Case Management ADVISOR™
Covering Case Management Across The Entire Care Continuum

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Technology helps case managers and nurses work more efficiently

Remote monitoring keeps at-risk patients safe

Healthcare organizations in a variety of settings are leveraging today's technology to increase the efficiency of case managers and nurses and for early intervention of patients who are experiencing exacerbation of their disease or other problems that might lead to an emergency department visit or hospitalization.

In a program developed by Geisinger Health Plan and Geisinger Clinic, with headquarters in Danville, PA, patients who received a combination of traditional case management and remote monitoring with interactive voice response technology, were 44% less likely to have 30-day readmissions than patients who received only case management interventions.

Heart failure patients who live in remote areas of Montana, make daily calls to a telemonitoring system at Billings (MT) Clinic heart failure program, and answer questions that alert the clinic's nurses when an intervention is indicated.

Bayada Home Health Care, a national home health agency with head-

EXECUTIVE SUMMARY
By using a variety of technological advances, case managers in a variety of settings are working smarter and setting priorities for interventions based on feedback they get from remote monitoring of patients.
• Appropriate patients at Geisinger Clinic's medical homes who receive a combination of traditional case management and remote monitoring are 44% less likely to be readmitted to the hospital within 30 days as a control group who receive only case management interventions.
• Billings Clinic monitors its heart failure patients in remote areas using a telephone response system that makes daily calls to patients. When patients' responses indicate clinical variances, nurses call and adjust the diuretics or electrolytes using a protocol developed by the cardiology department.
• Bayada Home Health Care nurses have the option to use a telephone response system or home monitoring equipment to monitor at-risk patients in between visits.

quarters in Moorestown, NJ, and 51 offices across the country uses a combination of telemonitoring devices and telephone calls to supplement the work of its home health nurses in its disease management programs.

"Technology can help case managers work smarter and understand which patients need assistance by stratifying their workload and concentrating on patients who need their assistance the most," says **Maria Lopes**, MD, MS, chief medical officer for AMC Health, a telemonitoring technology company with headquarters in New York City.

When telehealth tools are a part of the daily work flow, case managers can track the clinical progress of their patients. "This proactive approach targets the most appropriate patients and yields clinically meaningful and actionable information which can then be used to more effectively triage their caseload. Telemonitoring is a beneficial enhancement to proven case management best practices and creates efficiency and improves effectiveness in the case management process," Lopes says.

Jo Rowland, BSN, MA, CHFN, program coordinator for the Billing Clinic heart failure clinic says that technology helps the nurses in the program monitor the conditions of high-risk patients, many of whom live in remote wilderness areas. Billings Clinic is an integrated healthcare system that includes a 272-bed hospital with a Level II trauma center, a 90-bed assisted living and rehabilitation center, and the region's largest multi-specialty group practice with more than 310 providers. The healthcare system serves patients in Montana, Wyoming, and the Western Dakotas. A large portion of the area served by the health system is wilderness with fewer than six people per square mile and counties that share a single physician. Many patients live long distances from the nearest primary care provider and winter storms and floods often make the roads impassable.

"Even though we try to coordinate care and keep tabs on our patients in outlying areas, there often are glitches because it's not always easy for patients to see their local physician or come into the clinic. With the telemonitoring system, patients get daily calls and we can tell from the patient's response to the questions when there is a problem, then call to get more information and decide what intervention is needed," Rowland says. *(For details on Billings Clinic telemonitoring program, see related article on p. 52.)*

Eric Thul, MBA, division director with home health practice of Bayada Home Health Care says his organization's use of technology is still in the infancy stage and the company is looking for a balance between lower cost and high-touch solutions to help patients learn to self-manage their conditions and to optimize the time of the nurses and case managers.

"We continue to take a balanced and measured approach toward telehealth in an effort to understand which interventions and which types of services add value by increasing patient engagement and preventing hospitals admissions, he says. *(For more on Bayada Home Health's use to technology, see related article on p. 53).*

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Doreen Salek, BS, RN, director of population management partners for Geisinger Health Plan reports that in a survey, more than 96% of Geisinger case managers said that the interactive voice response technology helps them work more efficiently, and more than 85% said the program helps keep their patients out of the emergency department.

Geisinger Health Plan case managers set up the interactive voice response program for appropriate patients who have been discharged from the hospital. The system makes outbound calls to the patients once a week for approximately four weeks, asks a series of questions about the patient's condition, and alerts the case managers if the patients' answers indicate they may be experiencing problems. *(For details on the program see related article, below.)*

"Technology is an efficient new way of extending the reach of case managers. Patients don't necessarily know when they are experiencing an exacerbation or problem," Salek says. The interactive voice response system allows them to identify early indicators of infection, exacerbation of chronic diseases, or anything else that looks like it might be problematic and intervene to keep the patient out of the hospital or the emergency department, according to Salek. ■

Technology supplements old case management

Voice-response system monitors patients

Case managers at Danville, PA-based Geisinger Health Plan who are embedded in primary care practices, and those who provide case management telephonically in the community, use a combination of traditional case management and interactive voice response technology to monitor the conditions of patients discharged from the hospital.

A project conducted over a two-year period demonstrated that patients who received the combination of services were 44% less likely to be readmitted within 30 days than patients who received only case management. The interactive voice technology system is now used for appropriate patients in all Geisinger primary care practice sites, and at seven other practices that provide care for Geisinger Health Plan patients, and some Medicare fee-for-service patients managed by Geisinger Health Plan.

"The interactive voice response system is a tool in the case manager's toolkit. It doesn't replace case management telephone calls and interventions. If the case manager determines that the patient needs a phone call every day from the case manager, that option is open," says **Doreen Salek**, BS, RN, director of population management partners for Geisinger Health Plan.

The health plan's case managers are located in the clinic and work face-to-face and over the telephone with the patients and their family members. They typically are responsible for coordinating the care of 150 or more high-risk patients, most of whom have a combination of chronic illnesses. They also coordinate transitions from hospital to home.

The case managers call patients who qualify for case management within 24 to 48 hours after they are discharged from the hospital, complete a comprehensive assessment of the patient's condition, conduct medication reconciliation, and determines the patients' needs and line up any support such as home health or assistance from community agencies.

When patients are appropriate for the interactive voice response program, the case manager sets up the system to call the patients once a week for approximately four weeks, at a convenient time and day. Not every patient who has been hospitalized participates in the interactive voice response system. The case manager may determine that the patient needs personal phone calls at more frequent intervals. Patients who have hearing problems or who are not cognitively or physically able to participate are not included in the program.

During the interactive voice response telephone calls, which typically last about three minutes, patients are asked a series of questions about their adherence to the discharge plan and symptoms that may indicate an exacerbation of problems. If a patient doesn't answer the call, it is tried again later. The system uses branching logic to ask additional questions based on the patient's response.

Questions depend on the reason for the hospitalization and may include: Have you scheduled a follow-up appointment? Did you get your prescription for medication filled? Do you have a fever? Are you short of breath? Are you having pain?

The interactive voice response system interfaces with Geisinger Health System's electronic medical record systems and issues an alert to the case management documentation system whenever the patient's answers indicate a problem. This noti-

fies the case manager to call the patient to find out more information and determine if the patient needs to come in to the clinic. "The key to the success of the program is that it allows case managers to understand what is happening in the home after discharge and intervene when there are problems or gaps in care," Salek says.

Jove Graham, PhD, comparative effectiveness researcher with the Geisinger Center for Health Research, adds that the interactive voice response calls are not a substitute for case management. "They enhance what the case managers are doing and make them aware of any problems in a timely manner. Case managers become aware of whether the patient has filled prescriptions, has a follow-up appointment with their primary care physician, and if he or she is experiencing signs and symptoms that may indicate a problem," he says.

Patients in the program responded well, possibly because it's not over intrusive for patients to accept four phone calls over a four week period. Graham adds, "There was a very high compliance rate. Only 4% of patients failed to take all four weeks of calls," he says. ■

Telemonitoring cuts readmits for HF patients

Nurses coordinate care with community docs

Just 15% of heart failure patients at risk for readmission who participated in a telemonitoring program at Billings (MT) Clinic's heart failure clinic, were readmitted to the hospital within 30 days, according to an analysis conducted by the clinic staff.

Billings Clinic is an integrated healthcare system that includes a 272-bed hospital with a Level II trauma center, a 90-bed assisted living and rehabilitation center, and the region's largest multi-specialty group practice with more than 310 providers. The healthcare system serves patients in Montana, Wyoming, and the Western Dakotas.

In the program, patients whose condition was stabilized and whom nurses contacted by telephone periodically had a 10% readmission rate within 30 days. The statistics compare to a 42% readmission rate for patients who were not in the clinic's heart failure program. The readmissions were for all causes, not just heart failure, says **Diana Parker**, BSN, MBA, director of cardiovascular services for the Billings Clinic.

The clinic is managed by the health system's cardiology department and is staffed by registered nurses with expertise in heart failure. The nurses use telemonitoring for patients with the highest risk of readmissions. Stable patients are followed routinely in the cardiology clinic and by telephone by the heart failure nurses who call them periodically to check on their condition.

Jo Rowland, BSN, MA, CHFN, program coordinator for the Billing Clinic heart failure clinic, attributes the success of the program to using specially trained heart failure nurses, patient and caregiver training about heart failure, signs that indicate an exacerbation, and the need for following the treatment plan, and ready access to clinicians trained in treating heart failure.

The clinic sees patients who are referred to the heart failure program by cardiology within a week. The heart failure clinic conducts a sleep disorder breathing screening on all patients and has standing orders for an outpatient pulmonary consultation if indicated. Patients are screened for depression and undergo a six-minute walking test to assess their functional capacity.

Those patients who live a long way from Billings typically are referred to their primary care physician for follow up. Patients who live in proximity to the clinic come in for assessment every two weeks until their condition is stabilized, then see the nurse practitioner, physician assistant or cardiologist every three months. Very stable patients come into the clinic twice a year. Every patient sees his or her cardiologist annually.

"The nursing team at the clinic uses a nurse case management model to educate and monitor the conditions of these patients." Rowland says. A nurse from the heart failure clinic is assigned to the hospital and reviews the census every day to determine which patients have heart failure, either as an admitting diagnosis or comorbidity, and educates patients on their condition, the importance of follow up care and following their treatment plan.

When patients are appropriate for telemonitoring, the heart patient nurse who is assigned to the hospital goes over the instructions, gives them written materials, and calls them the day after discharge. If the patient does not have a scale at home, the clinic provides one. Every day, patients dial into a toll-free number which connects them to a web server that asks six questions. The patients enter their weight each day and answer six questions such as do you have more swelling today? Are you short of breath? Do you feel lightheaded?

Answers are recorded by pressing 1 for yes and 2 for no on a touchtone phone. The computer program separates answers into clinical and non-clinical variances.

If patients' weight fluctuates three pounds or more in a day or if they say yes to any of the questions about symptoms, the nurse calls the patient to get more information and determines what kind of intervention is needed. "Many times, we do rescue therapy over the telephone. We do a lot of counseling about diet and medication adherence. Sometimes patients get worse because they took over the counter medication for a cold, or ate foods with a lot of sodium," Rowland says. The nurses enter their progress notes in the clinic's electronic record which is available for providers who are affiliated with Billings Clinic can access.

The clinic's cardiology and internal medicine departments developed diuretic protocols and electrolyte protocols so nurses can manage patients' medication over the telephone if the symptoms indicate. "When the patients call in, we can check their conditions and treat them every day if their medications need adjusting," Rowland says.

Rowland says that when patients do not respond to diuretic protocols, the heart failure nurse, by protocol, recommends that the patient see his or her local provider. Sometimes in outlying areas, follow-up is difficult. For instance, one patient was a rancher who, following a major spring flood, was taking a boat to see his cows. "There was no way he was going into town to get labs or see a provider. This happens sometimes and we just do the best we can," she says.

The nurses work closely with primary care providers in the outlying community to coordinate care for the patients. "We make an effort to have a good working relationship with the outlying community physicians. They're the ones who see the patients frequently and can provide information we can't get over the telephone. We also coordinate with many other services such as home health agencies, hospice services, ventricular assist device and cardiac transplant teams, as well as specialists such as nephrologists and pulmonologists," she says.

Parker reports that the clinic is planning to expand the home telemonitoring system in which all capable heart failure patients will call in periodically and answer the same questions as people who call in every day.

"We want to check on patients after they are stable. We realize that stable patients can become unstable and we feel like it's valuable to assess them periodically," Parker says. ■

Home health organization balances technology, touch

Remote monitoring, EMR part of program

Bayada Home Health Care, with headquarters in Moorestown, NJ, uses an automated voice response service that calls high-risk patients with chronic diseases at intervals selected by their home health nurses. The service asks questions designed to identify any problems the patients might be having and any exacerbation of their conditions.

The program targets patients with chronic obstructive pulmonary disorder, heart failure, diabetes, and hypertension, but can monitor patients with any condition if their physicians order the service. The system alerts a case manager in the office by email, and by a flag on the computer screen. The case manager decides what intervention is needed depending on the situation, and may call the patient's doctor or send out a nurse.

When physicians request it, the agency uses digital weight scales and blood pressure monitors in patients' homes in conjunction with the regular visits from home care nurses. The devices, typically in the home for 60 days, assist in allowing patients to self-report their vital signs through an automated voice response system which telehealth nurses who monitor up to seven days a week.

Using the data, the home health nurses determine if the patient is experiencing an exacerbation and the telehealth nurse works with the local Bayada branch case manager and physician to determine what steps to take.

"We have a variety of options available to provide the best care and monitoring of our patients. We're still analyzing the various types of services to determine the best balance between live calls and technology," says **Eric Thul**, MBA, division director with home health practice.

The company's most recent adaption of technology has been to replace a paper record system with a fully functional electronic medical record in 2011. Nurses, therapists, social workers, and home health aides take electronic tablets with them as they visit patients, and complete the vast majority of their documentation in the home.

"It created efficiencies in terms of back office processing but we also found that it increases the amount of documentation that happens in the

home, cutting down on the amount of time the nurses spend writing out their treatment notes after hours, and improves the quality of the documentation as well," he says.

The process allows nurses to easily review what's been going on with their patients over time and to track the results of their interventions, he says. The organization is rolling out a physician portal that allows physicians to log in to review and sign orders orders and to see their patients' basic health status online. ■

Care coordination cuts hospitalizations

Nurses help uninsured at primary care sites

MetroHealth System's care coordination program for the uninsured, Partners in Care, has resulted in 34.8% fewer inpatient stays at an average cost of 15.4% less than a demographically similar group of patients who were not enrolled in the program. Patients in the program with diabetes demonstrated a 6.6% improvement in HbA1c control and a 6.8% improvement in cholesterol control and hypertensive patients had a 4.1% improvement in blood pressure control.

Located in Cleveland, OH, the health system includes MetroHealth Medical Center, a 740-bed, county-owned hospital that is the largest safety net hospital in the state of Ohio, and 17 community health clinics. Uninsured patients make up 18% of the health system's outpatient practice.

Faced with a steady increase of uninsured patients, the health system looked for ways to provide care in the most cost-effective and clinically effective way and created Partners in Care, says **James Misak**, MD, associate director for family medicine in the MetroHealth System Center for Community Health. "As a public hospital and provider and payer for care, we spent more than $100 million out of a total budget of $750 million on providing healthcare for the uninsured in 2011. Anything we can do to provide care in a clinically effective and cost-effective way is a win-win for us and the patients," he says.

The health system began transforming its outpatient primary care services into a patient-centered model of care in 2007 and created care teams to work with patients across the continuum. The team created Partners in Care, a program exclusively for the uninsured that connects them with a care coordinator to help them navigate the healthcare system.

In the first phase of the Partners in Care program, the health system placed nurse care coordinators at six practice sites with a goal of rolling the program out throughout the system. About 16,000 patients are enrolled in the Partners in Care program at the six primary care sites.

The health system mines its electronic medical record system that includes inpatient and outpatient services to identify uninsured patients for the program. When an uninsured patient is hospitalized or visits the emergency department or an urgent care center, the patient is automatically listed in the daily acute care registry. Patients with chronic illnesses are entered into the disease management registry.

Geneva Jones, RN, BSN, MEd, care coordinator at MetroHealth Broadway Health Center in Cleveland, says the daily acute care registry is her most active registry. She begins her day by reviewing the list of patients who have been admitted to the hospital and those who have had emergency department or urgent care visits and contacting them to find out their needs and barriers to care.

"Many of the patients who visit urgent care or the emergency department don't have a primary care provider. I talk to them about the benefits of having a primary care provider and help them sign up for one. If they are frequent users of the emergency department, I talk with them to try to identify barriers to care," she says.

After patients are discharged from the hospital, she calls them to review their discharge instruc-

EXECUTIVE SUMMARY

After MetroHealth System, with headquarters in Cleveland, OH, launched Partners in Care, a care coordination program exclusively for uninsured patients who have been hospitalized or have chronic conditions, inpatient stays for patients in the program were 34.8% less than for a control group.

- Nurse care coordinators at primary care sites work with patients who have been hospitalized. They make sure they have follow-up appointments, transportation, and have filled their prescriptions.
- When patients don't have a primary care provider, the care coordinator helps them identify one and encourages them to make regular visits.
- Patients with complex care needs or chronic conditions that are not under control are placed on a case management registry and receive phone calls and education as often as needed.

tions and assess their clinical status. She helps them establish a primary care appointment if needed and lines up transportation if they don't have a way to get to the clinic. If she can't reach the patients, she sends them a letter and asks them to call her.

Misak points out that because of a lot of different barriers to care, the uninsured often put off receiving preventative services and seeing a doctor until their condition gets so serious they can't ignore it. "With this program, we want to help them understand the importance of preventative care and to encourage them to establish a relationship with the primary care team. The care coordinators do whatever is necessary to overcome what barriers exist to getting patients re-established with their primary care team and achieving their healthcare goals," he says.

Patients typically stay on the acute care registry for 21 days, Jones says. She puts patients who need extra support on her case management registry, which reminds her to check back regularly. She works closely with the clinic social workers and may make referrals if patients need help with community resources such as medication assistance or free dental care.

The program's disease management component focuses on patients with hypertension and diabetes, two diagnoses which are most prevalent in the uninsured population. Patients with chronic conditions are enrolled in disease management registry and receive telephone calls or education by mail, depending on their risk stratification. If patients do not have their chronic conditions under control, Jones enrolls them in case management and follows up as often as every day, or as infrequently as once a quarter, depending on their needs.

Jones says that she works with most of her patients over the telephone. Sometimes providers bring patient to meet Jones. In other cases, if she sees someone with whom she's been working on the appointment schedule, she'll make it a point to see them. "I ask some people to come in and meet with me because I feel like I can help them better face-to-face. A lot of my job is building relationships. Most patients know me and call if they have questions," she says.

"This program has shown good results in reducing hospitalization rates but it's an expensive intervention since it adds another clinician to the episode of care. We're analyzing the results to determine if this is the best use of resources to drive down hospitalization," he says. ■

Getting it right on readmissions

What didn't work is helping discover what does

If you say it out loud, people will agree intuitively: You can learn more from your failures than from your successes. But that agreement doesn't mean people want to trumpet what doesn't work. That caveat makes what's happening at Henry Ford Health System in Detroit so special: They are actively looking at what is still wrong as they try to get a handle on unplanned readmissions so that they can figure out what's right.

Long before payers started saying they'd stop paying for unplanned 30-day readmissions, the leaders at Henry Ford Health System decided to look at the topic, says **Beth Anctil**, RN, MSN, director for care coordination for the system. "Our CEO thought we should tighten up our processes for discharging patients," says Ancil, noting that over four years, the rate hasn't changed — or at least not enough, or not for long enough. "It will be down for three or four months, and then it pops back up again," she says.

Anctil says she gets that the reason is complex: part is culture and getting people to change the way they do things. Part of the reason is that every patient who bounces back is different, and figuring out which variable led to the readmission is difficult. "We study it, and it seems like everything we do is more complex than we thought initially."

Currently, there is a bundle that is considered standard of care, based on Institute of Healthcare Improvement suggestions. This bundle includes doing a risk assessment for readmission and flagging the charts of patients considered at risk; providing education for patient and care provider; providing a medication reconciliation and consultation; ensuring a follow-up appointment within a specified time; and providing discharge instructions and a summary to the patient and next provider.

"It's not rocket science, but it is different than what we did before, and there are barriers to it at every turn," Anctil says. She is trying to implement this system in five hospitals, including two community hospitals and one medical-group based hospital. "I don't have the same control

at the community hospitals I do with the staff model hospital," Anctil says.

It has been particularly difficult to ensure that patients have a timely follow-up appointment with their community care provider. "There are four drivers to that: the hospital processes to facilitate the appointment and information flow, physician issues, patient/family issues, and financial issues," says Anctil.

Concerning the first reason, there was no place in the record to capture who the primary care provider is, nor was there an obvious place to flag patients who were deemed by assessment to be at higher risk for readmission, she says. Those omissions meant that high-risk patients either weren't having appointments made because no one knew who to call or because someone didn't realize they were at high risk. There also was an issue of ensuring a physician was available to see the patient in three to five days, Anctil says. If an appointment is made, how do you ensure that all the documentation — which in the past might have taken a week or more for a physician to complete — is done within the time period and delivered to the primary care physician?

"In the regulatory world, they have 30 days to proof and sign their notes," Anctil says. "Now we are telling them to do that on the day of discharge and to make sure that it includes information on pending test results and how the attending physician thinks the primary care doctor should proceed."

What happens if the appointment isn't kept? Who is supposed to follow up: the physician or the case manager? "We told them that until the handoff to the primary care physician is successful, they still have ownership of the patient," Anctil says. Not all the physicians agree. "Most would agree it's a good idea, but putting systems in place is hard," Anctil says. "What do we expect them to do? Drag the patient in?"

Furthermore, each of these items is variable depending on the physician, the patient, the patient's support network, and insurance. In the latter category, Anctil notes that some might provide an outpatient case manager, and some might not. "You have to get buy in, you have to know if they have transportation and whether they have money to pay the copay for their doctor," she says.

All of these areas of conflict and trouble have plagued Anctil's efforts to reduce readmission rates. But they keep plugging away.

They are asking every patient who is readmitted within 30 days of discharge why they think they were readmitted and what they might have done differently to avoid it. Often, the reason is medication-related. *(For a related story about readmissions, see story, below.)* "Patients won't take them, or they have a generic at home and a name brand here, and when they get home they take both, which is a double dose of something," Anctil says. "We have to spend a lot more time educating patients now. We ask them what their goals are. If they are on 15 medications, they might say they want to only take two, because that's all they can afford."

While the patient decision is based on money, that decision might not be the best one for their health. If they will only take two medications, it's better that a provider determine the two most important medications to take.

SOURCE

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Profiling groups with chronic readmissions

Beth Anctil, RN, MSN, director for Care Coordination at Henry Ford Health System in Detroit, has taken a page from an article she read last year in *The New Yorker* that talked about hot spots: how a group of people who were falling and being readmitted to a hospital in Camden, NJ, all came from a single apartment building.

Thinking of the readmissions as some sort of cohesive group — hot spotters rather than frequent fliers — is allowing Anctil to better profile the group. She knows, for example, that a third of them have end-stage renal disease; two-thirds have some sort of addiction issue or mental health problem.

"That's only 92 patients last year who had six or more readmissions within 30 days, and probably more besides that. Those patients were responsible for over 2,000 admissions last year. And for all I know, they are at another hospital if they aren't here," says Anctil.

Even among that group of patients, only 4%

are uninsured. "Our efforts with them will focus on end-stage renal disease, which should hit a third of the patients." One finding that research has shown is that some of those patients aren't receiving their full dialysis. They leave early or come late, dependent on someone else to drive them and at the mercy of that driver's imperative to be somewhere else. "We are actually working on a checklist to capture the reasons for under-dialysis," Anctil says.

They have also found a problem with how well they communicate dry weight changes to the dialysis center, she says. "We have a cross functional team now that is looking at solutions," Anctil says. On the table is mentoring and starting a primary care clinic in the dialysis center so that comorbidities can be addressed while the audience is captive.

The initial bundle includes a home care visit paid for by Henry Ford if the patient doesn't have insurance to cover it. "The reality is we have to be frugal, so I don't know that we will need a social worker at the dialysis center, and a mentor, and a home care visit. But I don't know which will work. We'll be able to evaluate some of it by looking at compliance and measures of other health status," says Anctil.

Shortly, Anctil says they will begin following a group of patients from home to dialysis — some who are compliant and some who are not. Patients on home dialysis will be monitored, too, so that they can see if those patients have something to teach about end-stage renal patients who can't stay out of the hospital.

As for that bump in the middle? Anctil knows something isn't working there, either. Part of the problem is that not all aspects of that five-pronged bundle have been implemented consistently, she says. "We want to flag those high-risk patients, but we couldn't find a good place to do it. On the chart? Where on the chart? On the board?" Anctil says that there are pockets of providers who do this well and always have, but others don't. The only thing that can be done according to Anctil is track it and publicly show who is doing well and who isn't. "We'll make it competitive, hospital to hospital. We'll tell Henry Ford Hospital that someone else is doing it better and they'll figure out a way to get it done."

They are also doing additional disease education in the hospital, and then doing it again post-discharge, she says. "It is the same education in all settings." A pharmacy consultation and home health referral also are provided, and if the home care visit isn't covered, Henry Ford will pay for at least one visit. "It costs less than a readmission," says Anctil.

RESOURCE

• **Gawande A**. The hot spotters. *The New Yorker*, Jan. 24, 2011. Web: http://nyr.kr/H3KSVD. ■

Higher hospital spending linked to lower mortality

Higher hospital spending was associated with better survival, lower readmission rates, and better quality of care for heart attack, heart failure, hip fracture, and colon cancer patients in Ontario, Canada, according to a study[1] published in the *Journal of the American Medical Association* (JAMA).

"This study shows that in Ontario, a province with global hospital budgets and fewer specialized healthcare resources than the United States, outcomes following an acute hospitalization are positively associated with higher hospital spending intensity," the authors conclude. "Higher spending intensity, in turn, is associated with greater use of specialists, better patient care and more use of advanced procedures. These results suggest that it is critical to understand not simply how much money is spent, but whether it is spent on effective procedures and services."

REFERENCE

1. Stukel T, Fisher E, Alter D, et al. Association of hospital spending intensity with mortality and readmission rates in Ontario hospitals. *JAMA* 2012; 307:1037-1045. ■

Race and neighborhood linked with chronic pain

University of Michigan Health System study shows unequal burden among the 116 million adults who suffer chronic pain

The study was led by pain medicine specialist **Carmen Green**, MD, a pain medicine expert at the U-M Health System, Green suggests doctors might need to be more aware of a patient's life circumstances and resources when treating their

chronic pain.

Living in a poor neighborhood was linked with worse chronic pain for young adults, according to a study[1] by the University of Michigan (U-M) Health System, but young black patients faced difficulties with pain management no matter where they lived.

With the study, the University of Michigan researchers have opened a new frontier in addressing chronic pain in America. The results were published in a recent issue of *The Journal of Pain* and showed where a patient lives, its structural barriers, affluence, and access to resources such as pain medicines play an important role in pain management.

"Acknowledging the patient's life circumstances and resources may facilitate physician-patient communication, increase adherence, improve health care effectiveness and efficiency, and improve the patient's health and well-being," says Green.

The study included 3,730 adults, all under age 50, and was designed to examine the association between race and neighborhood socioeconomic status in young black and white adults with chronic pain. Living in a lower socioeconomic neighborhood was associated with increased sensory, affective and other pain, pain-related disability and mood disorders such as depression and anxiety, according to the study.

But blacks, especially young adults, had significantly more pain and disability whether in lower or higher socioeconomic neighborhoods, the study showed.

"Our results provide support for race as well as neighborhood socioeconomic status influencing the pain experience, but further suggests that better socioeconomic status is not protective for young blacks in the same way it is for young whites," says Green. "Our findings show an unequal burden of pain in blacks and among those living in poor neighborhoods among the 116 million adults who experience chronic pain. As the U.S. increasingly diversifies, and the prevalence of pain increases, it is critically important to examine health disparities due to pain in vulnerable populations."

REFERENCE

1. Green C, Johnson T. The association between race and neighborhood. Socioeconomic status in younger black and white adults with chronic pain. *J Pain* 2012; 13:176-186. ■

GUEST COLUMN

Cultural competence enhances outcomes

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Many factors come together to affect a patient's attitudes toward healthcare and ability to adhere to a regime of self-care. Among them are cultural issues, from religious beliefs to socioeconomic status and health literacy. For the professional case manager, developing "cultural competence" and "cultural sensitivity" enhances case management practice and ensures the attainment of desired outcomes, including clinical, financial, and patient satisfaction.

Cultural competence can be defined as having specific cognitive and effective skills that are essential to building culturally relevant relationships. In the hospital or other acute-care setting, cultural competence is critical, and its importance has been recognized by the Joint Commission.

Professional case managers, particularly those who are board certified, can enhance the ability of a hospital or other healthcare organization to deliver culturally competent

care to patients. The Commission for Case Manager Certification (CCMC), the first and largest nationally accredited organization that certifies case managers, requires all board-certified case managers to adhere to a Professional Code of Conduct, which sets a high standard for delivering patient-centered care. Among the specific principles in the code is the requirement that "certificants will respect the rights and inherent dignity of all their clients," which speaks to cultural competence.

Some cultural aspects, such as certain religious practices, might be common to a particular group. Others are far more individual and reflect a person's cultural identity and upbringing. Thus, the professional case manager cannot make blanket assumptions that all patients who appear to have a particular cultural attribute will think or act in a certain way. Such assumptions reinforce stereotypes that undermine the relationship between case manager and patient, which always must be based in advocacy.

Thus, for professional case managers, the goal of being culturally competent and culturally sensitive requires compassion, open-mindedness, and self-awareness about their own attitudes and beliefs. A culturally sensitive case manager recognizes the importance of cultural assessment as a tool to gain insight about patient values and cultural differences to achieve effective outcomes.

Patient attitudes and cultural influences can only be determined through one-on-one contact with a professional case manager who is attuned to cues about how a person's beliefs and perspectives influence decisions and behaviors around healthcare. Using techniques such as "motivational interviewing," the case manager can ask open-ended questions to encourage two-way communication, establish rapport, and uncover patient attitudes and behaviors. For example, case managers may ask: "What are your goals for improving your health and wellness?" The patient's reply might reveal a willingness to engage in prevention, or a belief that going to the doctor should happen only when a person is sick.

Supporting the patient on a journey toward improved health and wellness requires a holistic, patient approach, addressing not only clinical factors, but also those human elements such as cultural influences. By becoming more culturally sensitive and aware, professional case managers elevate their advocacy, contribute to the healthcare organization's patient support and services, and, ultimately, empower individuals to make their own health and wellness a priority. ■

COMING IN FUTURE MONTHS

- Keeping elderly patients safe in the community.
- Case management opportunities in the Veterans Administration.
- How case management increases adherence in people with HIV.
- Ways your peers are reducing hospital readmissions.

CNE QUESTIONS

1. How often do patients in Geisinger Health System's interactive voice response system program receive automated phone calls?
   A. Every day
   B. Once a week
   C. Twice a week
   D. It depends on their condition

2. How often do heart failure patients being followed by a remote monitoring system come into Billings Clinic?
   A. Once a week for two months
   B. Once a year
   C. Twice a year
   D. Once a month

3. When Bayada Home Health installs remote monitoring equipment such as digital scales in the homes of clients with chronic diseases, how long does the equipment typically remain?
   A. 60 days
   B. 30 days
   C. One year
   D. Indefinitely

4. What kind of patients are included in MetroHealth System's Partners in Care program?
   A. Uninsured
   B. Patients who have been hospitalized
   C. Patients with chronic diseases
   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. ■