



# SUCCESS STORIES



# Meeting hospital case managers helps Texas home health agency coordinate care



Melva Castillo, RN

A Director of Nursing for P.A.C.E. Health Care Inc. said she learned a valuable lesson by participating in the Medicare Care Transitions Project in South Texas.

“A face makes a difference,” said Melva Castillo, RN, who supervises the nursing department for the Weslaco home health agency.

Castillo’s not talking about the difference between a cover girl or guy and the ordinary person. Instead, she means it’s nice to have faces to go with the names of the hospital case managers she worked with for years but never met until she joined the Care Transitions Project. TMF Health Quality Institute, the Medicare Quality Improvement Organization for Texas, sponsors the project.

Castillo met her hospital counterparts during quarterly regional workgroup meetings that began in April 2009 as a way for participants to get together to discuss how they could work together to reduce the 30-day hospital readmission rate.

The meetings brought together community hospitals and all their downstream providers, including home health agencies, skilled nursing facilities, in-patient rehabilitation facilities, long-term acute care hospitals and dialysis providers.

In addition, the home health agency’s community outreach representatives set up in-service meetings with the hospital staff, according to Castillo. She said getting to know the case managers and their director greatly improved communication, which in turn led to better discharge planning.

“Within the last year, we’ve gotten to know them a lot more. Before they would just fax us documents, and that was basically it. There was minimal communication. Now it’s much easier for them to say they’re going to call Melva to ask about making arrangements for the patients,” she said, and whenever she has a question, she calls and asks for whomever she needs to talk to, and in no time, she has the information she needs.

Now that it’s easier for the home health staff and the hospital case managers to call one another whenever they have a question, the transition for the home health patient is almost effortless, she said.

For example, the home health nurses used to go to patients’ home, only to find the medication they needed nowhere in sight. Now if that happens, the home health nurse calls the hospital and finds out what pharmacy is filling the prescription. A call to the pharmacy usually resolves the problem, not that it’s much of a problem anymore.

“Now, most of the time, the medication is already there, so it’s not a problem like it used to be,” said Castillo.

Taking part in the Care Transitions Project has also helped improve communication within the agency, said Castillo, and she makes sure to educate staff at in-services so they know what they need to do to help keep their patients out of the hospital.

After joining the project, P.A.C.E. began using tools courtesy of TMF Quality Institute to help patients manage their diseases. Brochures help explain the signs and symptoms patients should report to their nurses, so they can intervene.

“We make sure our patients call us before going to the hospital,” she said. “If it’s 10 p.m. or midnight or 4:30 a.m., we tell them to call us unless it really is an emergency. We also educate them about what symptoms or red flags that put them at risk. If they call in the middle of the night, we’ll go see them. We tell the nurses to make the visit and call the physician to see what we can do to prevent them from going back in. We have helped patients avoid preventable trips to the emergency room by providing care in the home.”

TMF Quality Institute also provided brochures about chronic obstructive pulmonary disorder, heart failure and diabetes. Heart failure is one of the main reasons patients go back into the hospital, and diabetes is particularly prevalent among the region’s Hispanic population, she said.

“Each nurse knows what to instruct the patient on,” she said.

The Care Transitions Project wraps up in July, but Castillo plans to continue to stay in touch with the hospital case managers. If there’s a change in personnel, she plans to suggest they get together for lunch or an in-service because a good relationship with the staff benefits the patients.

“Communication with the hospital has allowed us to have a much more complete picture of the patient,” she said.

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