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Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Avoid common ethics violations while keeping patients' best interests in mind

Put your feelings, monetary considerations aside

When it comes to being an effective, professional — and ethical — case manager, it all boils down to being a good advocate for your clients, **John Banja**, PhD, asserts.

The role of case managers is to advocate for their clients and to keep their best interests in mind, even if the client is difficult to deal with, or the case manager doesn't like him or her, or their boss wants them to do things another way, adds Banja, professor, department of rehabilitation medicine, medical ethicist, the Center for Ethics at Emory University in Atlanta.

Banja served on the Commission for Case Management Certification (CCMC) for six years and was a member of the ethics subcommittee for the commission. In the latter role, he reviewed ethics complaints about case managers received by the CCMC, many of which were in workers' compensation cases when a personal injury attorney was involved.

"In the majority of cases, the personal injury attorney came across material in the case management documentation and reports that would not reflect well on the professionalism of the case manager," he adds.

Banja emphasizes that the vast majority of case managers do not commit ethics violations.

"Overwhelmingly, case managers are good-hearted, well-educated professionals who advocate intensely for their patients, but there are about 100,000 people out there who call themselves case managers and not all of them are that careful, professional, and discreet," he adds.

Standards of Practice guiding principle

Case managers who are charged with ethics violations can face a reprimand, probation, suspension from CCM certification, or revocation of CCM certification.

But regardless of whether they have achieved CCM certification, case managers should keep the CCMC's Standards of Practice in mind as they go about their work, as guiding principles, Banja says.

"If a case manager is ever involved with a lawsuit, the CCMC standards would be where the court would look to determine ethical behavior for case managers," he points out.

The first responsibility of case managers is to advocate for their clients and it's when they forget about this that ethical violations often occur, Banja says.

In many of the ethics violation cases that came before the CCMC committee, the case managers were frustrated and discouraged from dealing with difficult clients and articulated their frustration in their reports, Banja says.

He cited hypothetical examples of cases that were similar to those that came before the commission: "The injured worker did not attend therapy because it was the first day of hunting season." Or, "The injured worker was clearly exaggerating his pain." Or, "The client's wife is obnoxious and argumentative."

Case managers should guard against letting their personal feelings and frustrations interfere with their objectivity when they write their reports. They especially shouldn't put anything in a written report that would be embarrassing if the client read it, Banja advises.

"Most of the time, nurses, doctors, and case managers are not going to have ethical dilemmas or problems if things go well," he says.

Patients who make case managers uncomfortable or anxious or who exhibit threatening or quirky behavior are the most challenging ones. Ethical lapses typically occur when the case manager has a difficult patient, treatment doesn't go well, or the patient and the case manager simply don't get along, Banja points out.

Objectivity compulsory

He advises case managers to maintain objectivity in their relationship with clients and to avoid imposing their own values on them. For instance, don't write in the record that the patient says he has financial problems but continues to buy cigarettes or to comment on the client's personal appearance, assuming it has no bearing on the client's care program.

"It's easy to be a good case manager with a patient you like and who likes you, who is compliant and the treatment plan works. When case managers are confronted with a client they don't like, they should be extra careful and extra reflective not to let their feelings interfere with doing their best for the patient," he says.

Notes to the payer, physician, or therapist that contain biased language can influence the opinion of the other clinician, Banja points out.

Ethical violations also occur when case managers overstep their authority and make determinations, such as medical necessity, that only a physician can make, Banja says. For instance, a case manager should not write, "I will not authorize an MRI; the client doesn't need one," or "Physical therapy is not indicated after this procedure."

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Editorial Questions

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"Experienced case managers have seen a lot of maladies, diseases, and disabilities and they may be totally right, but only physicians can determine medical necessity and case managers should not write anything in the record that indicates they are practicing outside the boundaries of their competence, training, and professional experience," he adds.

Case managers should be objective when they write their reports and keep in mind that the physician calls the shots on medical necessity. "Case managers may call the medical director's attention to certain things but they have to do it in a way that does not bias the mind of the person making medical necessity determination," he says.

When a case manager's actions are solely geared at trying to save his or her employer money but the patient reasonably needs the covered benefit, it's a flagrant violation of the standard of advocacy, Banja says.

"For instance, particularly egregious ethics violation occurs when a workers' compensation case manager steers a client to a particular physician because she knows that the physician will likely side with the payer in saying that the patient is ready to go back to work or doesn't need a particular treatment, whereas most other physicians would reasonably and loudly disagree," Banja says.

"Some physicians will almost write the treatment plan according to what the payer would like to pay. In these cases, the case manager is advocating for his or her boss, the payer, and not the patient. Ultimately, case management ethics is all about the advocacy," he says.

Constantly ask yourself if you are doing what you are doing for the sake of the patient or for other reasons. Don't let saving money for your employer interfere with your professionalism and patient advocacy, he advises.

Case managers should be scrupulous when it comes to disclosing or entering information on medical records so as not to violate HIPAA, Banja says.

When there is a request for medical records, the recipient should get only documentation that is relevant to the issue at hand and not the whole medical record.

Make sure you get the client's written permission to share confidential information to a third party.

Case managers have an ethical obligation to be as knowledgeable as they can be so they can identify and coordinate all the resources that their clients need.

"Continuing education is part of a case manager's ethical responsibility. They have an obligation to read the literature and go to conferences so they'll have all the knowledge they need to manage their clients' care," he says. ■

John Banja's no-brainer test of ethical behavior

Ask yourself three questions:

- Is it legal?
- Would my mother approve?
- What if my behavior was described on the front page of tomorrow's *New York Times*?

Plan provides patients with referrals, home care

Demonstration project aims to reduce hospitalization

A Medicare demonstration project at Montefiore Medical Center in New York City provides care coordination to help high-cost, fee-for-service beneficiaries comply with their medical treatment plan and access the community services they need to manage their chronic conditions.

"We are leveraging the experience we have in a managed care environment and applying it to a fee-for-service, high-cost population. We are using some of the principles of case management that are used in managed care and applying them in a non-managed care environment while working directly with patients, providers, and caregivers," says **Ann Meara**, RN, MBA, associate vice president, network care management.

Part of CMS demonstration project

Montefiore Medical Center, the largest health care provider in the Bronx, is one of six health care providers chosen by the Centers for Medicaid & Medicare Services (CMS) for a three-year demonstration project showing how care coordination, assistance with social support, and monitoring of patients' medical conditions can help prevent complications from illness and

reduce emergency room visits and hospitalizations.

CMS has identified chronically ill Medicare beneficiaries who live in 16 designated zip codes in the Bronx and meet the criteria for the Care Guidance care coordination program. Participants in the program are all fee-for-service Medicare beneficiaries. If they join a Medicare Advantage or other plan, they are automatically withdrawn from the program.

"All of the participants have had some contact with the Montefiore system. It may be as minimal as having blood drawn here but CMS did include a loyalty criteria in the selection process," Meara says.

Each Medicare beneficiary who agrees to participate is assigned a care coordination team, depending on where they live and what their primary language is. The teams, led by a nurse case manager, include outreach specialists, patient educators, and social workers.

The care management team works with patients to understand the challenges they face in complying with the medical treatment plan. They identify social issues and other challenges that may hinder patients from fully complying with their treatment plan and work with them to overcome the challenges.

"This is not a disease management program. It is a program that deals with those issues that interfere with a patient's ability to adhere to a treatment program. We are providing caregivers with the resources they need to take care of the patients and help them stay healthy," she says.

For instance, the teams have found more appropriate housing for some participants whose living arrangements had been contributing to their frequent hospitalizations.

CMS help with life planning

They may arrange transportation for medical visits or connect participants with community services, such as Meals on Wheels.

Life planning is one of the biggest issues that the team addresses with the participants, Meara says.

"We talk a lot to the patient and family members about health care proxies and advance directives and the importance of having these documents in place," she says.

Many of the participants don't understand their medication regimens and the case managers work to educate them. They educate the participants about their conditions and about lifestyle changes they can make, such as exercising or good nutrition, to help keep them under control.

They refer people who are at risk for falls to the hospital's falls risk prevention program.

"The case managers make a lot of referrals for conditions that have not gotten attention. For instance, we have identified a network of dentists in the community who will treat Medicare beneficiaries and who have arrangements that base payments on a sliding scale that is tied to income," she says.

When the program was initiated, the medical center hired a temporary outreach team of community members with previous customer service experience and trained them on the program and how to communicate with the beneficiaries. Some of them are peers to the people they are calling.

After the initial group was enrolled, the medical center hired three members of the outreach team to continue enrolling participants.

How it works

When a participant enrolls in the program, a case manager calls him or her on the telephone and conducts an extensive assessment that covers nine domains, including: cognitive capacity, level of function, risk of falls, medical condition, end-of-life planning, and previous medical history, she says.

The information is collected in an electronic system, which stratifies the participants based on their psychosocial and medical needs and how much intervention they are willing to accept. One group of beneficiaries is self-directed; they are willing to participate but didn't want to complete an extensive assessment.

The care coordination team uses the electronic system to generate a problem list and develops an individual care plan for each member. The nurse team leader reviews the plan with the team, and depending on the participant's needs, assigns the person to a member of the team. For instance, if a participant needs help scheduling an appointment, that task is assigned to a non-clinician.

The teams are supported by a full-time pharmacist, a full-time nutritionist, a geriatric psychiatrist, and an internist. For instance, if there is a polypharmacy issue, the pharmacist calls the patient or caregiver and reviews the medications.

Follow-up calls are made according to the stratification level of the participant.

The Care Guidance program began a telemonitoring initiative for patients with heart failure in late 2007. Participants who meet certain criteria for congestive heart failure receive a scale with a

monitoring device that connects to their telephone. They weigh themselves each day and answer a set of questions that they transmit into an electronic system that notifies the care coordinator if the patient appears to be having problems.

The case management interventions are primarily telephonic. The nurses may go to the home if the participant is uncomfortable doing the assessment over the phone, if he or she is hard of hearing, or if the primary caregiver prefers to be present.

Home assistance

Home-bound patients who are not receiving regular medical care from a primary care physician are referred to the medical center's Medical House Calls program, a team of physicians and nurse practitioners who provide care to patients in their home.

The team gets a hospital census every day to identify anyone in the program who has been admitted to Montefiore. If someone is hospitalized, the team's physician visits them in the hospital, assesses the condition, and makes a determination about appropriate follow up.

"This program is under our network care management program. The nurses who are conducting the telephonic case management work with the nurses at the hospital who are involved in utilization management and care management," Meara says.

The Care Guidance team coordinates care with the utilization nurses and case managers in the hospital and with the treatment teams throughout the health care system. Everyone in the health system has access to the same clinical information system and can share information.

"One of the things we've tried to do is to integrate what we do when people are outside the hospital with what we do when they are in the hospital," she says. ■

CM department scores big on member satisfaction

Multidisciplinary team collaborates on patient care

Blue Cross Blue Shield of Rhode Island's case management department consistently scores in the 90th percentile on satisfaction surveys sent to members who have completed a case management program.

The 2006 surveys show 99% of respondents reported being treated with dignity and respect; 97% rated their experience "good to excellent;" 98% reported being able to reach the case manager by telephone; 93% reported usually or always receiving a return phone call within 24 hours; 93% said the education they received helped improve their health habits; and 96% would recommend the service to family and friends.

The not-for-profit managed health care plan has been recognized by J.D. Power and Associates for providing an outstanding experience to its PPO members and received an "excellent" rating from the National Committee for Quality Assurance (NCQA). In addition, the case management department was one of the first three Blue Cross plans nationwide to receive the highest accreditation from URAC.

The case management department's multidisciplinary team collaborates to provide all the services that members need to learn to manage their health, says **Yvette Chartier**, RN, BS, CCM, CPUR, manager of case management for the Providence-based health plan.

The integrated case management department includes RN case managers, social workers, dieticians, tobacco cessation specialists, and RN health coaches who are experts in working with members on specific diseases, such as asthma, diabetes, or cardiac conditions. They can call on the medical director, staff pharmacists, and other resources within the company to help meet the needs of the members, Chartier says.

"The nurses in our program have an average of 18 years of clinical experience.

We have nurse case managers on staff who have specialized in pediatric care management, oncology management, and management of transplant patients so they have the expertise to coordinate the care for these patients," she adds.

Having all the disciplines in one department makes it effective for the team to collaborate on patient care, Chartier says. In addition, the health plan contracts with an external vendor for behavioral health services and dedicated behavioral health case manager on site at the health plan.

"Our staff can collaborate with the behavioral health case manager and co-manage members with both behavioral health and medical issues," she says.

The health coaches focus on specific conditions and provide telephone coaching, monitoring, and

evaluations.

When members have more than one chronic condition or comorbidities, the team determines whether the member would be better served if the case manager or the health coach was in charge.

All of the staff are cross-trained to handle any needs the members may have, allowing continuity of care when a member's care is being coordinated by one team member and he or she develops an additional condition.

For instance, if a health coach is already working with a member on diabetes control and the member fractures his or her hip, the health coach could continue to manage the members.

The case managers have basic knowledge of community resources, such as medication assistance or Meals on Wheels, but also consult with the team's social workers for additional help.

Members eligible for case management are identified by through health risk assessments, predictive modeling, and claims information triggers that identify patients with certain diagnosis codes, and those who have been admitted to the hospital. Customer service representatives identify issues that members need help with when they talk with members on the telephone and utilization review nurses refer members for case management services.

"We have worked with our provider community to help increase the number of referrals from physicians," Chartier says.

Introducing a member

When a member is identified for case management, a nurse calls them and begins to establish a relationship.

"There is a lot of concern when members get a call from their health insurer. The role of the case manager during this phone call is to explain how we are there to help them navigate the complex health care system," Chartier says.

The health plan contracted with an external vendor to train the case manager on effective ways to educate members about the services that the health plan can offer. "As nurses we are not as comfortable with marketing as we are with patient care. We wanted to give the nurses skills to help them engage the member and see the benefits of participating in our programs," she says.

If the member expresses interest in participating in the case management program, the case manager completes telephone assessment to help the member identify potential areas where the health plan can be of assistance. The assessment includes information on the member's medical condition, medications, and psychosocial, and behavioral issues.

The member is then assigned to the team member who can help with their problems.

"This is where having an integrated team is of benefit. The member might need to speak with the dietician for help with nutrition or may need to work with a social worker to coordinate community resources," Chartier says.

Setting goals

The case managers have been trained on motivational interviewing and readiness to change and use this knowledge to help the members set goals.

The nurses match the members' readiness level to the types of interventions that will benefit them. Many of the goals revolve around providing education about their condition, diet, and exercise. The case managers work with the members on medication compliance, helping them understand how to take medication correctly and to understand side effects.

"We educate the member to talk to the physician for an alternative if they experience side effects, rather than stop taking the medication," she says.

In other cases, the case manager may work with a member who is recovering from a catastrophic injury or undergoing treatment for cancer or another condition. For instance, a member going through chemotherapy and radiation treatment might not understand the treatment regimen and the side effects the medication may cause. The case managers educate the members about what to expect from their treatment and when they should call the doctor if they are experiencing certain symptoms, Chartier says.

"Members who are seriously ill or going through chemotherapy may not be thinking about what questions they should ask the doctor. The case managers are here to help them understand their disease and their treatment and to be prepared so they can make the most of the next doctor's visit," she says.

One of the triggers for referral is when members have had two hospital admissions within a six-month period.

If a member agrees to participate in the program, the case manager contacts the member's physician to collaborate on a treatment plan.

The health plan has made a concerted effort to

promote a collaborative relationship with physicians. In 2004, the health plan started reimbursing providers $50 for a telephone consultation. As a result the physician collaboration rate increased from about 23% to as high as 60% some months.

The case manager faxes the physician a form, which lists all the medications the member has reported taking and any other issues or potential problems. "We fax them in advance to let them know that we will be contacting their office within 24 hours and ask them to let us know if there is a better time to communicate with them," Chartier says.

When the case managers call the physicians, they review the medication and make sure the member's self-reported medication plan matches what the physician has on file, such as the member is taking the appropriate dose at the appropriate time.

"Many times, if a member has just been discharged from the hospital, the primary care physician may not be aware of new medication," she says.

The case managers discuss the members' goals with the physician and find out how they can help reinforce the treatment plan the physician has developed.

The average members stay in case management for four to six months, Chartier says.

"At the outset of the relationship, the member sets individual goals and they are discharged from case management when they complete the goals unless they are willing to work on other goals," she says. ■

Message of prevention key in heart disease fight

Work to get basic information out to the public

Choosing February as American Heart Month is not coincidental. With Valentine's Day in February, it is a month in which people are heart-centric, in the spirit of honoring the emotional needs of the heart. So it is appropriate to extend that thought process from the emotional fulfillment to what is required physically to keep the heart healthy, says **Clyde W. Yancy**, MD, FACC, FAHA, FACP, medical director at Baylor Heart and Vascular Institute in Dallas and chief, cardiothoracic transplantation at Baylor University Medical Center.

While more and more medical interventions save people with heart disease, it is far better to avoid the disease than to treat it and education is key to prevention, he states. "The best way to treat heart disease is to never get it. I don't think that message gets out there. What gets out is the breakthrough discovery, the new technique and new strategy. It all sounds like we can fix anything," says Yancy.

In reality, heart disease shortens longevity, decreases economic productivity, and decreases quality of life. All these factors in turn disrupt families, society, and the economy, says Yancy.

Educating the patient

To prevent heart disease, people need to know that there are lifestyle choices they can make to lower their risk. However, certain factors that put a person at higher risk cannot be altered, says Yancy. For example, people cannot pick new parents, change their gender, change their race, or change their age.

They can choose not to smoke, to lead an active vs. a sedentary life, what kind of diet to follow, and try to lose pounds if overweight. People with high blood pressure should be seen by a physician on a regular basis to get the problem under control and those with diabetes also need regular treatment.

"These are all things that are important in the consideration of heart disease, particularly diet, obesity, smoking, and hypertension — all of which can be modified by each individual's own activity, and that comes back to education," says Yancy.

People need to know that even modest changes in lifestyle can make a big impact on their risk for heart disease, and that how they currently live impacts their future. The message concerning future health can be difficult to convey. "In our culture we are often reactionary. What we are trying to do is get people to be proactive and take a preventive position," says Yancy.

For example, high blood pressure is a huge issue as people age. That is because about 90% of people over the age of 60 become hypertensive as a result of blood vessels getting stiffer and dietary intake patterns that take their toll. If people in their middle years can be encouraged to keep their weight down, exercise regularly, and refrain from smoking, the likelihood of delaying high blood pressure is much better, says Yancy.

Most health care professionals, however, real-

ize it usually takes more than the message to create lifestyle changes. Knowing the steps for delaying high blood pressure with the onset of age and actually following them are two different things.

Creating a sense of community is a great way to tackle lifestyle changes, says **Maxine Barish-Wreden**, MD, an internist with Sutter Medical Group and the medical director for Women's Heart Disease Prevention at Sutter Heart Institute in Sacramento, CA.

The American Heart Association created an employer-based program called "Start" to encourage employees to begin an exercise and fitness program at work, such as walking, and not wait until the evenings and weekends when they often are too tired.

"The Start program is a way to make people feel that they aren't alone. It's a way to have people spend time every day during work getting exercise, and a more powerful way to stay engaged than trying to do it yourself," explains Barish-Wreden.

Lifestyle changes can be a community affair as well, she adds. A woman in Nevada City, CA, a small town in the foothills north of Sacramento, wanted to lose 40 pounds by her 60th birthday. A newspaper reporter showed up at the gym to chronicle her efforts, adding to her feeling she had to remain committed.

To stay on track, she partnered with the owner of the gym and they decided to invite everyone in Nevada County to get fit. They called the program the Nevada County Meltdown and fitness clubs offered free time for people wanting to start an exercise program. About 2,000 people got involved, so they formed teams that competed against one another. The group lost 8,000 pounds.

"Again, it was the power of getting a whole community involved and doing it together that made the difference," says Barish-Wreden.

Group approach effective one

The same group approach is helpful in addressing children who are obese and inactive, she adds.

A healthy lifestyle needs to be a family affair; it doesn't do much good to teach children about good nutrition if their parents pick up fast food for dinner each night. "We can't expect children to shift their behavior. It has to be adults modeling good behavior, or there is no change," says Barish-Wreden.

Another way to motivate change is to provide a reward, she says. For example, the local newspaper company in Sacramento has a 24-hour fitness center onsite and offers financial incentives to employees who use the gym and take care of themselves, says Barish-Wreden.

It takes more than motivation

But she says it takes more than motivation to get people to put what they learn into practice. It also is important to address barriers to change, says Yancy. Some cannot see a physician on a regular basis or there is no money in their budget to add more heart-healthy foods to their diet.

Informing people of the dangers provides the foundation for change. Yancy encourages health care facilities to offer community awareness programs, such as blood pressure and weight screenings. "The kinds of things that are low tech and high touch make a big difference and make a big impact," says Yancy.

Sometimes the way to deliver the message must be considered as well. Yancy says that although many teens are at risk for developing heart disease at an early age due to poor dietary habits and lack of exercise, they function in an information overload.

"Public health messages are imbedded amidst so many other messages. It's not that they don't listen; I think we have to find a way to make the message important," says Yancy.

The American Heart Association develops campaigns to reach various at risk populations and encourage lifestyle changes.

For example, to raise awareness that heart disease is the No. 1 killer of women, they developed the "Go Red" campaign. According to AHA statistics, one in 2.6 women die of cardiovascular disease while one in 30 women die of breast cancer.

Yancy says it is informative programs that made women more aware of their risk for breast cancer and the importance of early detection through screenings, and the same proactive attitude needs to be developed for heart disease as well.

"If we could simply get more people to embrace the prevention message and really understand the best way to treat heart disease is to never get it in the first place, we would be that much ahead of the game," says Yancy. ■

Rising rate of MRSA increases need for education

Identification of infection critical

Antibiotic-resistant infections are not new to the health care setting, but headlines throughout the country have increased public awareness of the potential risk of infection.

According to a study by the Association for Professionals in Infection Control and Epidemiology, methicillin-resistant *Staphylococcus aureus* (MRSA) accounted for only 2% of all *Staphylococcus aureus* health care-associated infections reported to the Centers for Disease Control and Prevention (CDC) in 1972. Today, MRSA accounts for more than 60% of *Staphylococcus aureus* infections.

Although there are no studies that have looked specifically at home care, infection control experts point to the need for home care staff members to be knowledgeable about these organisms in order to minimize risk. Unfortunately, even with increased publicity of MRSA in the community, not all health care providers recognize the infection.

"I went to visit my 90-year-old mother who lives on the East Coast and she showed me a wound that wasn't healing," says **Marcia R. Patrick**, RN, MSN, CIC, director of infection control at Multicare Health Systems in Tacoma, WA. "It was classic MRSA so we went to see her physician," she says.

Although the culture that Patrick had to insist upon did show the presence of MRSA, it became clear to Patrick and her mother that the physician did not know how to treat the infection. After visiting a vascular surgeon, then treating the wound with silver dressings, the wound healed, but not before it had grown from the size of a quarter to a 4-by-6 inch area that left a permanent scar, she points out.

"We don't always know who has MRSA or any other antibiotic-resistant infection because a patient can be a carrier without having an active infection," Patrick says. "Many hospitals are testing a wide range of patients upon admission to identify patients who may be carriers."

Although testing of all home health patients is not practical or necessary, Patrick recommends an increased awareness of the signs and symptoms of bacteria-resistant infections so that treatment can be provided early and so that home health staff can ensure good outcomes for patients.

Patients at highest risk for MRSA or vancomycin-resistant enterococci (VRE), the two antibiotic-resistant organisms seen in the community, are those with wounds, catheters, a history of boils, or patients on dialysis, says Patrick. It is critical to recognize these patients higher risk for infection and monitor them carefully, she says. "MRSA often appears as a spider bite that doesn't heal, or a wound that won't heal," she adds.

Screening patients

"We don't screen all patients for MRSA or VRE upon admission but we have an active staff education program designed to heighten awareness of these infections for all staff members," says **Shannon Quaritsch**, RN, MS, CPHQ, quality improvement specialist at Northwest Community Home Care in Arlington Heights, IL. Staff education includes guidelines that identify different organisms and describe the type and duration of isolation necessary to prevent spread of the infection, she says.

Inservices include case scenarios that give nurses a chance to discuss the challenges faced by home care providers when a patient must be isolated, points out Quaritsch.

Although nurses use standard precautions in patients' homes, not all nurses were handling patient education in the same way before the awareness program, she admits. "Now, all of the nurses have a checklist that they use to ensure that patients and family caregivers are taught about laundry procedures, the need to clean the patient's area frequently, and the need for gloves or aprons when dealing with body fluids," she says.

CDC prevention recommendations

The most common methods to prevent spread of the infection in the home that are recommended by the Atlanta-based CDC are:

- Caregivers should wash their hands with soap and water after physical contact with the infected or colonized person and before leaving the home.
- Towels used for drying hands after contact should be used only once.
- Disposable gloves should be worn if contact with body fluids is expected and hands should be washed after removing the gloves.

• Linens should be changed and washed if they are soiled and on a routine basis.

• The patient's environment should be cleaned routinely and when soiled with body fluids.

• Notify doctors and other health care personnel who provide care for the patient that the patient is colonized/infected with a multidrug-resistant organism.

One part of Northwest Community Home Care's protocol for antibiotic-resistant infections is the need to culture any unimproved wound at the two-week point, says Quaritsch.

"Pressure ulcers are more difficult to culture in the home so they generally have to be biopsied in the hospital," she adds.

Once MRSA or VRE are diagnosed, patients are started on antibiotics that are known to work on these infections and caregivers are taught how to keep the patient's area, linens, and clothing clean to prevent the spread of the infection, she says.

It is difficult to treat patients with MRSA in the home because you have to rely upon family caregivers who may not be able to take care of themselves, as well as a patient who requires additional care, says Quaritsch.

"They are also reluctant to ask for help so it is up to the nurse to notice if additional help is needed, or if the patient must be transferred to another provider until the infection is controlled," she says.

"It is not unusual for a home care patient with MRSA to go to an extended-care facility for a brief time to ensure proper treatment of the infection," she adds.

The best way to approach diagnosis of MRSA and VRE is to realize that MRSA is everywhere, says Patrick. "It all goes back to basic hygiene and washing hands," she says. "Teach patients and staff members to wash hands and the risk of infection decreases." ■

Facility, insurer seek to create a 'healthy city'

Move toward preventive health

Improving the health of patients in your hospital is a large enough challenge, but imagine taking on the well-being of an entire city. Well, that's exactly what The Cleveland Clinic and Medical Mutual of Ohio are doing in Solon. Their collaborative initiative, called "Healthy Solon," seeks to improve the health of the entire town through prevention.

As part of the initiative, the Cleveland Clinic is providing free medical screenings and health care advice to anyone who lives or works in Solon, a city of about 25,000 people just southeast of Cleveland. The goal of the program is to educate participants and encourage them to take an active role in their own health through walking, smoking cessation, and stress prevention programs, as well as improved nutrition.

A shift in focus

Getting involved in this initiative was important for the Cleveland Clinic because it was in line with a shift in focus that the organization has been taking, says **Daniel Sullivan**, MD, a staff physician who specializes in internal medicine.

"It's important predominantly because of our big shift as an organization, to where we are now focusing on wellness," he says. "This is a dramatic shift from how many of us were trained; we've been trained to wait for illness to come to us and treat it — rather than focusing on prevention."

The rationale behind this shift, he continues, "is that we've identified that there are a variety of illnesses that are preventable, and if we can make a difference in prevention that will have a big impact on outcomes."

In addition, says Sullivan, such a program fits comfortably within the facility's mission. "Our focus is all about patient outcomes and experiences — whether they are inside or outside our walls," he emphasizes. "Health care is becoming prohibitively expensive, and if we can make an impact outside our walls to make it less costly inside them, it will make it easier for employers and people who are self-insured."

What's more, he points out, hospitals in the United States are now scored by many national organizations, such as The Joint Commission, on outcomes. "If someone has diabetes, whether they are treated within or outside our walls, if they are under our care and if they have a good outcome that will affect our scores positively," he observes. "Companies look at these outcomes in deciding whether to use the Cleveland

Clinic."

Not only is it important to have good outcomes in terms of national measures, he notes, "but every insurance company is measuring us as well."

Targeting a city

The "Health Solon" initiative got its start in December 2006, when the initial groundwork was laid. "Medical Mutual was looking at trying to improve their outcomes within their insured customers, and in reviewing the demographics, they saw they had a large number of insured in Solon," says Sullivan. "They figured it would make a lot of sense if they started a pilot program there." Medical Mutual wanted to partner with a city, and Solon has a "phenomenal" community center with exercise rooms, pools, and so forth, Sullivan says.

"When they started the process, they contacted us and asked if we wanted to be partners and we said absolutely yes," he says, adding that it is unique to see the three different types of organizations — which are sometimes on opposite sides of the fence — working together.

A key part of the program involves monthly gatherings at the community recreational center, each with a different focus. "For example, this past Saturday it was men's health," notes Sullivan. "I was one of the speakers. I gave a brief talk, and then invited the other speakers — a wellness expert and a former Cleveland Cavaliers [basketball] player — to address the group." In addition, free screenings were provided for blood sugar, cholesterol, and so forth, and free first-aid kits also were handed out.

Impact on the hospital

If the program is successful, might it not actually hurt the Cleveland Clinic down the road if admissions are reduced? "Potentially, yes, but health care is not just local anymore," notes Sullivan, pointing out that because of its reputation the Cleveland Clinic draws patients from all over the world. "Our perspective is to put the patient first, and do the right thing. If we do that, then as a business, we will succeed — rather than focusing on the economic model, which does not necessarily put patients first."

The participants are not yet able to determine if the program is succeeding, says Sullivan. "Right now, in terms of measuring outcomes, we and Medical Mutual are working together to find out the best way to capture data," he says. "It's a little tricky, because you have to identify people from Solon who participate in the program. Our IT people are looking at it; we have an [electronic medical record], but we still need to create a match between people from Solon who are also with Medical Mutual and who also participate. We hope to have that available by early 2008."

Clearly, both the Cleveland Clinic and Medical Mutual have great interest in these data, Sullivan continues. "Medical Mutual wants to see if they should expand this program to other areas, because healthier clients help keep costs down," he explains. "And of course, we have an interest in showing that we care about fostering good outcomes, because it makes it more likely that insurers and employers will choose us for their health care services."

(For more information, contact ***Daniel Sullivan****, MD, at sullivd1@ccf.org.)* ■

CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

COMING IN FUTURE MONTHS

- How telemedicine saves money, improves outcomes
- Culturally competent case management
- Providing support for cancer patients
- Managing the care of chronically ill elderly patients

CE questions

1. According to **John Banja**, PhD, where would the court look first to determine if a case manager had acted unethically?
   A. documentation
   B. yearly review
   C. CCMC standards
   D. none of the above

2. According to **Ann Meara**, RN, MBA, one of the biggest issues the team addresses with participants is life planning.
   A. True
   B. False

3. To motivate the appropriate lifestyle changes to prevent heart disease, programs might offer which of the following?
   A. A sense of community.
   B. A reward.
   C. Family support.
   D. All of the above.

4. How does **Shannon Quaritsch**, RN, MS, CPHQ, quality improvement specialist at Northwest Community Home Care, ensure that nurses properly educate patients about the precautions to take in the home when MRSA or VRE is diagnosed?
   A. She relies upon their years of experience.
   B. She reminds staff wash their hands.
   C. She provides a checklist to use in the home.
   D. She covers MRSA in new employee orientation.

Answers: 1. C; 2. A; 3. D; 4. C.

CE instructions

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