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Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Telephone calls, home visits help members avoid preterm births

Program saves $2.80 for every $1 spent

A combination of telephonic case management and home visits has helped Optima Health decrease preterm births and low-birth-weight infants.

Optima Health estimates that it has saved $2.80 for every dollar spent on its award-winning Partners in Pregnancy program and has avoided nearly 3,000 days in the neonatal intensive care unit since the program began in 2002.

Optima Health, the health plan division of Norfolk, VA-based Sentara Healthcare, established the program to promote healthy pregnancies and reduce premature births for both its Medicaid and commercially insured populations.

The high-risk population includes both Medicaid and commercial members, often for different reasons, says **Karen Bray**, PhD, RN, CDE, vice president, clinical care services.

EXECUTIVE SUMMARY

Healthy pregnancies mean healthy babies and health care savings

Faced with increasing numbers of preterm births and rising costs for neonatal care, health plans across the country have launched initiatives to help pregnant women stay healthy and carry their babies to term.

According to the March of Dimes, the national rates of preterm births have increased more than 30% since 1981 to more than 400,000. The direct cost of care to employers for a preterm baby averages $41,610 compared to $2,830 for a healthy full-term delivery.

More than 1,300 preterm infants are born every day, according to the Centers for Disease Control and Prevention. The agency estimates the cost of preterm births at $5 billion annually.

In this issue, you'll get the details about initiatives implemented to combat these obstacles.

"The Medicaid members often have financial and social issues. In our area, we have a renowned in vitro fertilization program and we are managing the care of a number of older women in the commercial population who are carrying multiple babies," she adds.

The health plan partners with Virginia's Comprehensive Health Investment Project (CHIP) to conduct home visits to assess the needs of hard-to-reach members and to follow them through the pregnancy if needed.

The majority of members in the program are identified when their physicians send in authorization forms for obstetrical services. Members can self-refer or physicians can directly refer them. In addition, the health plan scans its claims database regularly to identify members who have had positive pregnancy tests.

'We rarely miss a pregnancy'

"We rarely miss a pregnancy," Bray says.

As soon as the plan identifies a member who is pregnant, the information is automatically transmitted to the Partners in Pregnancy team.

Women who are likely to be at risk for problems during the pregnancy, such as very young women, older women, and women with a history of problems in pregnancy, automatically are assigned to a case manager who calls them and conducts a detailed risk assessment over the telephone. Low-risk pregnant members are assigned to patient service coordinators, who contact the member, conduct the risk assessment, and determine whether the woman should be referred to a case manager.

The patient service coordinators and case managers make monthly telephone calls to the women throughout the pregnancy, talking to them about how things are going, and conduct serial risk assessments to screen the members for problems with the pregnancy.

"The patient service coordinators and case managers can increase the frequency of the telephone calls if the members request it or if they feel the member would benefit," Bray says.

When the case managers or patient service coordinator can't get in touch with a pregnant woman who lives in an area with a high incidence of low-birth-weight babies, Optima calls on its community partner, CHIP, to locate the members and conduct a risk assessment. If the member is at high risk for complications of pregnancy, CHIP continues to provide home visits by nurses and other outreach workers, if appropriate.

Contracting with home health

In areas where there are no CHIP programs, Optima contracts with home health agencies to provide specific services. The case managers can also call on CHIP if they have concerns about the situation in a pregnant member's home.

"In these cases, the case manager feels that a more thorough evaluation of the home situation may help to determine the risk level," she says.

CHIP lay workers and nurses who visit the home evaluate the home condition, family's financial and social issues, and the stress level of the

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Editorial Questions

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mother-to-be. "We know that stress seems to be a factor in low-birth-weight infants. Some of these members are at risk of losing their home or have terrible family problems. We get them in touch with community social services and have gone so far as to intercede with landlords who were trying to evict a family," Bray says.

CHIP services include transporting women to medical appointments, connecting them with substance abuse programs, teaching them how to care for their infants, and connecting them to social services agencies that can provide assistance.

The case managers follow the members throughout their pregnancy, making sure they receive the standards of care, such as regularly seeing the physician. They help the women manage any complications or comorbidities, such as gestational diabetes or hypertension, and educate them about community services that are available if appropriate.

For instance, poor dental health can adversely affect a pregnancy. "Many women don't realize that the condition of their teeth can affect their baby. We send them toothbrushes and toothpaste and refer them to a dental provider if needed," she says.

The health plan sends out regular packets to the mothers with information about pregnancy and a small gift. For instance, the stress management packet includes information about how to deal with stress and a bottle of lotion. T-shirts, water bottles, diaper bags, and a book about their baby's milestones are other gifts that the members receive as long as they are in the program and talk regularly to the case manager or patient service coordinators.

The Partners in Pregnancy program has won numerous awards including a national award from the Disease Management Association of America. ■

CM program keeps preterm delivery rate low

Doulas pitch in when moms-to-be need extra help

A program that targets women at risk for premature deliveries for case management has paid off for ConnectiCare, a regional HMO based in Farmington, CT.

ConnectiCare's preterm delivery rate (babies born before 37 weeks) ranges from 7.8% to 6.5% compared to national rates of 11.3% to 12.7%.

In 2006, ConnectiCare's low-birth-weight rate (less than 5.5 pounds) was 6.8% compared to a national average of 8.2%.

"It's hard to compare our statistics year by year because every nine months, there's a whole new set of people with a whole new set of risk factors. One year, we may have a preponderance of women with preterm deliveries and the next year, a large number of multiple births," **Maggie Perracchio**, RN, program manager and nurse case manager for the ConnectiCare's Birth Expectations program.

The program was developed in 1995 to help women identify signs and symptoms of preterm labor, the primary cause of preterm births.

Women identified in risk assessment

Women are identified through a risk assessment form that asks for medical history, including chronic conditions, such as hypertension and diabetes that may put them at risk for a preterm delivery. Other risk factors include an incompetent cervix, a history of preterm births, or multiple births.

When physician offices precertify pregnant women with ConnectiCare, the health plan mails the members a risk assessment to fill out and return.

"Many of the physicians fill out the risk assessment and they alert us when there are risk factors so we don't have to wait for the member to return the assessment," Maggie Perracchio says.

If a woman hasn't returned the survey by the time she's 23 weeks pregnant, ConnectiCare sends another survey. And the health plans sends another survey to pregnant members at 23 weeks to find out if anything has changed.

"Sometimes someone might find out later in the pregnancy they are carrying twins or that they are having issues with their cervix that could put them at risk for a preterm delivery," she says.

In 2006, the health pan completed a risk assessment on 91% of all women precertified for maternity benefits.

Once a member is identified as having a risk factor for a preterm delivery, Perracchio makes an outreach call.

"My goal is to educate them regarding what to expect, what to watch for, and what to report to their physician. I can't prevent anyone from going into preterm labor but I can educate women with potential risks about the early signs and encourage

them to seek medical care," she says.

When a physician determines that a woman needs to be on complete bed rest in order to have a full-term delivery, the health plan may offer the services of a doula if the woman has small children at home or otherwise needs extra help.

Doulas provide physical and emotional support to women before and after childbirth. ConnectiCare contracts with a doula service to provide doulas for a certain number of hours a day, depending on the needs of the mother.

"If a woman is the primary caregiver of a toddler, there's no way she can stay in bed. We live such fragmented lives that we don't have support from mothers or sisters who live nearby like we used to. That's where the doulas come into play," Perracchio says.

"We want to make sure our pregnant members have the physical and emotional support they need to have a healthy pregnancy with a good outcome," Perracchio adds.

The frequency with which Perracchio calls the members depends on what the women need. Some members in the program don't need much reinforcement. Others need to be called frequently, she adds.

She advises them on the importance of nutrition and healthful habits and encourages the diabetic members to follow their diet and take their medications in order to avoid being hospitalized for complications of pregnancy.

"My job is to make sure they know what symptoms to look for that may be a sign of problems and when they should call their physician. Women are sometimes reluctant to bother their doctor but I tell them it's better to find out they're OK than to wait until they have to be hospitalized," she says.

At 22 weeks

When the women in the program are 22 weeks along in their pregnancy, Perracchio may increase the frequency of contact, depending on what is happening with the member and the pregnancy.

"Sometimes I follow up to talk about the results of their last appointment. Sometimes when we are talking they'll bring up something that happened and I may tell them to ask the doctor or at the next visit or to call right away," she says.

The plan also covers post-partum doulas as part of its early-discharge program. If members opt to stay in the hospital for a shorter period of time than their coverage will pay for, ConnectiCare will provide a doula to help out with the children, prepare meals, do grocery shopping, or take care of other household tasks so that the mom can rest and take care of the baby.

"Some women like to leave the hospital early when they can have additional support at home," she says.

The post-partum doula program is available to all pregnant members, not just those at risk for complications of pregnancy. Members call ConnectiCare to sign up for the benefit.

"We don't do outreach for this program. All pregnant members get mailings during the course of the pregnancy with information about all the services available to them. This program is not limited to members in case management," Perracchio says. ■

Programs follow moms through pregnancy, NICU

Case management is program's strongest component

Two programs at Passport Health Plan help pregnant Medicaid recipients overcome the obstacles to a healthy pregnancy and follow preterm infants through the neonatal intensive care unit and back home.

Passport Health Plan is a Medicaid health plan, serving 140,000 people in 16 counties in the Louisville, KY, area. The plan is sponsored by the University of Louisville, local hospitals, and traditional safety net providers. AmeriHealth Mercy Health Plan of Philadelphia administers its programs.

The Mommy and Me Program aims to improve the prenatal care and infant and maternal health of members. The Tiny Tots Transition Program helps promote a smooth transition to home for newborns with serious health conditions, according to **Theresa Watson**, RN, BSN, manager of health management for the health plan.

The health plan also partners with community agencies to sponsor events to promote healthy pregnancies.

Passport Health Plan stratifies the approximately 7,000 pregnant women it serves each year into three risk levels. Depending on their level of risk, members' care during the pregnancy is managed by a non-clinical outreach staff member or a

nurse case manager.

Women eligible for the program are identified when their physician offices contact the plan to get global authorization for prenatal services, through community agencies, and by self-referral. New members, who become eligible for Medicaid by becoming pregnant, are identified through their new member information form.

Three risk levels

Members who fall into Level 1 are at low risk and receive a basic education packet and a book about healthy pregnancies and what to expect. A Passport outreach staff member calls the Level 1 members, conducts a basic assessment, and educates them about community resources, such as the Women Infants and Children's program (WIC). They educate the women on the importance of making regular visits to their physician and attending prenatal classes.

"If there are any indications that the woman is having any difficulties with her pregnancy, she is referred to a nurse," Watson says.

Members who have some medical problems that may interfere with the pregnancy, such as urinary tract infections, anemia, uncontrolled asthma, and chronic hypertension are stratified to Level 2 and are monitored by a nurse case manager. Young women who will be younger than 15 when they give birth also are placed on Level 2.

Level 2S members smoke but otherwise have few risk factors. They receive outreach calls from a non-clinician who directs them to a smoking cessation program.

Members at highest risk are those who have had a previous poor birth outcome or who have one or more risk factors for possible poor outcomes for mother or baby. They are stratified to Level 3 and receive intensive monitoring and assistance from nurse case managers.

Level 1 and Level 2S members typically receive an initial phone call when they are enrolled in the program and another between 20 and 24 weeks, during which the outreach staff member educates them on what to expect during the delivery. The nurse or outreach staff member will discuss symptoms of preterm labor, which may occur at that point in pregnancy.

Level 2 and Level 3 members receive regular telephone calls throughout their pregnancy, depending on their needs.

When appropriate, the Passport nurse case managers may go with the members to doctors appointments or send a home health nurse into the home if they need follow-up care, such as blood pressure monitoring.

When a woman has been hospitalized before delivery, the case manager may refer her to the local departments of health in Kentucky for follow-up education in the home. Health department personnel will address warning signs of early labor or recommend a special diet for women with severe hypermesis (uncontrolled vomiting).

"Our nurses work with the members' physicians to ensure that the pregnant women get everything they need. The nurses we have on staff cannot provide the medical care but we join forces with home health agencies or the department of health to assist with the clinical piece," says **Helen Homberger**, RN, director medical management and Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

Members in levels 2 and 3 receive phone calls at least once a month and can call the nurse directly if they have a problem or call the health plan's 24-7 nurse plan if it's after business hours.

"In the beginning, these members may need telephone follow-up as frequently as twice a week. When they call into the 24-7 nurse line, their case manager is alerted so she can follow up," Watson says.

CMs monitor babies in the NICU

When infants end up in the neonatal ICU, their care is managed by two hospital-based Tiny Tot Transition program nurse case managers, who work with the hospital NICU staff and case managers to ensure a smooth transition to home.

The nurses are assigned to Norton Kosair Children's Hospital in Louisville, where the majority of babies are treated. Each of the nurses also is assigned one other hospital with a Level 3 neonatal intensive care unit.

"It's a hybrid program. The nurses do both utilization management and case management. They are in the hospital, monitoring the baby's progress every day, reviewing the records, and working with the family as they progress toward discharge," Homberger says.

Case management is the strongest component of the program, she adds.

"When we studied the length of stay for our NICU population, we did a chart review and determined that it was critical to engage the baby's caregiver in the educational process early

in the admission. What we thought would be a utilization program became a care coordination model," Homberger says.

The case managers actively work to get the caregivers into the facility and train on how to take care of the tiny infants. They work with the family, calling in community agencies when needed, to ensure that the family has everything they need for a safe discharge, including a place to live, water, and electricity.

"These mothers have a lot of barriers to overcome. They have transportation issues, other children in the home, and many of them work and don't get paid if they take time off to come to the hospital. We work through those barriers to help them come to the hospital and learn to take care of the infant when they are home," Watson says.

The case managers address the mothers' concerns, help them get the supplies they need such as baby beds, make sure they have the durable medical equipment they will need to monitor and care for the baby at home. They help with enrollment in WIC and other programs that can assist them.

Choosing a primary care provider

"We work with them to pick a primary care provider for their infant and set a follow-up appointment before the baby is discharged. We monitor whether or not they kept the appointment and if they didn't set up another appointment for them. We'd like for them to have a follow-up visit within a week after discharge," Watson says.

About 97% of the members in the program reach the health plan's goal of having their infant seen by a primary care physician no more than 30 days after discharge. The other 3% took their baby for a follow-up visit but it was after 30 days.

Through the Tiny Tots program, Passport Health Plan has reduced readmission rates for these tiny babies by 30%, from a 10% readmission rate in 2001 to a 7% readmission rate in 2006.

"One of the things we have not been able to impact with the program is the rate of emergency room visits. This is an understandable factor with tiny babies and first-time moms. They're dealing with a new situation and a child on multiple types of equipment and medications. Although the ER visits haven't decreased, they have remained stable," Homberger says.

Passport Health Plan has collaborated with community agencies to sponsor regular events to educate pregnant women on how to have a healthy pregnancy.

The plan sponsors monthly "baby showers" at county community mental health centers in collaboration with the Seven Counties Community Mental Health System and the Kentucky Department of Health. The parties, funded in part by Kentucky's tobacco settlement money, include lunch, gifts for the moms, and an educational segment on tobacco use.

The Mother's Day Out program, held at a larger venue in collaboration with the Department of Health, includes lunch, gifts, fun activities, a massage therapist, a manicurist, and a speaker who educates the women about drugs and alcohol. The program also addresses domestic violence and EPSDT for children.

"The program is open to any women served by these agencies. Not all of the women who attend the programs are Passport Health Plan members. However, our goal is to support healthy pregnancies throughout the community. We are aware an adverse event during pregnancy can result in an adverse birth outcome and an infant may need multiple medical services for many years. These infants may be our future members and we want to promote health pregnancies and healthy babies," Homberger says. ■

Court decides if EMTALA should apply to inpatients

Issue likely to come up again, says Frew

A 2003 Center for Medicare & Medicaid Services (CMS) regulation that interpreted EMTALA not to apply to inpatients does not have the "force and effect of law," according to a recent decision by a U.S. District Court in Puerto Rico.

The court ruled that a mother could continue with her suit alleging that Hospital San Pablo del Este (HSPE) transferred her newborn child without providing stabilizing care while the infant was in a profoundly unstable condition.

The judicial finding that the regulation is only an interpretation has the potential to bring up the issue on appeal in this or other cases, and perhaps ultimately return the Emergency Medical Treatment and Labor Act to the Supreme Court for further clarification, says **Stephen A. Frew**, JD, a web site publisher and risk management specialist (www.medlaw.com).

The mother gave birth by Caesarean section at the HSPE and the infant originally was taken to the hospital's newborn unit, according to a summary of the case. The child developed emergency conditions, including upper gastrointestinal bleeding, and was vomiting blood, the court opinion stated.

The following day, the physician at HSPE ordered the infant transferred to Hospital Interamericano de Medicina Avanzada, where the child was described on arrival as being "critically ill." Medical records showed that the infant left HSPE "totally unstable … with active upper gastrointestinal bleeding," the court noted. The child died two days later.

The hospital moved to dismiss the case on the grounds that under the 2003 CMS regulation, it was not bound by the stabilization and transfer rules of EMTALA because the infant was an inpatient.

The court ruled that the 1998 *Lopez-Soto v Jose Hawayek* case had held previously that EMTALA did apply in almost identical circumstances, and emphasized that EMTALA's clear language is not limited to hospital emergency departments. The Lopez-Soto case is the only significant court of appeals case to interpret the Supreme Court ruling on EMTALA in the 1999 *Roberts v Galen* case.

The judge refused to throw out the case because of the CMS interpretation not being binding on the court, and stated that it would not apply in any case because the interpretation was issued after the child's death. The court noted that retroactive applications are not favored by law.

The decision allows the mother to proceed to trial, but she still must prove her allegations and that the conduct did violate EMTALA. Further appeal of the ruling is not likely to be allowed until a final verdict has been rendered in the case, Frew said.

"The original Roberts court clearly felt that EMTALA was not affected by what door the patient entered or what the patient's status in the hospital was, and applied it to an inpatient discharge situation," he notes.

"The interpretation that EMTALA sections are to be read separately is also critical to the building debate over whether the CMS interpretation that 'EMTALA does not apply to inpatients' alters the requirements for hospitals with specialized capabilities to accept transfers under EMTALA," Frew adds.

Specialty units, transfers explained

In other EMTALA-related comments made in answer to a query he received, Frew goes on to emphasize that — despite what some providers assume — whether hospitals have a specialty unit has nothing to do with whether they have to accept EMTALA transfers.

"If you have the specialists or special equipment, you have to accept," he adds. Frew cites a ruling in the *St. Anthony v U.S. Department of Health and Human Services* case, which states in part, "The act does not define precisely the term 'specialized capabilities or facilities.' Section 1867(g) provides examples of the types of capabilities or facilities that are considered to be specialized: 'burn units, shock trauma units, neonatal intensive care units, or regional referral centers.' But, it neither states nor suggests that such capabilities or facilities are limited to those examples."

The ruling concludes that Congress did not intend the term "specialized capabilities or facilities" to be interpreted narrowly or limited to the examples stated in the act.

Rather, it states, the term is intended to encompass those capabilities and facilities that enable a hospital to offer specialized care that is not offered by hospitals that are less well-endowed.

In response to a question Frew received regarding physicians who maintain that "they are the specialists and will decide when, how, and if a patient will be transferred — not the [sending physician]," he says:

"Wrong again. EMTALA rules state that the responsibility for deciding if, when, where, and how belongs to the *sending* physician, because he or she is signing the certification." The receiving hospital and its physicians, Frew continues, can turn down a patient if the following conditions apply:

- The patient is not an EMTALA patient in need of a higher level of care.
- It is a patient-initiated transfer, rather than a transfer for need.
- The hospital lacked the capability or capacity to care for the patient.

Even if it turns out the sending physician was wrong, the receiving hospital or physician likely will still be cited for turning down the request, he adds. "The first physician will just get cited for his errors along with you for yours." ■

Promoting patient ed vital to keep it at the forefront

Promotional methods must be uniquely tailored

Patient education must be promoted so clinicians will understand how to effectively teach patients and use the resources available to them to do a good job. Yet without support from leadership, patient education initiatives often falter.

"Many of the initiatives that are patient education-related need staff support to enact the principles, concepts, or ideas, and administrative support is needed to remove barriers to organizational wide acceptance and to enforce it," says **Susan M. Kanack**, BSN, RN, the patient education coordinator for ProHealth Care, Center for Learning & Innovation, Patient & Family Resource Center at Oconomowoc Memorial Hospital in Waukesha, WI.

When staff and administrators buy in to patient education, it leads to a more cohesive approach that ultimately impacts the patient, she adds.

Patients have the right to receive information about how to take care of themselves once they are discharged, says **BJ Wingert**, RN, BSN, MS, a patient education specialist at OhioHealth in Columbus, OH. One of the biggest challenges is to get staff to use the resources available for patient education and to provide patients with information to reference at home.

"I think teaching takes place but because recall is difficult when people are sick, they need something to take home to refer to at a later date," says Wingert.

Good patient education helps patients and family members feel more comfortable and less stressed, says **Carol Klingbeil**, RN, MS, CPNP, a clinical nurse specialist for education at Children's Hospital and Health Systems of Wisconsin in Milwaukee.

In addition, if patient education is not completed and documented, misunderstandings can occur and patients might not comply with self-care instructions, medication regimens, or necessary lifestyle changes.

Documenting patient education as a part of the daily work routine helps explain how staff spend time, says Klingbeil. "People think you can do much more or take care of more patients when you are not really able to account for how much time you spend interacting and educating families," she states.

To help staff and leadership realize the importance of patient education and understand what constitutes best practices, patient education managers need to determine what points they want to get across and the best methods for delivering the message.

Pinpoint a strategy

When many changes and improvements are necessary, it is best to begin with something non-threatening, says Kanack. She chose health literacy and set about educating staff on the statistics of low health literacy and concepts of clear language. Soon they began to notice that many of the materials they used were at a 10th grade reading level.

"The organization began to ask for solutions, and then I knew they were ready to hear what we needed to change," says Kanack.

She delivered the message on health literacy in a presentation format at leadership meetings and sometimes one-on-one. She offered to do in-services as well and used health literacy month to highlight the information.

Kanack says she also quickly learned that linking patient education to the organization's strategic goals helps it gain acceptance as well as importance.

For example, due to the fact that ProHealth Care is a multi-hospital, multi-clinic health care system, a strategic goal was to have what leadership called more "systemness."

"I explained that we wanted to function as a system and integrate our services so if we moved toward a system approach with patient education it would help meet our goal," says Kanack.

Taking part in committees within a health care organization gives patient education coordinators the opportunity to advocate for patient education, says Klingbeil. For example, when a new computerized system was being implemented Klingbeil asked how it would improve the distribution of teaching sheets.

According to Wingert, promoting patient education initiatives to staff requires a different strategy than that used to reach leadership.

For nursing and other staff who teach, the biggest challenge is to convince them that the initiative is worth their time, and saves time and money with fewer follow-up calls and readmissions.

With staff, if some sort of prompter such as a flow sheet can be incorporated to make the process simple it is more readily embraced, says Wingert.

It is important to tell staff about patient education initiatives and resources once, then keep reminding them. Wingert finds newsletters helpful. "Often in our monthly newsletter, we focus on something that might not be brand new but is a resource we want to keep on the forefront," she says.

Leadership has a different mindset and will be more supportive of patient education initiatives that are linked to patient satisfaction surveys, key admissions, standards set by accreditation agencies such as The Joint Commission, or key focus areas such as patient safety. Now that The Joint Commission has focused on low health literacy, leadership is sending Wingert articles on the topic, even though she has been talking about it for many years.

Penny Morgan Overgaard, RN, manager of the Trach & Airway Program at Phoenix (AZ) Children's Hospital agrees that strategies to promote patient education are not the same for leadership and staff.

For administrators to appreciate patient education initiatives, link them to outcomes the healthcare organization is trying to achieve, advises Overgaard.

For example, patient satisfaction scores are important to administrators because they bring business to the health care facility. It's not just patients that need to be satisfied but insurance companies as well, for they will want to place their patients at a hospital with good education as that equates to fewer readmissions.

"In this day and age when health care dollars are hard to come by, it is not enough to say this is the right thing to do. You have to be able to follow that dollar into outcomes," says Overgaard.

Currently, the patient education committee at Phoenix Children's Hospital is focusing on educating patients, family members, and staff on follow-up because the survey score in this area was declining. Patients need to know who to call if there is a problem and when to call. Also staff need to make sure patients have this information upon discharge, says Overgaard.

"Frequently, in patient education, people think teaching someone how to do a skill is the education they will need to go home with. But the truth is the most important thing you can teach might not be the skill but to problem solve," says Overgaard. ■

'Discharge by appointment' taking 'hard-wiring'

'Patients really like it,' director says

A "discharge by appointment" initiative at St. Joseph's Medical Center in Towson, MD, has had some success, but is being challenged by physician delays and families who aren't arriving on time.

"We're finding that some weeks are better than others," says **Jackie Connor**, RN, MS, CCS, director of case management. "We're working now to push up the number of patients scheduled. Our goal is 80% of the patients [in the project] will get a scheduled discharge date and time, but the most we've been able to achieve is about 50%."

Of those with scheduled dates and times of discharge, close to 80% were sent home on time, Connor notes. "We have to keep working with the physicians. The nursing staff is doing a great job, but many times, we are waiting for the physicians to arrive."

In addition, "the nursing staff is trying to be more proactive with patients and families," she says. "Another reason [for delays] is the family not getting here in a timely manner."

The idea was piloted in 2006 on the hospital's surgical unit and with interventional cardiology patients, and was expanded in early 2007 to include the patients of a large cardiology group and St. Joseph's hospitalists, Connor says. Initially, the project was to have expanded to all patients at that time, she adds.

"We decided just to expand on the cardiology unit, because to do it on seven units — with the follow-up and action planning — would have been very resource-intensive," Connor says.

It also was part of the original plan to identify a date and time of discharge within 24 hours of admission, she says, and there was a concern that the process would get confusing when the cardiology patients were transferred off that unit.

The project parameters were changed, Connor adds, when "we found that we were not successful in identifying candidates for successful discharge within 24 hours because the patient population was too complex."

"Patients came in and were here for a day or two or three being worked up," she explains. "We couldn't make a discharge plan when we didn't even have a primary diagnosis." Until that primary

diagnosis and the treatment for it were determined, Connor says, "it was too difficult to determine the discharge date."

In view of that, the decision was made to schedule discharge the day before it occurs, she says. "Every day, the nursing staff and case managers do rounds and identify patients we believe are most likely to be discharged the next day." The discharge is not actually scheduled until an agreement is reached with the physician, Connor says.

"Some of the processes are automated," she explains. "In order for the scheduled discharge appointment to be recognized by the physician and the ancillary departments, we have to communicate that time. Before the date and time can be put in to the system to alert the physicians and the ancillaries, there has to be agreement between the case manager or nurse and the physician."

Because the information is not entered until that agreement is made, Connor says, "if we see a date and time on the census reports that nurses use, the case management reports, or the physician roster, everybody can be assured" that the plan is set.

A small project team — made up of Connor, the nurse manager and case managers from the unit involved, a physician advisor, and one of the ancillary department managers — meets weekly to review data and decide what action steps to take, she says. Ten weeks into the project, Connor adds, "we are happy with the results achieved. We believe we've accomplished what a lot of hospitals have not."

Follow-up telephone calls to those whose discharges were scheduled indicate that "patients really like it," she says. "They can plan, and look forward to [the discharge date]. It's all about the planning."

While the process "requires a lot of oversight and hard-wiring," the payoff is worth it, Connor says. "We've decided to continue our focus."

(Editor's note: Jackie Connor can be reached at jackieconnor@catholichealth.net.) ■

Heart failure patients present challenges

Comorbidities, patient attitudes make care difficult

Patients with heart failure may be among the most challenging for case managers who are coordinating their care. Patients with heart failure must take multiple medications, eat a low-salt diet to keep their condition under control, and monitor their condition constantly. And even if they do everything right, they are likely to find themselves back in the hospital or emergency department several times a year.

"Heart failure has substantial quality-of-life implications for patients. It has a higher mortality rate than most cancers, and it's difficult to get patients to manage their condition because they think it's an episodic event and not a chronic disease," says **Jill Howie-Esquivel**, PhD, RN, FNP, associate clinical professor at the University of California-San Francisco School of Nursing.

It's also an expensive disease. The American Heart Association estimates that heart failure will cost $26.9 billion in direct and indirect costs in 2006 for the 5 million people with the condition. The organization estimates that about 500,000 patients are diagnosed with the condition every year. Heart failure deaths have doubled since 1979 and average 250,000 a year.

"Congestive heart failure is one of the largest admitting diagnoses to acute care hospitals. It's a diagnosis with a high mortality rate, and patients with heart failure consume a lot of health care resources, says **Pam Hagley**, RN, BSN, MSHA, ACN, director of clinical resources at New Hanover Regional Medical Center in Wilmington, NC.

A telephonic case management program for heart failure patients who have been discharged from the hospital has cut readmissions and reduced length of stay, Hagley says.

Many heart failure patients also suffer from depression, a condition that makes it difficult for them to manage their condition, points out Rick Precord, MSW, director of clinical care management at Health Alliance Plan (HAP) in Detroit.

HAP's case managers screen all their heart failure patients for depression and refer those who screen positive to the health plan's behavioral health specialists.

When Howie-Esquivel conducted a study of heart failure patients to determine what factors can be used to predict which patients would be readmitted to the hospital, she found that an astonishing 50% of the 72 patients she followed were readmitted within 90 days.

The average age of the patients was 61, and 50% were anemic upon admission and scored 3.25 on the New York Heart Association Classification for

Congestive Heart Failure, a four-point scale for classifying heart failure patients.

She looked at clinical factors and activities of daily living, such as how far the patient could walk in six minutes. Her studies showed that women and people who are not white are more likely to be hospitalized. "I was surprised to find that gender and ethnicity were stronger predictors of outcomes than hard clinical data," she says.

One factor may be that the women patients were more frail than the men. They couldn't walk as far, an indicator that they might have problems taking care of themselves at home, Howie-Esquivel says.

Another factor could be that many heart failure patients do not understand their disease. They don't understand that they have a chronic illness that won't ever go away.

"Patients don't understand that when they leave the hospital, they still have heart failure. They think it's like pneumonia. You have it and you're treated and then you're cured," says **Renee Slater**, RN, a case manager with New Hanover Medical Center's telephonic heart failure case management program.

Case managers should work to help heart failure patients understand that they must think about their disease every day, monitoring their sodium intake at every meal, weighing themselves every day, and calling their doctor if they gain weight, Howie-Esquivel says.

"Heart failure patients are notorious for having high rates of readmission around the holidays and in the winter months when they may be eating a lot of canned soups, gravies, and broths. Case managers should caution them to be particularly careful about their diets during the holidays," she says. Case managers should urge patients to write their weight down and to understand that gaining three pounds in a day or five pounds in a week is a signal that they are going to have problems, she adds.

"Case managers should remind patients that if it's harder to sleep at night or they're more short of breath, this could be an indication that they are getting in trouble and may need their diuretic dosage adjusted," she says. Get a sense of the patient's condition by asking them specific questions about activities of daily living, Howie-Esquivel suggests.

If you feel that a heart failure patient could benefit from exercise, talk to the physician about ordering an exercise program. "We know that exercise benefits patients with heart failure, but it's extraordinarily rare to find a heart failure patient involved in an exercise program. Being involved in an exercise program can't harm the patients, and it can help keep them out of the hospital," she says. ■

COMING IN FUTURE MONTHS

- Helping your clients cope with chronic pain
- How worksite programs promote better health
- Managing the care of members with complex needs
- Keeping elderly members safe and independent

CNE questions

21. According to Optima Health's **Karen Bray**, stress does not seem to be a factor in low-birth-weight infants.
    A. True
    B. False

22. Doulas provided by ConnectiCare assist mothers by:
    A. helping out with children
    B. taking care of household tasks
    C. grocery shopping
    D. all of the above

23. According to **Stephen Frew**, EMTALA's Section 1867(g) provides examples of the types of capabilities or facilities considered specialized. Which of these is in that category?
    A. burn units
    B. shock trauma units
    C. regional referral centers
    D. all fhe above

24. The American Heart Association estimated the cost of heart failure in direct and indirect costs in 2006 to be:
    A. $51.1 billion
    B. $70.4 billion
    C. $26.9 billion
    D. $46.5 billion

Answers: 21. B; 22. D; 23. D; 24. C.

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 those issues 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 by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with this issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■