and the more aware you are of the risk of heart disease for women, the better able you are to be proactive." ■

Readmission rates respond to collaborative process

Working together multiplies benefits

There's not a healthcare organization around that isn't focused on reducing unplanned readmission rates. They cost money and are the focus of a variety of regulatory and payer organizations that are either no longer paying for care related to such readmissions or will soon stop.

But as much as everyone wants to find some magic bullet that will work in multiple settings, the truth is that no one thing is going to solve the problem. Indeed, what works at one hospital for a particular type of patient might not work at another hospital 50 miles away for the exact same patient. That system makes the idea of a state hospital association collaboration something of a head scratcher. If it all depends on where you are, the kind of patient, the time of day, and phase of the moon, then really,

shouldn't we all just figure it out on our own?

Absolutely not, says **Alison Hong**, MD, director of quality and patient safety of the Wallingford, CT-based Connecticut Hospital Association. Hong is working with hospitals in Connecticut on a multi-year collaborative to address statewide readmissions for congestive heart failure (CHF). People are forgetting one key aspect to the question: whether what any hospital does in isolation from the rest of the healthcare continuum does will make much difference at all.

That's part of what makes this collaborative different: It involves not just association member hospitals, but also organizations outside the acute care setting who are involved in caring for these patients: nursing homes, home care, and community physician practices, large and small. All of the parties are working together, looking through data, performing chart reviews, and going through every possible process to find common factors that lead to unplanned readmissions among CHF patients. The group is using the Institute of Healthcare Improvement's (IHI) Transforming Care at the Bedside document as its QI template. *(For more information about accessing this document, see resource, right.)*

The collaborative started last year, in person and electronically, to focus on five strategies:

- **delivering evidence-based care;**
- **using enhanced admissions assessments of post-discharge needs** — start planning for discharge as soon as the patient is on the unit, talking with family, discussing social issues, medication issues, and logistical issues that might arise;
- **engaging family and patients** — identifying the right caregiver, asking patients why they think they returned to the hospital, using advanced teach-back methods;
- **medication safety;**
- **post-acute care follow-up** — requiring patients to have an appointment with a community physician or clinic made before they leave the hospital and see they get to that appointment within seven days of discharge, with no outstanding issues to address, including transportation to the appointment.

This is the fifth collaborative that the members of the hospital association have worked on, says Hong. There is a lot of interest in it and in using the team dynamic to create traction. Even those with fairly low CHF readmission rates are working on this and seeing an effect.

"We all know that this is important to community health and the patient. We all know that this is going to be our parents in a few years, or us."

SOURCE/ RESOURCE

For more information on this topic contact:

- **Alison Hong**, MD, Director of Quality and Patient Safety, Connecticut Hospital Association, Wallingford, CT. E-mail: hong@chime.org.
- IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement Transforming Care at the Bedside. (Available on www.IHI.org) ■

COMING IN FUTURE MONTHS

- CM opportunities in the Wounded Warrior program
- Legal issues you should keep in mind
- Engaging patients in lifestyle changes
- How your peers are reducing readmissions

CNE QUESTIONS

1. True or False: According to Margaret Leonard MS, RN-BC, FNP, senior vice president for clinical services at Hudson Health Plan, many state and federal grant programs require face-to-face case management interventions.
   A. True
   B. False

2. How many times a year on average does the average nurse in Health Quality Partners' community case management program visit patients in their homes?
   A. 9
   B.13
   C.15
   D. 21

3. How long do patients remain in Health Quality Partners' community case management program?
   A. Up to a year
   B. 90 days
   C. Until they move out of the area or die
   D. Until they are stabilized and able to manage on their own

4. In what setting does Sharon Gauthier, RN, MSN, iRNPA, owner of Patient Advocate for You, visit her clients?
   A. At home
   B. In the hospital
   C. In post-acute facilities
   D. All of the above

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. ■