September 2013 | Vol. 11, No. 9

CASE IN POINT

Leading the Care Coordination Team with Knowledge, News and Learning

DEPARTMENTS:

Earn 4 CE Credits: This issue has been pre-approved for 4 contact hours. Learn more about Case In Point Learning Network and how to access your CEs, including how to take your exam, at www.dorlandhealth.com/subscriptions.

FEATURES:

DORLAND HEALTH
a division of Access Intelligence

CASEINPOINT
DORLAND HEALTH
a division of Access Intelligence

www.dorlandhealth.com

SENIOR VP/GROUP PUBLISHER
Jennifer Schwartz

PUBLISHER
Carol Brault ~ 301-354-1763
cbrault@accessintel.com

EDITOR IN CHIEF
Anne Llewellyn, RN-BC, MS, BHSA, CCM, CRRN
954-254-2950
allewellyn@accessintel.com

MANAGING EDITOR
Richard Scott
rscott@accessintel.com

ART DIRECTOR
Yelena Shamis

STAFF WRITER
Steven Dashiell

SENIOR MARKETING MANAGER
Kristine Keller

SENIOR PRODUCTION MANAGER
Joann M. Fato ~ 301-354-1681
jfato@accessintel.com

ADVERTISING

ACCOUNT EXECUTIVE
Kim Luna ~ 720-870-2440
kluna@accessintel.com

REPRINTS
Wright's Media
877-652-5295
sales@wrightsmedia.com

Vol. 11, No. 9, September 2013
Case In Point (ISSN #1542-6971) is published monthly by Access Intelligence, LLC. Subscription rates: $199 per year.
For subscription inquiries or change of address, contact: Client Services, clientservices@accessintel.com. Tel: 888-707-5814, Fax: 301.309.3847.

Access Intelligence, LLC
Chief Executive Officer
Don Pazour
Executive Vice President & Chief Financial Officer
Ed Pinedo
Exec. Vice President, Human Resources & Administration
Macy L. Fecto
Divisional President, Access Intelligence
Heather Farley
Senior Vice President, Chief Information Officer
Robert Paciorek
Senior Vice President, Corporate Audience Development
Sylvia Sierra
VP, Production, Digital Media & Design
Michael Kraus
Vice President, Financial Planning and Internal Audit
Steve Barber

Access Intelligence
4 Choke Cherry Road, Second Floor , Rockville, MD 20850, 301-354-2000
www.accessintel.com

Leading the Way to High-Powered Care Coordination

Welcome to the September 2013 issue of *Case In Point*. In this issue we look at Care Coordination Across the Continuum. Care coordination is viewed as a critical tool that each member of the team can utilize throughout the healthcare system in order to improve quality and control escalating healthcare costs. Case managers have the opportunity to lead the team in understanding the importance of care coordination as it is one of the essential activities and knowledge domains identified by the Commission for Case Manager Certification.

As complexity of care increases, and the demand for accountability grows within new models of care, the role of the case manager is leaping in importance.

Today's case manager has a key function in coordinating diverse types of care through all settings of the healthcare spectrum. They serve as liaisons between the patient, the family and members of the care team. Using their clinical skills and healthcare expertise, case managers work to ensure that each patient understands their role and is empowered to be active participants in their care.

In this issue, we have gathered professionals from across the care continuum to share how they are using care coordination in their practice and realizing improved outcomes.

Because care coordination plays such an important role in in today's healthcare system, it is important that all members of the healthcare team have a firm handle on what it is, who is accountable for practicing it and the responsibility of all members of the healthcare team. To assist case managers and other members of the team I am excited to announce a new onsite and e-learning program that we are introducing on September 19 as a preconference to the Dorland Health Measurement Conference 2013.

The Care Coordination Achievement Program: Skills and Competencies for Today's Healthcare Leader provides a platform that professionals can use to gain insights into why care coordination is important, the competencies needed to coordinate care efficiently and effectively, and how to overcome barriers. The course provides 15.0 contact hours after all aspects of the program are completed to nurses, social workers, board certified case managers, disability management specialists and patient advocates.

You can review the Care Coordination Achievement Program and the Measurement Conference at www.dorlandhealth.com/measurement_conference. The website provides an overview of both events and the value they will bring you as part of your professional development.

After reading this issue, don't forget to access the learning portal and complete the posttest and program evaluation and claim the four containing education credits for which the issue has been pre-approved. If you need assistance accessing the portal, email our Client Services Department at clientservices@accessintel.com. Have a great month!

Anne Llewellyn

Anne Llewellyn, RN-BC, MS, BHSA, CCM, CRRN
Editor in Chief, Dorland Health Group
allewellyn@accessintel.com

HEALTHCARE BRIEFS

WORKERS' COMPENSATION

Workers Over 65 at Highest Risk of Traffic Death

Older individuals who drive as part of their job have a significantly higher risk of morbidity than their younger counterparts, according to a recent ***Morbidity and Mortality Weekly Report*** from the Centers for Disease Control and Prevention. While the overall risk of death is low (approximately three deaths per 100,000 people), workers aged 65 and older are at triple the risk of death than workers under the age of 65. The increased risk of death from a motor vehicle accident starts to grow at age 55, and then increases rapidly over 65, according to the study's lead researcher Stephanie Pratt, who works with the CDC's National Institute for Occupational Safety and Health. However, employers can play a part in reducing the risk of death through safety-oriented interventions. "Employers can provide opportunities for older drivers to reduce their exposure to driving," said Pratt. This may include using alternative modes of transportation, allowing flexible work schedules that avoid driving at night, and the chance to take breaks while driving. Employers can also provide education to their employees about the situations that are most hazardous, like taking medications that cause drowsiness, making left turns and driving at night. According to the study, motor vehicle accidents resulted in the fatality of more than 11,500 workers over the age of 18 between 2003 and 2010; nearly 30 percent were of adults over 55. CIP

CLINICAL

Antipsychotics May Triple the Risk of Diabetes in Children, Says Study

As the use of antipsychotic drugs among children has risen sharply in recent years (a Columbia University study pegs it as a sevenfold increase), the side effects of this upsurge are just beginning to reveal themselves – and some of them appear dire. According to a new study out of Vanderbilt University, the use of antipsychotic drugs to treat bipolar disorder, ADHD and other mood disorders like depression is tied to a severe onrush in rates of diabetes among large-scale pediatric populations. The study tracked the prescription records of nearly 30,000 kids and young adults on Medicaid between the ages of 6 and 24, noting which children began an antipsychotic drug regimen for reasons other than schizophrenia and comparing the clinical outcomes of those children with kids prescribed other psychiatric medications, such as mood stabilizers, antidepressants, psychostimulants, and anti-anxiety drugs. Researchers found that the children prescribed antipsychotic medications (including Seroquel, Abilify and Risperdal) saw triple the risk of developing type 2 diabetes compared to their counterparts on other psychiatric medications. According to researcher Wayne Ray with Vanderbilt's division of pharmacoepidemiology, this class of drugs appears to cause rapid weight gain and result in higher rates of insulin resistance. "Diabetes can develop relatively soon after beginning these drugs," said Ray. The study appeared in ***JAMA Psychiatry***. CIP

HEALTHCARE DELIVERY

Guide Provides Details About New Codes Related to Transitional Care Management

As a follow-up to the release of its transitional care management (TCM) codes that will allow medical professionals to bill for transitional and care coordination services, the Centers for Medicare and Medicaid Services (CMS) recently issued a guidebook that further explains how the codes work and what the services entail. The guidebook identifies the scope of TCM services; the healthcare professionals who may furnish the services; settings where the services are appropriate; how to bill for TCM services; frequently asked questions; and a selection of resources for further reading. The following list of professionals can provide TCM services, according to CMS: physicians in any specialty; certified nurse-midwives; clinical nurse specialists; nurse practitioners; and physician assistants. When it comes to the appropriate setting, TCM services will be compensated for if a patient is discharged from one of the following inpatient hospital settings: inpatient acute care hospital; inpatient psychiatric hospital; long-term care hospital; skilled nursing facility; inpatient rehabilitation facility; hospital outpatient observation or partial observation; and partial hospitalization at a community mental health center. For more information about services and coding questions, visit www.dorlandhealth.com/case_management/trends/Transitional-Care-Management-Services_2898.html. CIP

ACUTE CARE

Telemedicine Use Enhances Pediatric Outcomes in Rural ERs

For doctors in rural areas, it can be a difficult proposition to optimally treat pediatric patients requiring specialty care because such patients present so infrequently. However, the use of telemedicine – in this case, where one doctor or facility communicates with another doctor via videoconference – can significantly enhance outcomes and improve patient satisfaction, according to a new study conducted by researchers from the University of California Davis Children's Hospital. For the study, researchers installed telemedicine systems at five rural hospitals and assessed high-risk pediatric patients in need of immediate care, both before and after the use of the telemedicine systems. The researchers then tabulated a total score, on a range of one to seven, based on the quality of care of individual cases. They found that the average quality of care for cases that used telemedicine was 5.76, compared to a 5.26 score in cases where there was no consultation and a 5.38 average score where doctors used phone consultations. Additionally, patients reported higher rates of satisfaction when telemedicine was used. "It's a great way to leverage technology to improve the quality of care that we provide," said study author Dr. James Marcin. The study appeared in ***Critical Care Medicine***. CIP

MANAGED CARE

Medicare Part D Premiums Hold Steady for Another Year

For the fourth year in a row monthly premiums for Medicare Part D prescription drug plans have remained stable, according to data released by the Department of Health and Human Services (HHS). The average premium for a basic prescription drug plan is projected to cost $31 per month in 2014, following three straight years of $30 average monthly premiums for Medicare Part D plans. The estimate for monthly premiums in 2014 is based on bids that drug and health plans made to HHS in the summer of 2013 and calculated by the Office of the Actuary within the Centers for Medicare and Medicaid Services (CMS). Seniors and their caregivers are in for more welcome news, as CMS also announced that the deductible for Part D plans will fall to $310 in 2014, from $325 the year before. This news comes as the 2014 open enrollment period approaches for individuals on Medicare. The open enrollment period, during which beneficiaries and their families and caregivers can choose suitable plans for their expected needs, runs from October 15 to December 7. New plans, including Part D drug plans, are effective January 1, 2014. CIP

EDITORIAL BOARD

Cathy Cress, MSW
Principle, Cress Geriatric Care Management

Dana Deravin Carr, DrPH, RN-BC, CCM
Care Manager, Jacobi Medical Center

Mary Ellen Gervais, PhD, MS, CCM
Executive Vice President, InforMed Medical Management Services

Sandi Greenwalt, RN, MCHA-Wellness Promotion, CCM, CCP, CPHQ
Manager, Accreditation Services, URAC

Cathy Kauffman-Nearhoof, BSN, RN, CCM, LNC,
Senior Director, Clinical Operations, Blue Cross of Northeastern Pa.

Meg Lang, RN-BC, MSN, CCM, CPHRM
Director, Corporate Risk Management, Executive Health Resources

Kathryn Serbin, MS, BSN, CCM
Immediate-Past Chair, Commission for Case Manager Certification;
Section Chief, Women's Health Clinic for the James A. Lovell
Federal Health Care Facility

Sandra M. Terra, DHSc, MS, BSN, RN-BC, CCM, CPUR
Principle, Aspros & Terra Inc., Case Management Consulting

PROFESSIONAL Patient Advocate INSTITUTE

Save the Date!

3rd Annual Patient Advocate Conference and Workshop

DEC 2013 5-6

Loews Royal Pacific Resort at Universal Orlando, Florida

An interactive learning event to explore, learn, share experiences and celebrate successes.

The Professional Patient Advocate Institute invites you to an interactive conference to shed light on this emerging practice, provide education to like-minded advocates, and promote a culture of clinical and professional competence that will improve the health and welfare of your clients.

Take this opportunity to build your skills and knowledge while meeting and networking with like-minded colleagues and mentors.

www.patientadvocatetraining.com

22044

Numerical Analysis of Care Coordination

In this edition of By the Numbers we explore some key concepts behind the emerging art of care coordination, including mechanisms for achieving care coordination (with a look at both broad approaches and essential activities.)

5 Broad Approaches Related to Care Coordination

1. Teamwork focused on coordination. Integration among separate healthcare entities participating in a particular patient's care (whether healthcare professionals, care teams, or healthcare organizations) into a cohesive and functioning whole capable of addressing patient needs.

2. Healthcare home. A source of usual care selected by the patient that functions as the central point for coordinating care around the patient's needs and preferences. This includes coordination among all participants in a patient's care, such as the patient, family members, other caregivers, primary care providers, specialists, other healthcare services (public and private), and non-clinical services, as needed and desired by the patient. Other terms are frequently used to describe this model, such as medical home, patient-centered medical home, and advanced primary care.

3. Care management. A process designed to assist patients and their support systems in managing their medical/social/mental health conditions more efficiently and effectively.

The Case Management Society of America defines case management as: "A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes."

The Disease Management Association of America defines this term as: "A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant."

4. Medication management. Reconciling discrepancies in medication use in order to avoid adverse drug events associated with transitions in care.

5. Health IT-enabled coordination. Using tools, such as EHRs, patient portals, or databases, to communicate information about patients and their care between healthcare entities or to maintain information over time.

9 Activities of Care Coordination

1. Establish accountability or negotiate responsibility. Make clear the responsibility of participants in a patient's care for a particular aspect of that care. The accountable entity (whether a healthcare professional, care team, or healthcare organization) will be expected to answer for failures in the aspect(s) of care for which it is accountable.

2. Communicate. Share knowledge among participants in a patient's care. Communication may occur through a wide variety of channels, but for the purposes of measurement, we distinguish two key modes of communication:

Interpersonal communication. The give-and-take of ideas, preferences, goals, and experiences through personal interactions. Examples include face-to-face interactions, telephone conversations, email, and letters.

Information transfer. The flow of information, such as medical history, medication lists, test results, and other clinical data, from one participant in a patient's care to another. For example, a written summary of laboratory results sent from a primary care practice to the patient, verbal confirmation of a laboratory value from the laboratory to a physician, or transfer of a disk containing CT images from a hospital to a primary care office.

3. Facilitate transitions. Facilitate specific transitions, which occur when information about or accountability for some aspect of a patient's care is transferred between two or more healthcare entities or is maintained over time by one entity.

4. Assess needs and goals. Determine the patient's needs for care and for coordination, including physical, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations, including prescribed medications; and need for support services.

5. Create a proactive plan of care. Establish and maintain a plan of care, jointly created and managed by the patient/family and healthcare team, which outlines the patient's current and longstanding needs and goals for care and/or identifies coordination gaps.

6. Monitor, follow up, and respond to change. Jointly with the patient/family, assess progress toward care and coordination goals. Monitor for successes and failures in care and coordination. Refine the care plan as needed to accommodate new information or circumstances and to address any failures. Provide necessary follow-up care to patients.

7. Support self-management goals. Tailor education and support to align with patients' capacity for and preferences about involvement in their own care. Education and support include information, training, or coaching provided to patients or their informal caregivers to promote patient understanding of and ability to carry out self-care tasks.

8. Link to community resources. Provide information on the availability of and, if necessary, coordinate services with additional resources available in the community that may help support patients' health and wellness or meet their care goals.

9. Align resources with patient and population needs. Within the healthcare setting, assess the needs of patients and populations and allocate healthcare resources according to those needs.

Source: Agency for Healthcare Research and Quality, "Care Coordination Measures Atlas"

New Drug Approvals: A Case Manager's Guide

COMPILED BY RICHARD SCOTT

This edition of Rx Pipeline, presenting the latest FDA drug approvals, has direct application to case managers and the patients they monitor. For the treatment of depression, epilepsy, HIV and more, these drugs are new tools for your mission of coordinating patient care effectively and cost-efficiently.

TROKENDI XR

Company: Supernus Pharmaceuticals Inc.
Date of Approval: August 16, 2013
Indication: Epilepsy

The FDA approved Trokendi XR, a novel once-daily extended release formulation of topiramate for the treatment of epilepsy. The company expects to launch the product and for it to be available in pharmacies over the next few weeks.

The approval letter states that the FDA has completed its review of the application and that Trokendi XR is approved effective August 16, 2013, for use as recommended in the agreed-upon labeling. The FDA granted a waiver for certain pediatric study requirements and a deferral for submission of post-marketing pediatric pharmacokinetic assessments that are due in 2019 followed by clinical assessments in 2025.

Trokendi XR is a novel once-daily extended release formulation of topiramate. Trokendi XR is an antiepileptic drug (AED) indicated for initial monotherapy in patients 10 years of age and older with partial onset or primary generalized tonic-clonic seizures; adjunctive therapy in patients six years of age and older with partial onset or primary generalized tonic-clonic seizures, and adjunctive therapy in patients six years of age and older with seizures associated with Lennox-Gastaut syndrome.

EPANED

Company: Silvergate Pharmaceuticals Inc.
Date of Approval: August 13, 2013
Indication: Hypertension

The FDA approved Epaned (enalapril maleate Powder for Oral Solution) to treat hypertension (high blood pressure) in people one month and older. Enalapril is one of the most commonly prescribed medicines in the United States to treat high blood pressure.

Epaned enables accurate dosing for children who until now have relied on an adjusted adult dose. It works by blocking a natural chemical in the body that causes blood vessels to narrow. As a result, the blood vessels relax. This lowers blood pressure and increases the supply of blood and oxygen to the heart.

Epaned reduces blood pressure. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions. Control of high blood pressure should be part of a comprehensive cardiovascular risk management, including, as appropriate, lipid control, diabetes management, antithrombotic therapy, smoking cessation, exercise, and limited sodium intake. Many patients will require more than one drug to achieve blood pressure goals.

According to the International Pediatric Hypertension Association: The effects of high blood pressure can begin during childhood. Mild to moderate high blood pressure is most commonly asymptomatic but may be associated with subtle changes in behavior or school performance; children with high blood pressure are more likely to have a definable cause for high blood pressure (such as kidney disease) than adults; children with high blood pressure also tend to have other medical problems, such as obesity, high blood lipids and/or diabetes mellitus; in addition, children with high blood pressure tend to have high blood pressure as adults.

TIVICAY

Company: ViiV Healthcare
Date of Approval: August 12, 2013
Indication: HIV Infection

The FDA approved Tivicay (dolutegravir), a new drug to treat HIV-1 infection. Tivicay is an integrase strand transfer inhibitor that interferes with one of the enzymes necessary for HIV to multiply. It is a pill taken daily in combination with other antiretroviral drugs.

Tivicay is approved for use in a broad population of HIV-infected patients . It can be used to treat HIV-infected adults who have never taken HIV therapy (treatment-naïve) and HIV-infected adults who have previously taken HIV therapy (treatment-experienced), including those who have been treated with other integrase strand transfer inhibitors. Tivicay is also approved for children ages 12 years and older weighing at least 40 kilograms (kg) who are treatment-naïve or treatment-experienced but have not previously taken other integrase strand transfer inhibitors.

Tivicay's safety and efficacy in adults was evaluated in 2,539 participants enrolled in four clinical trials. Depending on the trial, participants were randomly assigned to receive Tivicay or Isentress (raltegravir), each in combination with other antiretroviral drugs, or Atripla, a fixed-dose combination of efavirenz, emtricitabine and tenofovir. Results showed Tivicay-containing regimens were effective in reducing viral loads.

Common side effects observed during clinical studies include difficulty sleeping (insomnia) and headache. Serious side effects include hypersensitivity reactions and abnormal liver function in participants co-infected with hepatitis B and/or C. The Tivicay label gives advice on how to monitor patients for the serious side effects.

INJECTAFER

Company: Luitpold Pharmaceuticals Inc.
Date of Approval: July 25, 2013
Indication: Iron Deficiency Anemia

The FDA approved Injectafer, a parenteral iron replacement product used for the treatment of iron deficiency anemia (IDA) in adult patients who have intolerance to oral iron or have had an unsatisfactory response to oral iron. Injectafer is also indicated for iron deficiency anemia in adult patients with non-dialysis dependent chronic kidney disease (NND-CKD).

In the U.S. there are an estimated 7.5 million people with IDA, a condition that occurs when body iron stores are inadequate for normal red blood cell production. IDA is a frequent complication in many

GI disease states and conditions, affecting up to one-third of inflammatory bowel disease patients and up to 24 percent of patients who have undergone gastric bypass surgery. It is also prevalent in children and women, with over 3 million U.S. women of childbearing age affected due to conditions such as heavy uterine bleeding, postpartum anemia, and pregnancy.

Injectafer (ferric carboxymaltose injection) is the first non-dextran IV iron approved for the treatment of adult patients with IDA of various etiologies in addition to use in non-dialysis dependent CKD patients. A single dose of up to 750 mg of Injectafer can be administered undiluted as an IV push injection at a rate of 100 mg/minute or as an IV infusion in up to 250 mL 0.9 percent sodium chloride injection, USP, over at least 15 minutes.

The safety and efficacy of Injectafer for treatment of iron deficiency anemia were evaluated in two clinical trials (Trial 1 and Trial 2) in which Injectafer was administered at a dose of 15 mg/kg body weight up to a maximum single dose of 750 mg of iron on two occasions separated by at least seven days up to a maximum cumulative dose of 1,500 mg of iron. The inclusion / exclusion criteria for both studies allowed patients with various comorbidities, characteristic of this broad patient population. Additionally, patients with a history of drug allergies were included in the trials, providing robust safety data in this difficult to treat subset of patients.

Serious hypersensitivity reactions, including anaphylactic-type reactions, some of which have been life-threatening and fatal, have been reported in patients receiving Injectafer. Patients may present with shock, clinically significant hypotension, loss of consciousness, and/or collapse. Monitor patients for signs and symptoms of hypersensitivity during and after Injectafer administration for at least 30 minutes and until clinically stable following completion of the infusion. Only administer Injectafer when personnel and therapies are immediately available for the treatment of serious hypersensitivity reactions. In clinical trials, serious, anaphylactic/anaphylactoid reactions were reported in 0.1 percent (2/1775) of subjects receiving Injectafer. Other serious or severe adverse reactions potentially associated with hypersensitivity which included, but were not limited to, pruritus, rash, urticaria, wheezing, or hypotension were reported in 1.5 percent (26/1775) of these subjects.

FETZIMA

Company: Forest Laboratories Inc. and Pierre Fabre Laboratories
Date of Approval: July 25, 2013
Indication: Depression

The FDA approved Fetzima (levomilnacipran extended-release capsules), a once-daily serotonin and norepinephrine reuptake inhibitor (SNRI), discovered by Pierre Fabre Laboratories and co-developed by Forest Laboratories Inc. for the treatment of major depressive disorder (MDD) in adults.

Major depressive disorder, also known as depression, is a common debilitating disorder in which feelings of sadness and other symptoms interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities. MDD affects almost 16 million adults in the United States every year, with a range of severity from mild to severe.

In the placebo-controlled, pivotal Phase III studies of adult patients with MDD, statistically significant and clinically meaningful improvement in depressive symptoms (primary endpoint) was demonstrated across three Fetzima dosage strengths of 40, 80, and 120 mg once daily compared with placebo as measured by the Montgomery Asberg Depression Rating Scale (MADRS) total score (primary endpoint). Fetzima also demonstrated superiority over placebo as measured by improvement in the Sheehan Disability Scale (SDS) functional impairment total score (secondary endpoint).

The most common adverse reactions (incidence equal to or greater than 5 percent and at least twice the rate of placebo) in the placebo-controlled trials were nausea, constipation, hyperhidrosis, heart rate increased, erectile dysfunction, tachycardia, vomiting, and palpitations. Rates of adverse events were generally consistent across doses (40-120 mg); the only dose-related adverse events (greater than 2 percent overall incidence) were urinary hesitation and erectile dysfunction.

The efficacy of Fetzima was demonstrated in three positive double-blind Phase III studies comprising two fixed-dose studies and one flexible-dose study that compared Fetzima to placebo in adults with MDD. A total of more than 1,600 adult patients received a once-daily dose of either Fetzima (40, 80, 120mg) or placebo in the three studies. In each study, the primary endpoint was change from baseline to endpoint in the Montgomery Asberg Depression Rating Scale (MADRS) total score and the secondary endpoint was change from baseline to endpoint in the Sheehan Disability Scale (SDS) total score. In all three studies, statistically significant improvement was seen for the Fetzima group compared with placebo on both the primary and secondary endpoints using both the mixed-effects model for repeated measures (MMRM) and last-observation-carried-forward (LOCF) analyses.

LO MINASTRIN FE

Company: Warner Chilcott plc
Date of Approval: July 24, 2013
Indication: Contraception

The FDA approved Lo Minastrin Fe (norethindrone acetate and ethinyl estradiol chewable tablets, ethinyl estradiol tablets and ferrous fumarate tablets) for the prevention of pregnancy. The company is currently developing the commercial launch plans for Lo Minastrin Fe, which is indicated for use by females of reproductive age to prevent pregnancy.

Cigarette smoking increases the risk of serious cardiovascular events from combination oral contraceptive (COC) use. This risk increases with age, particularly in women over 35 years of age, and with the number of cigarettes smoked. For this reason, COCs should not be used by women who are over 35 years of age and smoke.

For additional information, including information on dosage and administration, contraindications, warnings and precautions, adverse reactions, and other important safety and other prescribing information, see www.wcrx.com/pdfs/pi/lo_minastrin.pdf.

Further drug information, including safety information, warnings, contraindications and other facts about general use, is available online at www.fda.gov/drugs. CIP

Resources Aim to Strengthen Consumer Education as Insurance Exchanges Approach

BY STEVEN DASHIELL

Multitudes of new healthcare options will soon be available for individuals in the U.S., many of whom will be obtaining health insurance for the very first time. The sheer diversity of these options led the Department of Health and Human Services (HHS) to introduce a number of assistance programs designed to guide these newly eligible individuals through details of the differing plans.

One of these positions, that of the "navigator," was designed in particular to help individuals understand and maneuver through the new healthcare marketplaces that are going live in each state. It is within these marketplaces that many new health plans, including those of Medicare and Medicaid, can be purchased.

Marketplaces will be mandatory by October 1, 2013, and many states have been slowly rolling out their marketplaces in preparation. Similar preparations were being made on the assistance programs created by HHS, including the navigator program, which began accepting volunteer applications shortly after its announcement.

These consumer assistance programs are finally taking shape as funding and new resources begin to emerge. HHS recently awarded $67 million to navigators in support of the creation and continued operations of the navigator program across various states.

LAYING THE GROUNDWORK FOR SUPPORT

How each state would go about implementing their marketplace was largely left up to the state itself. Unfortunately, the early period following the announcement of the marketplaces and consumer assistance programs was particularly devoid of information. Few were aware of the exact details of the marketplace and navigator programs, and many had no idea that they even existed.

HHS has since tried to correct this problem, releasing a series of its own resources and programs meant to spread awareness and answer questions about marketplaces and consumer assistance programs. Two websites have recently emerged from HHS that are dedicated to this cause.

A CONSUMER DIRECTORY

The first of these is targeted toward consumers, and it fulfills a utility that was desperately needed thanks to the way marketplaces are created. Prior to the expansion of the site, healthcare.gov, consumers had to research and discover their state's marketplace site themselves. This was often an unnecessarily difficult endeavor, as the sites were not necessarily standardized across the U.S. The HHS consumer website allows users to select their state from a drop-down box, allowing easy access to the appropriate marketplace website.

> "THE SITE FEATURES A HOST OF PRESENTATION MATERIALS FOR PROFESSIONALS WHO WISH TO HOLD INFORMATIVE AND EDUCATIONAL EVENTS ABOUT THE MARKETPLACE."

HHS also opened a call center designed to serve small businesses who wanted information on the "SHOP Marketplace," a program launching in October that gives small businesses new and expanded ways of delivering health plans to their employees.

BECOMING AN ARM OF THE MARKETPLACE

The second website, marketplace.cms.gov, targets healthcare professionals. Here, individuals and organizations can apply for partnership with the Centers for Medicare and Medicaid Services (CMS) in order to bring information regarding the marketplace to the right consumers. Training is required for those seeking to become partners, with each training program tailored to the position being volunteered for, whether navigator, agent or broker.

The site features a host of presentation materials for professionals who wish to hold informative and educational events about the marketplace. Articles, research data, multimedia, website graphics and outlays can all be found on the HHS professional site, including Spanish-language versions of the aforementioned materials.

Organizations that wish to help spread information about the marketplace and the options available to uninsured individuals may join the "Champions for Coverage," an initiative that lists the various companies that have agreed to educate and guide uninsured individuals through the multitude of plans available to them through their individual marketplace.

FUTURE PLANS

Even additions as simple as a website have made a world of difference in the accessibility of information since the initial announcement of the health insurance marketplaces. With the additional funding provided for the navigator program and the accolades and publicity to be obtained through the Champions of Coverage initiative, uninsured individuals will find it much simpler to obtain the information and assistance they need.

However, with October fast approaching, CMS and HHS are hard at work ensuring that the consumer experience is as smooth as possible. Earlier this month, HHS posted a notice calling for telephone and document translation services to be contracted for the Medicare and marketplace call centers. The requirements listed in the notice were rather demanding, including support of at least 100 languages, the ability to handle 50,000 calls a year, confidentiality agreements, and the assurance that all translators and interpreters are familiar with healthcare and health insurance terminology.

On the whole, HHS's progress over the last few months has shown promise for future developments. With an expected chaotic opening of the marketplaces and influx of new consumers, HHS is giving it a try to gain as much traction and support as possible before the gates are thrown open. CIP

Accountable Health: Accountable Care Meets Personal Accountability

BY MARY BETH CHALK

The greatest gap in accountable care lies outside of the treatment setting. Fact: Chronic disease constitutes 75 percent of all healthcare spending. Approximately one in two adults have at least one chronic condition wherein 25 percent experience significant limitations in daily activities.[1]

The Affordable Care Act codified what progressive physician groups and hospitals were already delivering: accountable, outcomes-focused care. The passage of the Act is a broad-based catalyst aligning provider accountability to payment structures to achieve and maintain positive clinical outcomes.

There is also little doubt that a significant percentage of chronic disease is due to consumer-controlled lifestyle factors.[1] The World Health Organization has estimated that "if the major risk factors (including inactivity, poor nutrition, excessive alcohol consumption and smoking[1]) for chronic disease were eliminated, at least 80 percent of heart disease, stroke and Type 2 diabetes would be eliminated; and 40 percent of cancer would be prevented."[2]

Accountable care will be optimally successful if consumers are engaged. This means taking responsibility (i.e., accountability) for their health to prevent chronic diseases, improve the control and management of their condition(s) and related clinical outcomes, increase adherence to medication, and comply with their discharge care plans. In order to significantly reduce the cost of healthcare while improving the quality, consumers must take control of their health. This will only increase in importance as various provisions of the Act gain traction and as high deductible plans continue to gain traction in the marketplace.

We know that attempts to impose programs on consumers, such as disease management, managed care, adherence and wellness, have not engaged a significant percentage of people to measurably improve and maintain optimal clinical outcomes necessary to bend the healthcare spending curve.

TRANSFORMING TO A CONSUMER MARKET

Integrating provider-centric accountable care with consumer-centric accountable health will improve engagement and optimize clinical outcomes.

In its "2012 Survey of U.S. Healthcare Consumers," the Deloitte Center for Health Solutions stated, "Health policy experts and economists have…reason(ed) that costs would be lower, services better, and quality substantially improved if the industry repositioned itself as a consumer market."[3]

Accountable care will inevitably focus on provider behavior. An equal amount of attention must be focused on the consumer, the party most capable of achieving accountable care's overall goal of improving health outcomes. This begs for a consumer-centric model that promotes accountability. The components in Figure 1 (below) are critical to supporting consumer accountability.

When accountable care joins together with accountable health physicians and consumers, they work together on the mutual goal of improving and sustaining optimal health and its associated clinical outcomes.

THE PRINCIPLES OF ACCOUNTABLE HEALTH

Consumer-centricity. Rightfully so, our current healthcare system is expert-centric. Meaning, the highly trained professionals that provide treatment to consumers talk and act in ways that are relevant to them. Within the emergency and acute care setting, this is a necessity for expediency and accuracy. If a patient is not horizontal (i.e., on a gurney) as they enter the treatment setting they will likely be engaging and interacting as a consumer.

The healthcare consumer's expectations are being shaped and honed by other industries that are making their services and experiences relevant, engaging, timely and actionable. The consumer then approaches healthcare with the same expectations that their interactions with providers be relevant, engaging and actionable.

In an expert-centric system, a consumer given a diagnosis of Type 2 diabetes is handed pages of care instructions and checklists and sent on their way to determine how to begin making the many lifestyle changes necessary to maintain stable blood sugar. This approach is largely due to the current fee-for-service reimbursement structure.

Consumer-centric models are emerging in which consumers with a new diagnosis of Type 2 diabetes are receiving a personalized health coach, a series of lifestyle classes (in person and online) and access to an online community of people with diabetes providing guidance and support. In a few cases, this new model is being integrated into a physician practice so that the expert-centric approach is integrated with the consumer-centric approach.

The success of accountable care will depend largely on how well we engage the consumer in effective prevention and self-management of chronic disease. This will require the integration of expert and consumer-centric models.

Outcomes-driven. Not all data is good data – the challenge that lies ahead is in parsing out the good from the "not helpful." Due to the Affordable Care Act and the emerging big data trend, there will be a proliferation of healthcare data in the years ahead. From the consumer's perspective, good data makes health relevant and actionable. From a risk perspective, good data supports and reinforces consumers in changing evidence-based health behaviors through the use of longitudinal, biometric feedback and correlates that data to lifestyle changes. Good data will be actionable information that assists a consumer in effectively preventing and managing a chronic condition, which ultimately lowers healthcare utilization. Data that is not helpful will simply create distractions for the consumer as well as healthcare professionals and drag down algorithm and software development efforts due to too broadly defined data requirements.

Evidence-based. It has been relatively easy for a person outside of healthcare to see that major improvements are needed in the area of engaging consumers in their health.

In recent years, we have seen an influx of software management talent developing healthcare apps, many of which are sold in app stores. While well intentioned, the evidence-basis of what works has often been left behind, with little reference to rigorously studied, evidence-based medicine. On the flip side, healthcare experts have not done a good job integrating the sciences of behavioral change and consumer marketing.

In order to create engaging accountable health approaches that result in improved health status, we must integrate medical, behavior and marketing science. This is challenging work because these areas of expertise typically reside not only in silos but in different industries. Software-based health services of the future must be created by a team of people from these three disciplines, informed by strong software management expertise. This is not easy, quick or inexpensive.

Dynamic personalization. I recently received an email from Amazon asking me, as a former purchaser of a product, to help another consumer who had a question about the product I had purchased. Wow. This real-life demonstration of the evolving profile Amazon is creating of me as a consumer, including my experiences and preferences, creates an expectation that other companies who have my data can do similar things. The algorithms and software that made this automated exchange possible are a perfect example of dynamic personalization.

As we integrate medical, behavior and marketing data, we will be able to accurately predict and proactively communicate with consumers around engagement, disengagement, health risk, behaviors and likely outcomes. If we combine the predictive and proactive capabilities with timely delivery of messages it will increase the likelihood of engagement in targeted behaviors that will result in improved outcomes. Over time, the algorithms will mature to support a consumer's evolving knowledge, experiences and preferences.

Promotes collaboration. The healthcare system has numerous stakeholders who, at times, need to be on the same page. Accountable health solutions will ensure secure, consumer-enabled sharing of data with providers, caregivers and friends using common data and privacy standards. The platforms to capture and hold the data are in development and, in some cases, the ability to share data is also being developed. However, there is a challenge in the interoperability of data standards. For example, a consumer who is using one app to manage their blood sugar may not be able to integrate it with the data from the app they are utilizing to track their caloric consumption. The result is an inability to aggregate a comprehensive picture of lifestyle modification and its impact on outcomes such as blood sugar and, ultimately, the HbA1c values contained in an electronic health record. This type of integrated information can have a positive impact on the speed of treatment efficacy (i.e., medication titration, etc.).

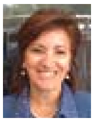
Technology-enabled. The proliferation of smart phone and tablet technology is enabling increasing numbers of people with access to health information and apps. The apps, both web-based and mobile, provide access to consumers anywhere, anytime. This real-time access to consumers will allow what has historically occurred in the healthcare treatment setting to becpme embedded in daily living in ways that meet federal and state regulatory requirements.

CONCLUSION

If accountable care is to be successful, it must create consumer-centric solutions that can be leveraged by relevant healthcare stakeholders and also deliver on the promise of improved health outcomes in a way that is evidence-based, dynamically personal and technology-enabled.

REFERENCES

1. Centers for Disease Control website: www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm.
2. World Health Organization website: www.who.int/chp/chronic_disease_report/part1/en/index11.html.
3. Deloitte: 2012 Survey of U.S. Healthcare Consumers: The performance of the healthcare system and healthcare reforms.



Mary Beth Chalk, the chief engagement officer with Healthrageous, has more than 20 years of healthcare stakeholder experience, including business strategy and business model innovation, and designing new health behavior services and programs. Contact: marybeth.chalk@healthrageous.com

Figure 1

Accountable Health™	Value to Consumers
Consumer-centricity	Personalizes the health experience in a way that is relevant, engaging, timely and actionable.
Outcomes-driven	Reinforces behavior through the display of longitudinal, biometric feedback and correlations of lifestyle changes.
Inspiration-guided	Enables the achievement of personal inspiration for health and leverages multiple methods of influence.
Evidence-based	Provides selection support around the lifestyle factors with the greatest impact on targeted clinical outcomes.
Dynamic Personalization	Supports evolving knowledge, experiences and preferences around improving or maintaining health.
Promotes Collaboration	Ensures secure, consumer-enabled sharing of data with providers, caregivers and friends using common data and privacy standards.
Technology-enabled	Enables health anywhere, anytime while meeting federal and state regulatory requirements.

Quality Blueprint: Establishing an Outpatient Clinical Documentation Program

BY LINDA RENEE BROWN, RN, MA, CCDS, CCS, CDIP

Outpatient/observation clinical documentation improvement is an outgrowth of the traditional inpatient clinical documentation improvement (CDI) program. For a long time, most CDI specialists thought that clinical documentation improvement specialists could make little to no impact on outpatient or observation charts, but with the expansion of recovery auditors into the outpatient arena and the inclusion of outpatient/observation issues within the Office of Inspector General (OIG) work plan, many hospitals are considering expanding their CDI program into the outpatient arena.

Experienced CDI specialists (CDIs) can review documentation, charge and claims data, medical necessity standards, and use their findings to educate physicians, coders, case managers, nurses and other members of the healthcare team. The scope of outpatient/observation CDI is contingent on the objectives of the organization and the resources and time that can be made available for the process. Many CDI programs are housed within case management departments – ideal settings for working with case management on admission status.

DEFINING KEY PRINCIPLES

Developing and nurturing collaboration among health information management, CDI, nursing, case management, billing and physicians is absolutely essential. Knowledge must be shared. CDI specialists traditionally have worked in the inpatient setting, and almost exclusively with physicians rather than other care providers. As part of CDI program growth, CDIs must have specific education in the unique documentation issues found in the outpatient setting, to include documentation by nursing, therapy, etc. Although outpatient/observation cases heavily rely on CPT/HCPCS (Current Procedural Terminology/Healthcare Common Procedure Coding System) codes, the advent of ICD-10 necessitates physician education to capture diagnoses that support observation/outpatient services.

Unlike inpatient diagnoses, outpatient diagnoses must be confirmed to be coded. The OP CDI specialist needs to work with physicians on confirmation of diagnoses and recording of documentation that supports those diagnoses with sufficient specificity. As one recovery auditor has stated, "Ensure the documentation addresses problems identified in the history and physical, treatment initiated, patient's response to treatment, major changes in the patient's condition and action taken, status of unresolved problems, discharge planning and follow-up."

Inpatient and outpatient documentation principles may be integrated into a physician documentation improvement education program. Physicians should understand the difference in documentation requirements; that both systems require strong foundations of documentation to support medical necessity and intensity of resource utilization; how their documentation in both the inpatient and outpatient settings affects their ability to assign and bill evaluation and management levels.

CMS has noted that observation or monitoring is a type of service that may be provided within the outpatient level of care. Observation services cannot be billed within the inpatient level of care. A structured review of outpatient/observation patients' documentation and billing practices should be included in the hospital's compliance plan.

Goals for a CDI program can vary by facility. Some possible objectives for a CDI outpatient program include:

1. Develop collaborative processes with coding and case management for overall program objectives.

2. Reduce legal risk through development of compliant documentation practices.

3. Develop processes for verification of observation hours. An effective CDI program achieves diverse tasks, including:

- CDIs review nursing documentation for evidence of monitoring of the patient and compliance with physician orders.
- CDIs assist in development of policies regarding documentation of observation hours.
- CDIs become part of developing medical record systems that accurately track the times when the patient is receiving diagnostic or therapeutic services under active monitoring (e.g., at radiology, having OP surgery, etc.) and audit records for compliance. Monitoring and observation services following an outpatient procedure are not observation services; the recovery, monitoring and medications following the procedure are an inclusive part of the procedure.
- CDIs collaborate with health information management/case management/nursing in development of an observation log that encompasses:
    - Conditions that require and justify observation status.
    - Where the documentation is located.
    - Number of observation hours.
    - Number of observation units billed.
    - Charges for observation status.
    - Any interruptions to observation status.
    - UR notes.

4. Develop processes for verification of infusions/injections. CDIs create and refine processes of reviewing documentation for route, sites, stop and start times, and consistency of nursing and physician documentation. As documentation experts, CDIs create documentation tools and policies for documentation of infusions/injections. As documentation educators, CDIs teach nursing the requirements for documentation of infusions/injections. By comparing documentation to charges, we can ensure that charges for supplies/medications are appropriate for the services documented.

5. Strengthen documentation of diagnoses under ICD-10 to support OP services and maximize ambulatory payment classification (APC) reimbursement. This is another reason why CDIs need to train physicians in ICD-10 documentation requirements. CDIs should be part of developing electronic health record templates that guide physicians toward documentation of diagnoses, rather than symptoms.

6. Assist in documentation of confirmed diagnoses. Just as with inpatients, CDIs teach physicians to link s/s to diagnoses and confirm diagnoses for emergency department and observation patients. Because unconfirmed diagnoses are not coded, CDIs connect confirmed diagnoses to documentation that supports medical necessity

7. Ensure that documentation meets medical necessity standards for the appropriate level of care assigned. CDIs work collaboratively with case management to educate physicians in documentation standards that validate medical necessity of observation/outpatient services, including retrospective record audits. They use the existing concurrent review process to help case management in verifying appropriate and timely status orders. At the same time, they evaluate outpatient therapy documentation for compliance with medical necessity requirements and educate therapists as needed. They audit records for medical necessity with documentation support of short-stay inpatients and targeted inpatient DRGs to educate physicians on observation/OP documentation requirements. As part of denials management strategy, CDIs work with case management on identifying gaps in documentation.

8. Promote accurate completion of medical record on a concurrent, rather than retrospective, basis. This will help reduce the Discharged, Not Final Billed (DNFB) list and failed claims.

9. Review documentation/claims to determine if issues are coding-related or documentation-related. CDIs nurture collaborative processes with HIM and billing.

10. Perform pre-bill claims reviews.

11. Review charges for accuracy and tensure that documentation/charges lead to all patients being billed consistently for the same services.

12. Provide education to physicians, nurses and ancillary staff regarding OP documentation and charge issues. Examples include: CDIs review colonoscopy documentation and educate physicians on documentation required for screening vs. diagnostic colonoscopy; CDIs review bone marrow biopsy and aspiration documentation and educate physicians on documentation regarding incision site; CDIs review surgical documentation of excision of lesions for type of service, tissue type, and margins of wound, and educate physicians on documentation requirements

13. Collaboratively develop documentation protocols and algorithms for admitting to observation/recovery/IP status. CDIs and case managers develop observation assessment guideline "cheat sheets" for physicians that can be placed in patient charts, provided within a reference guide, or otherwise made readily available for physician review.

14. Help develop review protocols for charge master.

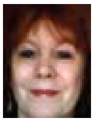
15. Look at observation patients who might qualify as IP given proper documentation. This should involve communication and collaboration with case management during the concurrent review process.

16. Ensure that documentation of OP wound care services reflects correct description of diagnoses, assessment, and treatment.

Establishing an effective outpatient/observation CDI program requires a high level of commitment and support. It is a tremendous choice for the brave of heart and the stout of mind. CIP

REFERENCES

1. OPPS vs. CPT: Coding injections and infusions. Briefings on APCs, May 2011, Vol. 12, No. 3.
2. Dig into the details of wound care documentation. Briefings on APCs, May 2011, Vol. 12, No. 3.
3. Johnson, L. The Implementation of an Outpatient Clinical Documentation Program. Ingenix White Paper, 2008.
4. Stanfill, Mary H. "Preparing for ICD-10-CM in the Emergency Department." *Journal of AHIMA*, 83, no.6 (June 2012): 38-41.
5. Abbey, Duane. Advanced Observation Services: Issues & Answers, PowerPoint presentation, Abbey & Abbey, Consultants, Inc. Version 9.6 – 2010.
6. HCPro, Inc. CMS tears down walls for physician supervision. APC Payment Insider, Jan 2011, Vol 13, No. 1.
7. LeMire, Diane. Documentation Improvement or Doctor Improvement? HIS Conference, 4/26/12.
8. Trailblazer Health Enterprises, LLC. Inpatient Admission Versus Outpatient Observation Following an Outpatient Procedure, Notice ID: 13067.
9. Trailblazer Health Enterprises, LLC. Documenting Outpatient Physical Therapy Services. Notice ID: 14456.
10. Trailblazer Health Enterprises, LLC. Inappropriate Hospital Admission Versus Outpatient Observation, Notice ID: 13804.
11. Mackaman, D. Carving out procedure time from observation hours. MedicareFind. 2/15/10.



Linda Renee Brown, RN, MA, CCDS, CCS, CDIP, is a clinical documentation improvement consultant and a former case manager. She is a featured blogger for the Association of Clinical Documentation Improvement Specialists. Contact: catladyrn@gmail.com

As Health Cost Transparency Increases, Will Physician Pay Be Next?

BY STEVEN DASHIELL

The Centers for Medicare and Medicaid Services' (CMS) pledge to increase transparency and lines of communication in the healthcare industry has been a goal for the federal body for decades, but its first real impact was felt earlier this year. The release of average charges for the 100 most common inpatient services in May and subsequent release of a number of outpatient charges caused quite a stir within the healthcare industry.

The data unveiled by CMS illustrated wildly different charges for the same procedure from state to state, with some charges greatly varying even between hospitals in the same area. It served as a demonstration of the inconsistencies of the healthcare system in the United States and bolstered support for the continued movement toward transparency in the healthcare system.

EXPANDING SUPPORT

This movement has led to the creation of a number of "transparency startup" companies, which are being fueled by investors anticipating a continued growth of the movement. Several such companies have been in the news recently for strides being made in funding and outreach in their programs.

TRANSPARENCY IN TRANSIT

Change Healthcare, a Tennessee-based healthcare company founded in 2007, was recently granted $15 million in total by a number of investors. Amongst them include HLM Venture Partners, Noro-Moseley Partners, BlueCross BlueShield Venture Partners and more – seven investors in total, a remarkable figure for such a fledgling company.

According to Change Healthcare's site, their mission statement is to "improve how healthcare is purchased in America by driving sustainable engagement at the individual level through personalized and actionable information." To achieve this, they offer two programs aimed at bringing transparency and education to users.

The Transparency Messenger is a data aggregation program that collects information on local healthcare providers and automatically suggests the highest quality, lowest price options to the user. The information provided is tailored specifically to the user based on healthcare utilization, benefit plan and other preferences, which is then emailed or sent directly to the user's phone.

Healthcare University is Change Healthcare's education program that engages users with an interactive experience that entertains while it informs. The basics of healthcare, ways of becoming a smarter health insurance shopper, and other healthcare areas are covered via videos, quizzes and games. To date, these programs have achieved 98 percent registration and 60 percent engagement rates, figures that helped Change Healthcare earn its investors' support.

IMPROVING EMPLOYEE CHOICE

Maxwell Health, with offices located in New York and Cambridge, also has an eye on creating greater transparency in the healthcare industry and has already begun gaining attention for its services, raising $2 million through sponsors.

Maxwell Health teams with various health plans to bring tools and advising to employees that help them make the best choices available in terms of quality and cost. The company offers a web-based service for comparing health plans, as well as an app available for tablets and other mobile devices.

"Maxwell Health is a big-picture solution for companies wanting to eliminate the enormous burden of HR administration, reduce healthcare costs and increase employee well-being," said Veer Gidwaney, co-founder and CEO of Maxwell Health, in a statement. "Everyone wants more healthcare options, but it's critically important to be able to make sense of them all, which is why Maxwell Health can play a key role in enabling people to make better choices."

NEW TERRITORY

Much of these recent advances and funding were made possible thanks to the public response to the release of average hospital costs in May. Now CMS faces an interesting new challenge. Dow Jones & Company and Real Time Medical Data, in a bid to access physician-level Medicare payment data, petitioned to have a 1978 injunction that prohibited the release of physician and provider data lifted. The appeal was uncontested and lifted on July 30 of this year.

Data on physician Medicare payments can now be distributed by CMS for parties who request it. However, no data has been released yet, as a policy instated by the Department of Health and Human Services (HHS) in 1980 ensures that the privacy of physicians cannot be compromised over the "public interest in the individually identified payment amounts" that physicians receive from Medicare. There now lies a conflict of public interests vs. physician privacy on the release of data. The Centers for Medicare and Medicaid Services has not yet decided on how best to release physician payment data and are now reaching out to the public to gauge just how or if this policy should be modified and what form this physician payment data should take before release.

> "THERE NOW LIES A CONFLICT OF PUBLIC INTERESTS VS. PHYSICIAN PRIVACY."

Unlike the release of hospital charge data, the benefit of releasing Medicare payment data for physicians is not as immediately clear – by comparison, the release of hospital charge data naturally lent itself to better healthcare decisions through price competition. Though CMS remains quiet on the matter due to the developing nature of the policy, it can be assumed that much like the public's support of the May release of hospital charges helped further development in transparency, CMS is counting on the public to steer its decision in the right direction. Whether physician payment data can make the same splash as hospital charges remains to be seen. CIP

Measurement Conference 2013

DORLAND HEALTH

Analyzing Data to Improve Clinical, Quality and Process Improvement in the Era of Payment Reform

Green Valley Ranch Resort & Spa
Las Vegas, NV

September 20, 2013

About the Conference

Dorland Health presents the first one-day Conference for professionals involved in care coordination aimed at improving clinical, quality and organizational performance through the use of data. For healthcare leaders seeking a critical edge in today's challenging environment, the Conference is designed to deliver better performance, better quality and a smaller cost burden by using data to capture quality improvement in the current era of payment reform. The faculty is comprised of industry leaders who will share the tools and resources that organizations can use to collect, trend and analyze data in order to stay ahead of the competition.

By attending this conference, you will:

- Learn how to leverage best practices, lessons learned, and data knowledge to achieve optimal health, and financial outcomes as a way to realize optimal performance for organizations.
- Find out how to use data analytics, tracking tools and transparency that reflect your patient population to identify areas where interventions can make a difference.
- Take away ideas you can use to achieve better healthcare and financial outcomes.
- Understand the role of data and data analytics in the emerging paradigm of accountable care.
- Learn how to capture data as it relates to the shift away from a fee-for-service to pay-for-performance model of healthcare delivery.
- Discover how organizations successfully collect, analyze, track and trend data to identify areas of risk and realize clinical, quality and performance improvement.
- Take away strategies to obtain organizational buy-in across departments as you seek to implement new models of tracking patients and capturing data.
- Learn the critical steps involved in building a plan for team education and performance improvement.

CONTINUING EDUCATION CREDITS WILL BE AVAILABLE

To review the agenda and register go to
www.dorlandhealth.com/measurement_conference

VENUE INFORMATION

Green Valley Ranch Resort & Spa
2300 Paseo Verde Parkway
Henderson, NV 89052
866.782.9487

CONTACT

Anne Llewellyn
Editor In Chief
954.476.7143
allewellyn@accessintel.com

Kim Luna
Account Executive
720.870.2440
kluna@accessintel.com

www.dorlandhealth.com/measurement_conference

Dorland Health 4 Choke Cherry Road, 2nd Floor, Rockville, MD 20850

22346

Building Buy-In: Using Education, Empowerment and Self-Care to Reduce Readmissions

BY VIVIAN CAMPAGNA, MSN, RN-BC, CCM

As hospitals deal with the implications of the Hospital Readmission Reduction Program for Medicare patients, best practices in case management could very well be the solution to this current challenge.

Under the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) is required to reduce payments to hospitals with excessive readmissions (within 30 days of discharge). To avoid such revenue losses from Medicare payments, hospitals are launching initiatives to reduce readmissions. A highly effective component of these approaches is to utilize professional case managers, with their emphasis on advocacy and empowerment of the patient/client (the individual receiving case management services) through education and promotion of self-care.

The better informed the patient becomes, particularly around follow-up care after discharge, the less likely readmission within the 30-day window will be an issue. Case managers are equipped to better educate a patient via motivational interviewing and patient engagement, thereby identifying potential risks, which in turn could lead to an unnecessary or avoidable hospital readmission. Equally important, the patient then will become an active partner in managing his own health, with greater buy-in to improve health outcomes.

Adherence and follow-up after hospitalization confronts the entire patient spectrum. Whether uninsured, underinsured, or even fully insured, patients may not always be compliant with follow-up care, although the reasons for a lack of adherence post-discharge may differ. A professional case manager, particularly one who is board certified, has the skills and expertise to engage patients in their care, by identifying and addressing impediments to compliance and troubleshooting the problems in advance.

Addressing the readmission risk is aligned with the case management process. As the Commission for Case Manager Certification (CCMC) describes the case management process in its Case Management Body of Knowledge™ (CMBOK), it spans screening, assessing, stratifying risk, planning, implementing (care coordination), following up, transitioning, communicating post-transition, and evaluation. The CMBOK states, "Centering on a client and the client's support system, the case management process is holistic in its approach to the management of the client's situation and that of the client's support system. It is adaptive both to the case manager's practice setting and to the healthcare setting in which the client receives services."[1]

Thus, evaluating the risks that lead to a higher incidence of readmission are part of the case management process.

UNDERSTANDING THE PROBLEM

The problem with readmissions is most acute among the uninsured. Indeed, this patient population yields lessons that show most dramatically the need for professional case management to identify resources to facilitate follow-up care.

When individuals are uninsured, access to primary care is limited. Moreover, a lack of financial resources may keep an individual from seeing a physician after discharge because of the cost involved. After being hospitalized, the patient may also feel better, which triggers the decision (albeit unwisely) to postpone or avoid follow-up care. Add to that the financial strain of paying for prescriptions, and adherence to post-discharge orders and instructions declines even further. Readmissions then become highly likely, even to the point of being expected.

It must be noted that although a hospital faces a financial burden under the readmissions reduction program when a noncompliant patient is hospitalized again within the 30-day timeframe, the legal and ethical obligation is to provide treatment. The board-certified professional case manager is held to the highest of ethical standards that require, at all times, actions that are in the best interest of the patient/client.

Before readmission occurs, however, a professional case manager can reduce that risk with some advance planning at the time of discharge. For example, a patient with no insurance can be linked to a community resource, such as a hospital or clinic, that will treat these individuals for a nominal fee, when other resources (such as Medicaid) are not available. When a patient cannot afford to pay for prescriptions, the case manager can help the individual access pharmaceutical programs, when appropriate, that provide free or reduced-cost drugs.

Such interventions require empathy for the patient, to understand that this individual's noncompliance may be the result of having to choose between filling a prescription or necessities of daily life, such as buying groceries or paying rent. Or if a prescription is filled, the person may try to "make it last," by taking the drug less frequently or in smaller doses than prescribed, which renders the treatment less effective.

Professional case managers can identify those individuals who are likely to be at risk for readmission by screening for diagnoses that are associated with frequent hospitalizations, or by screening for a personal history of two or more hospitalizations or emergency department visits in the past six months. When a higher risk of readmission exists, the case manager can devise a comprehensive follow-up plan, such as touching base with the patient within 24 hours of discharge to ensure that he sees a physician within 48 hours. For those who are at less risk, a follow-up appointment may occur within seven days.

Noncompliance and readmissions do not affect only the uninsured. The problem may also arise with individuals who have high-deductible insurance policies, which is common among young adults who do not have any chronic medical conditions. (With the implementation of the Affordable Care Act, individuals who purchase their own insurance may opt for high-deductible plans.)

When the unexpected happens – for example, appendicitis – a high-deductible policy becomes, essentially, underinsurance. A $3,000 bill for an appendectomy may only be partially covered by the insurance company. If the patient winds up with an infection and has to be hospitalized for seven days, the bill could swell to nearly $20,000 – of which the insurance company pays only a small portion.

Compounding the problem, high-deductible policies often do not have the contracted rates that many group policies have, whereby the cost of procedures and other treatments are reduced through negotiations between providers and insurers. Paying full charges for treatment soon turns a high-deductible policy into a payment nightmare.

Even when someone is fully insured, other factors can impact compliance. For example, a person may not stay off work as recommended by the doctor for fear of using up too much sick leave or getting behind at work. Filling prescriptions and taking all medication as prescribed is another barrier to compliance; when people feel better, they think of themselves as “cured” and stop taking their medication. Thus, relapses, reinjury or a lack of follow-up care can create a risk of readmission even for those who are fully insured.

EMPATHY, EMPOWERMENT AND EDUCATION

Across the patient population, adherence and follow-up care must be addressed at the outset in order to avoid unnecessary emergency department visits and hospitalizations. The solution is not simply to provide instructions to the patient. What’s needed is buy-in – emotionally, intellectually and physically. When patients understand the consequences of noncompliance – the escalating health risks that could lead to greater complications – they often become more committed to self-care.

An example is the person who is newly diagnosed with diabetes. Simply providing a copy of a recommended diet and literature on the importance of controlling blood sugar levels is not enough. Unless the patient has the necessary follow-up and support, he could end up back in the hospital. A case manager’s role is patient-centered, as an advocate for the patient. Understanding the impact of diagnosis on an individual is crucial to optimizing the short-term health goals and long-term health outcomes.

The professional case manager holds the key to patient engagement, to make sure the individual understands the importance of follow-up care and compliance, as well as the health risks that can result from a lack of adherence. With empathy and understanding, the case manager will develop a care plan that identifies and addresses the obstacles to adherence with creative and effective ways of getting patients the follow-up care they need and, in the process, reducing their risk of readmission. CIP

REFERENCES

1. Commission for Case Manager Certification, CMBOK, “Case Management Process,” www.cmbodyofknowledge.com/content/case-management-knowledge-2. Accessed Aug. 1, 2013.

Vivian Campagna, MSN, RN-BC, CCM, is a past chair and a commissioner of the Commission for Case Manager Certification, the largest nationally accredited organization that certifies case managers. She is also assistant vice president for case management at Lutheran Medical Center in Brooklyn, N.Y. Contact: ccmchq@ccmcertification.org

Creating an ‘Activated Patient’ to Bolster Transitions of Care

BY JAMES L. HOLLY, MD

In 2010, Southeast Texas Medical Associates LLP (SETMA) realized that the name “hospital discharge summary” had lost significance as a “transition of care” document; therefore, we changed the name to “Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan.” Over the last three years, SETMA has discharged more than16,000 patients from the hospital. Nearly 99 percent of the time, the patient, hospital and caregiver received this document at the time the patient left the hospital.

This Hospital Care Summary allows for the responsibility for care to be transitioned to the patient or to the caregiver, as it is “passed off” at discharge. Containing a reconciled medical list, follow-up appointments, risk of readmission assessment, diagnoses, and a plan of care, the summary functions as a baton, a secure transition from one person to the next. But hospital-to-outpatient is only one of the transitions in patient care; as a result, SETMA prepares several “batons” in the course of every patient’s care, all with the same purpose.

The image seen in Figure 1 is in every SETMA treatment room and a framed copy is found in every public area in all of our clinics. It illustrates the emphasis on transitions of care, as well as several components, including:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the “baton” which has been developed by the healthcare team is a coordinated effort between the provider and the patient.
4. That the healthcare provider understands the patient’s healthcare plan of care and the treatment plan, but that without its transfer to the patient, the provider’s knowledge is useless to the patient.

Figure 1

Firmly in the provider’s hand, the baton – the care and treatment plan – must be confidently and securely grasped by the patient if change is to make a difference 8,760 hours a year.

5. That the imperative for the plan – the “baton” – is that it be transferred from the provider to the patient if change in the life of the patient is going to make a difference in the patient’s health.
6. That this transfer requires that the patient grasp the baton, i.e., that the patient accepts, receives, understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.
7. That the patient knows that of the 8,760 hours in the year, he will be responsible for carrying the baton – longer than any other member of the healthcare team.

The promise of the patient-centered medical home (PCMH) is symbolized by the baton. Its display continually reminds the provider and patient that, to be successful, the patient’s care must be coordinated, which must result in coordinated care. As clinics transform into PCMHs, coordination begins at all points of care transitions, and the work of the healthcare team is that together they evaluate, define and execute care.

REVIEWING ELEMENTS OF A PLAN

The great value of a written plan of care and treatment plan is to provide the patient and the patient’s family with a means of reviewing what they learned during a hospital stay, a visit to the clinic or to the emergency department. Without the written plan, which has the patient’s name on every page and which has the patient’s personal laboratory and procedure results, little will be accomplished. With a written plan of care to review, the probability of real learning taking place is greatly enhanced.

Furthermore, as healthcare providers, we are committed to lifetime learning; now we want our patients to become students as well. The more the patient learns, the more they participate effectively in their own care. Having had a dialogue with their healthcare provider and having received a printed copy of their plan of care and treatment plan, the patient is prepared to accept responsibility for their own care all year long.

EXAMPLE OF FEEDBACK LOOP

Few things are as new to healthcare providers as the concept of a feedback loop. Most physicians were trained to have a monologue with patients. But a didactic exchange without a dialogue often results in two simultaneous monologues without effective communication.

In 2010, I saw a patient for the first time whose father, mother, sister and two brothers had diabetes. I thought, “Aha, I wonder if she has diabetes?” Upon testing, diabetes was proved. The day following the clinic visit, I called the patient and reviewed the diagnosis, condition and plan of care and treatment plan with the patient, which included medications, further evaluation with ophthalmology, endocrinology, diabetes self-management education, medical nutrition therapy and follow-up visits. The plan of care was evidenced-based, coordinated and communicated.

The patient agreed to all of the plans, but as I hung up the telephone, I thought to myself, “This patient is not buying any of it.” Using SETMA’s Clinic Follow-up Call template, I scheduled a call from our care coordination department for three days later. The call was made and I received the report: the patient appreciated the visit and the call, but she is not going to do the education, take the medication, or have any of the other evaluations.

UNINTENTIONAL NEGLECT

For several years, I remembered this patient as an example of excellent patient-centered care, until I realized how ineffective the transition of care had been due to my ignoring the patient's reason for seeing me. As I thought about this patient, I went back and read her record. Over and over, the words rang in my head, "I want to lose weight." I remembered that once I had completed the patient's history and settled on treating her diabetes, I unintentionally ignored the patient's desires. I was certain that the patient had diabetes, which she did. And I was determined to give the patient excellent care for diabetes, which I didn't.

Rather than explaining to the patient why I don't treat weight loss with Ionamin, thyroid and diuretics, I ignored her goal. Because I ignored the patient's goal, the patient ignored my plan. I realized that while I would have labeled the patient "noncompliant" using ICD-9 or ICD-10 codes and SNOMED nomenclature for that diagnoses, the real diagnosis should have been "provider failure to communicate," "nonpatient-centric care," "failure to activate the patient," and/or "failure to engage the patient."

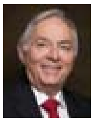
The fault was not the patient's; the fault was mine. What if I had engaged the patient in a conversation about weight reduction? What if I had walked the patient through SETMA's adult weight management program? What if I had said, "While we are helping you lose weight, we can also help you control your diabetes?"

RECOGNIZING A MISTAKE

Plutarch said, "To make no mistakes is not in the power of man; but from their errors and mistakes the wise and good learn wisdom for the future." My mistake can be forgiven if I learn from it. And how will I demonstrate learning? I think I shall never see a patient without asking the question, "What is your goal? What do you want to achieve in this visit and in the care you will receive from this clinic?"

That question is partially answered when the patient-encounter-record documents the patient's "chief complaint." But to make it more explicit, we added a "comment box" which is labeled "patient goal." It will be expressed in the patient's words. While we want to use structured data fields, this may be one case where structured data fields obscure the issue. As we have more experience with shared-decision making, we will clarify this data field more precisely. But, we will never ignore a patient's personal goal again. And, if the patient's goal is inappropriate or unattainable, we will address that directly, rather than ignoring it.

Transitions of care require a tool such as a baton, but it also requires the activation of the patient by engaging them in a process of taking charge of their care, and that requires an effective dialogue with the patient. If the patient does not accept the plan of care and agree to make it their own, the transition of care will fail, no matter how good it is. CIP



James L. Holly, MD, is founder and chief executive officer of Southeast Texas Medical Associates. He is adjunct professor at University of Texas Medical School in San Antonio. He is also associate clinical professor in the Department of Internal Medicine at Texas A&M College of Medicine. Web: www.setma.com | Contact: jholly@setma.com

---

READMISSIONS

The Business Angle: A Process for Using Community Resources to Reduce Readmissions

BY CYNTHIA BATCHER, MSN, RN-BC, CCM AND HEATHER KARINA LOYO, PHD

Care managers have many responsibilities but none more important than the transitional plan of care. With healthcare focused on the transitional design of discharge plans, readmissions and the bottom line, there are new questions we must ask: is the transition plan based on best practice and who provides the care? How long will this plan be in effect and what happens after? Does this plan support the patient or the discharge? Is this an effective care plan, can the process be streamlined, replicated, is the process sustainable, and does the solution work?

Is it possible for care managers to remodel our transitional plans by not only partnering with providers but by augmenting and leveraging all resources in the community, thus harnessing them to create a safety net for healing and managing fragile populations? As case managers we hold ourselves responsible and accountable for the transition plan and the outcome of patient disposition and, therefore, we become responsible for readmissions.

IF WE ARE ACCOUNTABLE, WHAT ARE OUR TOOLS?

As case managers continue to be responsible for readmissions, there will remain a need to promote, develop and involve the community in the integration of healthcare partnerships, services and resources, which then can be readily available to patients. It is this lack of cohesive community services that could be orchestrated by a case manager or case management partners to demonstrate improved quality of community care while decreasing acute care, length of stay and readmission.

Opportunities to improve care can take many forms. An early successful example, for me, was created by working for Integrated Care Collaboration, in Austin, Texas. This collaboration's partnership board was made up of area hospitals, clinics, organizations, universities and individuals. This collaboration was dedicated to improving care for the minimally insured and uninsured. The scope of work often involved local, state and federal agencies and physicians. For example, some of the programs developed were led by local physician groups who chose four to five healthcare disparities to review by chart audit, developing a community score card for asthma and diabetes.

Another program was the development of "PharmCare," a pharmacy program designed to deliver long term IV antibiotic therapy outside of the hospital. An opportunity to research and define the contextual factors of a chronic disease model for cardiovascular support was completed, in partnership with the Centers for Disease Control. This led to the development of a "Chronic Disease Collaborative" in Austin, made up of 50 individual partners, as well as an article published in Health Promotion Practice (Loyo et al., 2013).

In reality, case managers are responsible for both sides of the same coin, based on our maturing legacy from Florence Nightingale's practice of assessing the environment to promote health (Dunphy, 2006). When a case manager coordinates care, do we plan for just that episode, or take a different view to prevent readmissions, and assist to organize community resources? It is my experience that vetted community support may be designed, developed and implemented by active case managers in conjunction with key stakeholders by employing the development and vetting process below.

TOOLS FOR DEVELOPING & VETTING COMMUNITY PROJECTS

1. Identify and drive a networking strategy for a new care pathway based on data analysis and communicated to stakeholders through population statistics. There are many places to find vetted information: national databases, states epidemiologist, web, and local health assessments tools for identifying priorities (National Committee on Vital and Health Statistics, 2011). Vetted data will help the case manager create community support by identifying difficulties that are not currently being addressed. Identify what statistics jump out. What factors are important, and to whom? What would be the value of the program to acute care's reduction in length of stay and readmissions? How many patients would it impact, who are the stakeholders, and do you have the passion to rally others to the cause?

2. Identify key stakeholders and develop a core group. This is not an easy task and you may have to start small. They need to be interested or instrumental in this type of activity or have an outgoing personality that would attract others to support your efforts. Your hospital leadership can also help identify persons or organizations to approach.

> "IS IT POSSIBLE FOR CARE MANAGERS TO REMODEL OUR TRANSITIONAL PLANS?"

3. Design a straw man proposal using your or your core group's vision to explain the proposed program. Be clear, honest and straightforward. Include physicians, patients, pharmacists, foundations, healthcare district, boards, university scholars, community members, public utilities, and specific groups related to the disease. One may also approach elected officials. Gather their support by incorporating their thoughts and improvements into your plan, allowing them to assist in the process of change.

4. Build a case for action, letting your data and vision speak. Create a return on investment (ROI) and write a business plan. An example of an asthma ROI could be the reduction of missed school days by children in grade one. To make a case, take last year's number of children diagnosed with asthma in grade one, average the number of school days missed by those children and multiply by the dollar rate the student provides the school for each day not absent.

Ten children times five days missed by each child equals 50 days. Multiply this by $20 for each day the child misses, and this comes to $1,000 dollars lost to the school district.

CREATING A BUSINESS PLAN

Business plans or engagement summary's need to include:

1. **Executive Summary.** Include expected outcome and group expectations by name.
2. **Business Overview.** Identify what and where group members have volunteered to help.
3. **Market Analysis.** Include ROI, relevant to the community.
4. **Operations Plan.** Identify your main plan with several viable options based on stakeholder suggestions.
5. **Identify Barriers.** When barriers are identified, ask for suggestions to help mitigate the barrier.

NEXT STEPS IN THE BUSINESS PLAN

At this stage the business plan needs to state that it is a draft, with the footnote stating the date and identifying which draft copy it is.

1. Vet the draft plan in person to all supporting stakeholders and engage additional stakeholders. Take stakeholders with you to help, particularly if the stakeholder knows the audience. Ask for input and integrate into your plan. Build a timeline and milestone dates with your stakeholders. Include in your timeline media notifications, and state what will be included in your updates. Create a new draft and share the new draft with your stakeholders. Build momentum and don't let it slow down.

2. Communicate your progress and your new draft with stakeholders and interested parties via email. The case manager should remain responsible for the clinical development and provide oversight, but let others assist in the community management and oversight. An open invitation to meetings or the ability to provide public comment is essential.

Remember to be responsible to your stakeholders, supporters, boards and committees by providing monthly project updates and outcomes. If possible, get the projected outcomes added to your stakeholders' and supporters' dashboards.

3. Complete the revision of the draft business plan and timeline. Make sure all of your stakeholders and supporters approve of the plan. Then take off the word "Draft" and resend to all.

continued on page 35

PROFESSIONAL
Patient Advocate
INSTITUTE

Earn a Certificate in Hospital Patient Advocacy to Better Serve your Clients

Upon completion of the training program participants will receive:

- A Certificate, suitable for framing, that recognizes the completion of the Certificate In Hospital Patient Advocacy Training Program.
- A logo showing that you have completed the Certificate in Hospital Patient Advocacy by the Professional patient Advocate Institute on letterhead or other business materials.
- A lapel pin for professional identification.

The healthcare system is complicated, fragmented and costly. As a result, today's consumer is looking for direction and unbiased advice they can use to allow them to have a voice in their care as well as having someone who can assist them in making informed decisions. To meet this need, the emerging practice of hospital advocates are in place in hospitals across the country.

The Hospital Patient Advocate Certificate Program is an E-learning course that you can take at your own pace and is aimed at enhancing training for those involved in the specialized field of hospital patient advocacy. The goal of the program is to focus on the concepts of hospital patient advocacy and to assist advocates in improving the patient and family experience, which is one of the elements hospitals and others organizations, must meet as a core component of value-based purchasing. In addition, this program will reinforce the role of hospital advocates in ensuring that patients and their families have a safe and empowered in-patient stay.

The e-learning program is open to all who want to learn about this emerging field of hospital patient advocacy.

To enroll in the Certificate in Hospital Patient Advocacy Online Training program, please visit www.patientadvocatetraining.com

Sustaining Performance Outcomes in New Care Coordination Models

How case management accreditation can support hospital-based transitions of care

BY DANICE DEBERRY, RN, CCM, MSN, SUSAN DEMARINO, RN, MSHS, CPHQ, RN-BC AND SUSAN STERN, RN, CCM, MHA

Hospitals are changing, and as a result, are introducing new approaches to transitions of care as part of their case management departments. These new designs are being integrated into both small and large hospital systems and are impacting the way in which clinical care is being delivered. The rationale for change, overview of current trends and the value of accreditation within the landscape will be taken in turn.

WHY NOW?

Case management departments in the hospital setting have not traditionally been viewed as clinically important by senior executives, and as a consequence were often located in small remote offices away from the patient units. Often called "continuum of care" or "discharge planning" departments, historical examples of care management reveal a functional approach to managing the workload.

Responsibility herein was delineated by individual expertise: social workers handling post-care placements; utilization review case managers performing admission-related medical necessity chart reviews; and other case management staff dealing with continued stay reviews, denials and appeals management. While such a model remains both relevant and popular, the traditional approach has been challenged by the introduction of new regulatory initiatives and increased financial exposure for hospitals. The financial exposure is typified by increased denial rates, decreased revenues, and delayed discharges due to poor coordination and paying RAC penalties. There is often a disconnect between utilization review and timely discharge planning based on the patient's needs post-discharge.

REGULATORY IMPACT OF ACA PROVISIONS

The Affordable Care Act (ACA) created the Hospital Readmissions Reduction Program in March 2010 to reduce preventable readmissions and decrease Medicare's expenditures. On October 1, 2012, the Centers for Medicare and Medicaid Services (CMS) launched a new program that penalizes hospitals for what it determines to be excessive avoidable readmissions. The penalties are based on the belief that hospitals should:

- Make sure that patients and families are educated about their care when they leave the hospital.
- Improve transitions of care.
- Improve discharge planning hand-offs to community providers and ensure patients receive appropriate care after they have left the hospital.

> "HOSPITAL EXECUTIVES ARE BEING CHALLENGED WITH MAJOR CONCERNS RELATED TO INCREASING REVENUES."

The Medicare Payment Advisory Commission (Med PAC) identified seven conditions and procedures that accounted for 30 percent of potentially preventable readmissions. These conditions are heart failure, chronic obstructive pulmonary disease, pneumonia, acute myocardial infarction (MI), coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty and other vascular procedures. Hospitals are at risk for penalties for readmissions for these conditions that are readmitted with 30 days for the same condition.

Now that CMS has launched the Recovery Audit Contractor (RAC) initiative, there are penalties and money to be recouped by the government for avoidable readmissions within 30 days of the last admission for the same diagnosis. The scope of the RAC program was initially limited to include only Medicare Parts A and B, but now has been expanded to include Part C (Medicare Advantage) and Part D (Prescription Drug Benefits).

Supporting the success of CMS's RAC initiative to externalize costs, Medicare Managed Care Advantage Plans have implemented a similar review of readmissions. Considerations for introduction of a congruent program are currently being made by accountable care organizations (ACOs) that are taking risk for Medicare beneficiaries. ACOs, here, see the need to reduce avoidable readmissions for high-risk patients in the populations they serve.

GAINING CORPORATE BUY-IN

In addition to regulatory pressures, a key factor of influence mentioned earlier is the importance placed on the role of case management in the continuum of care. Hospital executives are being challenged with major concerns related to increasing revenues while simultaneously decreasing denial rates and improving patient experiences. They are coming to the realization that not every admission is the same and the case mix index will be drastically different in the next two to five years due to the new ACA regulatory requirements.

These concerns are made evident by recent actions within hospitals to redesign their case management departments with a strong emphasis on managing transitions of care. Many have done root cause analysis and quality focus studies to identify why patients are readmitted within 30 days. In response to the findings, organizations are in the process of implementing systemwide interventions to improve the discharge planning process. Integrated hospital systems and larger hospitals are leading the way with the redesigns. However, these changes may not be enough.

> "MANAGING TRANSITIONS OF CARE EFFECTIVELY IS IDENTIFIED AS ONE OF THE CRITICAL COMPONENTS TO REDUCING READMISSIONS AND POOR HEALTH OUTCOMES."

Considerations are being made for high-risk patients requiring social and community support services, who may otherwise be readmitted. Other hospital departments are engaging a transitions of care case management approach, including involvement across nursing, admissions, medical records, therapies, palliative care, and pharmacy and admitting physicians. To gain a broader understanding of the varied approaches taken and to gauge the common undercurrents across case management programs, descriptions of major models in popular use follow.

EMERGING TRANSITION OF CARE MODELS

1. Centralized Transitions of Care Models. Hospital systems with two or more hospitals have set up post-discharge programs through an in-bound and out-bound call center that offers free transitions of care planning to discharge patients that have been identified as high risk where patient participation is voluntary.

A registered nurse (RN) reaches out to the patient and/or caregiver to ensure discharge instructions are understood and enroll them in the program. The RN completes an assessment with a plan of care. Nonclinical staff provide ongoing support and offer practical interventions in the plan of care, such as ensuring appointments are made, arranging transport to doctor's office visits and outpatient follow-up tests, assisting patients with obtaining medications ordered by the doctor and following up on any post-discharge issues. These transitions of care units typically follow the patient for 30 to 45 days.

2. Readmission Case Managers (CM) Programs. In this model, the goal is to stabilize the patient and avoid an unnecessary readmission. A dedicated case manager is assigned to follow all high-risk patients who have met a risk score. The LACE index-scoring tool is often used to identify these patients. Utilizing telephonic and/or face-to-face outreach, the readmission case manager may be within the existing case management department or located in the hospital's outpatient clinics or in a home care agency. Additional coordination may occur between the patient and the pharmacist, who often will engage in reviewing the patient's medications.

3. Hospitalists-Dedicated Case Management. Many hospitals realize that when patients are all over the hospital it is difficult to develop relationships with doctors. Some hospitals have their own hospitalists (MDs), who act as the attending doctor for inpatients and also in select post-acute settings. As much as possible, patients are assigned to a hospitalist wing where a dedicated case manager and/or social worker complete an in-depth assessment, coordinate care and work with the hospitalists to achieve a timely discharge. The goal is to improve the patient experience, create a cohesive multidisciplinary team and document medical necessity with the appropriate plan and level of care administered. This approach provides a better hand-off to the next level of care, whether it is to a skilled nursing facility or the home setting. Patients on the unit with a specific diagnosis, such as CHF, pneumonia or MI, for example, can be offered a transitions of care follow-up program that includes extended community partners.

4. Integrated Special Needs Case Management Program. The move in care coordination here is toward an integrated model where the RN CM performs the utilization management review, initial discharge planning evaluation and continued stay reviews on an assigned unit – often with a social worker counterpart. In addition, the case management department as a whole uses root cause analysis and risk stratification to identify patients and caregivers who can be enrolled in a more intensive care coordination program while in the course of their hospital stay. Performance measures and outcomes are based on a more in-depth assessment of six categories and are tracked on each patient in the program. The goals are plotted against baseline measurements, and aim to lower length of stay, reduce readmissions, and enhance the patient and caregiver experience. Findings have led to the institution of enhanced offerings, like new technology that allows patients to take home their discharge instructions in a secure digital format. Many programs are developing applications for tablets and smartphones that can be provided to improve the patient experience. Like the Readmission Case Managers Program, this integrated special needs program includes pharmacy involvement in the drug therapy management of these patients prior to discharge, ensuring medication reconciliation and adherence with interventions.

5. Hospital and Provider Integrated Clinical Care Programs. Many hospital systems are moving toward integrated clinical networks and embedding case managers, social workers and support staff into community care teams. An example of this is currently taking place in ACOs that are capitated for 5,000 or more Medicare beneficiaries. The hospitals and providers are looking at new ways to improve the coordination of care for patients at risk for readmission due to social issues, and integrate clinically with primary care practices. Primary care practices that agree to participate are assigned a care team. At this time, CMS currently has demonstration projects that are looking to determine if this approach is a new model for ACOs. Other types of embedded care management teams are also being proposed in provider hospital organizations (PHOs) and independent practice associations (IPAs).

Regardless of the model that is chosen, the identification of populations where case management interventions will make a difference is imperative. Most hospitals' case management departments are faced with increased pressure to "work smarter" and demonstrate value with sparse resources. Developing criteria for case identification is fundamental to an effective case management practice model to ensure that program interventions target at-risk populations. URAC's Case Management Accreditation program builds upon essential program components and incorporates best practices to support and strengthen overall infrastructure in such ways as:

- Promoting use of consistent criteria for case identification to ensure that case

management services are offered with consistent application.
- Establishing and monitoring case management program performance measures.
- Incorporating the use of evidence-based and clinical practice guidelines with practical application that supports program interventions for improved health care outcomes.
- Underscoring the importance of using information support systems to achieve and measure case management performance goals.
- Integrating shared decision-making principles that emphasize patients' values and preferences for achieving self-management goals.

Case managers are positioned to make significant contributions that substantially impact prevention of avoidable readmissions and improvement of healthcare outcomes. This is achieved through proactive interactions for educating and engaging patients. Typically, when consent for case management is obtained, this provides an optimal opportunity for the case manager to establish and disclose the nature of the case management relationship. It is essential to incorporate a patient-centered and collaborative approach for obtaining stakeholder input. Additionally, this presents an ideal time for creating a climate conducive to providing "conflict-free" case management services and laying the foundation to promote informed decision-making through engaging the patient, families and/or caregivers chosen by the patient.

A thorough assessment is fundamental to developing an effective and patient-centered case management plan. Patients must be considered active participants for developing the plan of care. Executing the care plan requires that qualified and competent case managers demonstrate the ability to coordinate care, typically with an extended multidisciplinary healthcare team and community healthcare team.

As an additional component of the case management process, case managers must coordinate care for patients. Case manager competencies require clinical experience and critical-thinking skills for managing complex and high-risk patients while simultaneously assuming the patient advocate role to ensure conflict-free, unbiased and culturally competent care. Care coordination must also take into account patients' values, preferences and their choice to self-direct care.

Mandates in the ACA are reshaping healthcare delivery and driving the need to ensure safe and effective transitions of care across settings for patients. Managing transitions of care effectively is identified as one of the critical components to reducing readmissions and poor health outcomes. Effective case management puts the patient at the center of all care decisions and is an essential driver to ensuring that patients get the right care, in the right setting, at the right time.

Outcomes measurement reporting becomes essential at the outset when evaluating the work performed and the outcomes obtained. Such standardized and validated measurement should demonstrate sustainable, measurable, transparent and consistently documented results.

IN CONCLUSION

As hospital case management models continue to evolve, care coordination responsibilities for case managers will continue to expand with an emphasis placed on adopting a collaborative approach with active participation from patients to achieve better coordinated care with quality, cost-effective outcomes. This progression will require organizations to demonstrate the value of case management programs to include measureable clinical, process and financial outcomes. A case management accreditation program builds a pathway for organizations to validate their case management program for achieving viable and sustainable outcomes. CIP

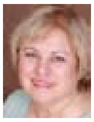
REFERENCES

1. Unplanned readmissions after hospital discharge among patients identified as being at high risk for readmission using a validated predictive algorithm Andrea Gruneir, Irfan A Dhalla, Carl van Walraven, Hadas D Fischer, Ximena Camacho, Paula A Rochon, Geoffrey M Anderson Open Med. 2011; 5(2): e104–e111. Published online 2011 May 31. (Note: The LACE index uses a validated algorithm to identify patients at high risk for readmission and examine actual hospital admission rates. L – length of hospital stay; A – Acuity on admission; C- Comorbidity; E – Emergency department visits.)
2. "Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7 – Care Coordination by Stanford University-UCSF Evidence-based Practice Center, Stanford, CA prepared for the Agency for Healthcare Research and Quality, Rockville, MD AHRQ Publication No. 04(07)-0051-7, June 2007.
3. NTOCC (National Transitions of Care Coalition) – Improving Transitions of Care: Findings and considerations on the "Vision of the National Transitions of Care Coalition". September 2010. www.ntocc.org
4. Policy Brief: Implementing Care Coordination in the Patient Protection and Affordable Care Act. Prepared by the National Coalition on Care Coordination (N3C) http://www.nyam.org/social-work-leadership-institute/docs/publications/N3C-Implementing-Care-Coordination.pdf

---

Danice DeBerry, RN, CCM, MSN, the senior manager for product development with URAC, has extensive clinical and comprehensive managerial experience in the healthcare industry business environment, specializing in the development, implementation, management and evaluation of healthcare programs such as disease management, utilization management and case management. Contact: ddeberry@urac.org

Susan DeMarino, RN, MSHS, CPHQ, RN-BC, is vice president of accreditation services for URAC. Ms. DeMarino brings more than 25 years of healthcare expertise, including case management, utilization management and quality improvement. Contact: sdemarino@urac.org



Susan Stern, RN, CCM, MHA, is senior business development executive at URAC. Ms. Stern has more than 25 years of experience in managed care operations and case management, including hospital case management. Contact: sstern@urac.org

DORLAND HEALTH

Care Coordination Achievement Program

Skills and Competencies for Today's Healthcare Leader

September 19, 2013 • 8:00 a.m. - 5:00 p.m.
Green Valley Ranch Resort & Spa
Las Vegas, NV

The Care Coordination Achievement Program is a learning platform for healthcare professionals and organizations as they seek to understand the latest intelligence about care coordination, including: what care coordination is; the core components that define the workforce; and why it is critical that all professionals recognize their responsibility in providing care that is coordinated across the care continuum.

For pricing along with package rates that include the Dorland Health Measurement Conference, please visit **www.dorlandhealth.com/care_coordination_achievement_program/**

Green Valley Ranch Resort & Spa
Las Vegas, NV

Hotel room block available at:
Green Valley Ranch Resort & Spa
2300 Paseo Verde Parkway
Henderson, NV 89052

Room block rate: $120/night
Make your reservation online or
call toll-free: 866.782.9487
Reference **Dorland Health** to get special rate

Agenda:

8:00 A.M. – 8:30 A.M.	Registration & Networking Breakfast
8:30 A.M. – 9:15 A.M.	Introduction, Background and Definitions Related to Care Coordination
9:15 A.M. – 10:00 A.M.	Professional Competencies for the Healthcare Workforce
10:00 A.M. – 10:15 A.M.	Networking Break
10:15 A.M. – 11:00 A.M.	Models of Care: New Opportunities for High-Quality Delivery
11:00 A.M. – 11:45 A.M.	Communication Advances Enabling Care Coordination
11:45 A.M. – 12:30 P.M.	Technology and Its Role in Care Coordination
12:30 P.M. – 1:30 P.M.	Networking Lunch
1:30 P.M. – 2:15 P.M.	Barriers to Care Coordination
2:15 P.M. – 3:00 P.M.	The Consumer's Role in Care Coordination
3:00 P.M. – 3:15 P.M.	Networking Break
3:15 P.M. – 3:45 P.M.	Transitions of Care
3:45 P.M. – 4:15 P.M.	Ethics of Healthcare
4:15 P.M. – 5:00 P.M.	Behavioral Health: Where It Fits In

To register call 888-707-5814 or visit us online at:
www.dorlandhealth.com/care_coordination_achievement_program/

Best Practices for the Coordination of Interstate and International Transitions of Care

BY JASMINE POLLARD LITTLE, RN, BSN, MSN, CCM

ABSTRACT

The Walter Reed National Military Medical Center in Bethesda, Md., provides comprehensive medical care for United States military service members and their families. Patients are sent to Walter Reed from all over the world, including our nation's Wounded Warriors. Coordination of care for patients with complex illnesses across vast distances can be a challenge.

In order to meet this challenge, the RAINING Down method was developed and piloted in the pediatric case management department at Walter Reed National Military Medical Center. Following implementation of the RAINING Down process, there were no gaps or fragmentations in care for patients experiencing transnational or international transitions of care. With minor modifications, this policy can be duplicated and implemented for any transition of care, inpatient or outpatient. It also makes no difference whether the patient is experiencing an increase or decrease in level of care or whether the patient is transitioning to a location across the street or across the globe.

Keywords: Case management, transitions of care, outpatient, pediatric, military.

At one time or another during a patient's life, it will become necessary to transition to new medical providers. Rationales for such a transition may include patient relocation, changes in availability of services or covered benefits, patient's age, changes in level of care requirements, or new benefits or coverage. Becoming established with the appropriate providers in a timely manner is crucial to ensure continuity of care for patients with complex medical needs. This article describes the "RAINING Down" process to coordinate incoming or outgoing transitions of care.

BACKGROUND

As mandated by the Base Realignment and Closure plan (BRAC), two large military treating facilities (MTFs), Walter Reed Army Medical Center (WRAMC) in Washington, D.C., and National Naval Medical Center in Bethesda, Md., merged on September 15, 2011, forming the largest military hospital in the world, Walter Reed National Military Medical Center (WRNMMC). The new location is in Bethesda, at the site formerly known as National Naval Medical Center (NNMC). WRNMMC is a military medical hub for receiving complex patients from overseas, including the nation's wounded, ill and injured. In addition to receiving patients from overseas, complex patients also arrive when families experiencing a Permanent Change of [duty] Station (PCS) are relocated to the National Capital Area from other MTFs within the continental United States. Prior to the time of the BRAC, there was not a pediatric case management program at the NNMC Bethesda campus.

THE ROOT OF THE PROBLEM

According to the United States General Accounting Office, 91 percent of military families will experience at least one PCS during a four-year period. Military families also often relocate as a part of the family care plan upon deployment of one or both parents. The PCS and deployment process often cause secondary problems related to access to or establishing medical care in a new, often unfamiliar location for the caregivers of children with complex medical needs.

Literature review produced little to no results regarding coordination of care for complex patients requiring transitions of care across long distances. According to Haas, Swan and Haynes, this is because "outpatient care is the least studied and poorly understood" (2013). Therefore, the RAINING Down process was developed from pediatric case management best practices and was piloted in the new pediatric case management department at WRNMMC for the purpose of preventing gaps or fragmentations in care during transnational or international inpatient or outpatient transitions of care. This eight-step process accomplishes the goal of minimizing the fragmentation of care and preserves continuity of care. The process is also adaptable for replication in any facility, military or civilian, and is useful for any type of transition.

IN FOCUS: THE RAINING DOWN PROCESS

Step 1: Review. Upon receipt of notification of incoming patient from an outside civilian facility or MTF, or that a family will be relocating to another area, review the medical records. Look for the following information:

1. Brief medical history containing patient's name, age, and diagnoses.
2. Contact information for transferring primary care manager (PCM), specialty, durable medical equipment (DME), and home service providers actively following the patient.
3. Listing of DME and other medical supplies. Note whether equipment is purchased vs. rented.
4. New local address of the family.

Step 2: Add. Contact the patient's family and/or respective providers to obtain additional information or for clarification as to what services are needed. When contacting the family, the case manager should also inquire about family concerns or issues.

Step 3: Identify. Use the information collected to identify and compile a listing of options for accepting PCM, specialty, DME and/or home service providers. Use the internet to locate providers geographically close to the family's new local address. For incoming families, utilize the "find a provider" function on the www.hnfs.com website to locate providers geographically close to the family's new local address. Contact DME providers to ensure the supplies/equipment the family currently has are available. If not, inquire if and when the company is able to obtain the needed supplies and equipment. Contact specialty and home services providers to determine if they are accepting new patients and if they are able to perform the needed services. If services are not currently available or if there is a waiting list, request information regarding estimates of when the requested services will be available.

For outgoing families, utilize www.humana-military.com if family is relocating to the south region, and www.triwest.com for the west region to locate the nearest MTF or civilian PCM if outside of distance/access standards. Contact the MTF/civilian PCM first to identify and speak with a case manager there who may be able to identify local specialty providers. If the patient will not have Tricare insurance benefits if the family is reintegrating into civilian life, for example, inquire about which civilian insurance coverage the patient will have and utilize the provider search function or contact the insurance carrier directly to obtain a listing of primary care providers.

Step 4: Notify. Email family the listing of potential providers compiled in the previous step. Offer to speak to the family to answer questions or concerns. Assist the parents or caregivers in choosing the desired providers.

Step 5: Inform. When PCM, specialty, DME and/or home service providers are identified, inform both the transferring and receiving PCM. Provide receiving PCM with list of previous medical providers as well as newly selected providers, including provider name, address, phone number, fax number and point of contact. Be sure to include as much contact information as possible, including the Tax ID number for accepting providers. Including the Tax ID number on the referral request will expedite the Tricare authorization process for home services and new DME companies.

Step 6: Navigate. Explain to the family how to navigate Tricare and obtain care within the MTF. Assist the family to obtain the initial PCM appointment. For outgoing families, ensure that the family has the contact information for the receiving case manager (civilian or military) or appropriate point of contact, if case management is not available. Empower the family to make a list of needs and concerns to bring with them to the initial PCM appointment. Also notify the receiving PCM or receiving case manager in advance of the appointment to make the PCM aware of the family's concerns. Provide teaching to parents as to how to utilize www.mytricare.com (www.humana-military.com for Tricare south region or www.uhcmilitarywest.com for Tricare west region) to obtain information regarding Tricare authorization status.

> "THERE WERE NO INSTANCES OF LACK OF ACCESS."

Step 7: Get orders. For incoming families, meet with the PCM following the appointment to get orders for services and care. Check the Center for Health Care Strategies (CHCS) and/or contact the Referral Management Center to make sure requests for services provided by civilian providers are routed to Tricare. For outgoing families, follow up with the parents and/or receiving case manager to ensure that referrals for services within the MTF are appointed and that the family is aware of the appointment date/time. Also, reinforce/assess the family's ability to obtain copy of Tricare authorization.

Step 8: Write it Down. Document progression through the above steps by charting in the Armed Forces Health Longitudinal Technology Application (AHLTA). This will assist the CM and other members of the medical team to remain updated on the progress of care coordination surrounding the transition of care. Follow up with the family. Assess for problems or issues and assist with resolution.

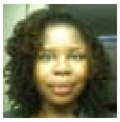
KEY FINDINGS

Between August 15, 2011, and August 14, 2012, the pediatric clinic at WRNMMC received 76 new pediatric referrals for requiring complex pediatric case management. Of these 76 patients, 11 cases, or about 15 percent, required care coordination due to a PCS or relocation to from another State. Of these 11 cases, six cases were incoming and five were outgoing PCS. The RAINING Down Method was utilized to transition care for these families. Follow up calls to the families were made within 30 days following the PCS date to follow up and assess if the family had any problems with the transition of care and services. All 11 families, or 100 percent, reported no problems or issues with the access to medical services/supplies. The RAINING Down method is applicable and effective for both incoming and outgoing transitions of care and can be implemented in any case management setting whether military or civilian. Following the implementation of the RAINING Down method, there were no instances of lack of access to care following transnational or international transition of care.

REFERENCES

1. Coalition takes on transition-of-care gaps. (2008). Case Management Advisor, Retrieved from http://search.proquest.com/docview/758858526?accountid=35812.
2. Haas, S., Swan, B. A., & Haynes, T. (2013). Developing ambulatory care registered nurse competencies for care coordination and transition management. Nursing Economics, 31(1), 44-9, 43. Retrieved from http://search.proquest.com/docview/1317619123?accountid=35812.
3. Zander, Karen (2010). Case Management accountability for safe, smooth, and sustained transitions: A plea for building "Wrap-Around" case management services now. Professional Case Management, 15(4), 188-199.

Editor's Note: The views expressed in this article are those of the author and do not reflect the official policy of the Department of Army/Navy/Air Force, Department of Defense, or U.S. Government.



Jasmine Pollard Little, RN, BSN, MSN, CCM, has over 10 years of experience as a registered nurse, over half of which was spent as a case manager. While working as a federal employee at Walter Reed National Military Medical Center, she pioneered and supported the pediatric case management program, the first of its type at that facility. Contact: jasmine.m.pollard.civ@health.mil

The Grand Slam: Solving Complex Cases with Multidisciplinary Care Plans

BY JULIE ADAMS, RN, MSN, PHN

Like a winning baseball team, multidisciplinary complex case discussions require great team players who are willing to show up and do the work. To accomplish smooth transitions of care, my facility instituted weekly complex case discussions where a multidisciplinary team comes together to improve quality of care and reduce length of stay. When the bases are loaded and the batter is ready to swing, anything can happen. The batter can strike out, hit a grand slam, or accomplish something in between the two.

I will explain some of the elements that create effective team functioning, facilitating care transitions, and optimizing patient outcomes. When these three elements come together in the delivery of patient care and case management, it is similar to a beautiful afternoon at the ballpark watching your favorite baseball team win a game against its top rival. Imagine warm sun, the smell of hotdogs, and the crack of a bat that sends the ball over the fence – you know you're in a good place. These are not ordinary times. Regulations from the Centers for Medicare and Medicaid Services (CMS) and the Affordable Care Act mandate that healthcare delivery systems step up to the plate. Outcomes improve when multidisciplinary teams join together to discuss patient situations that go beyond routine transitions of care.

IDENTIFYING PATIENTS AND CARE TEAMS

When preparing for multidisciplinary complex case discussions, the first thing to do is to identify the patient(s). This needs to be someone who would benefit from a multidisciplinary approach to care. To help us identify the right patients, we ask ourselves the following questions: Does the patient have complex clinical needs? Do they have complex pharmaceutical regimens? Are there financial barriers? Is there a history of psychosocial challenges? Are they at high risk for readmission? Are the goals of care unclear, or not aligned with a poor prognosis? A "yes" answer to one or more of these questions qualify the patient to be on the agenda.

The team consists of patient care coordinator/case manager, attending physician, nursing floor manager, social services, and resource management leadership. Other ancillary players are invited to attend as appropriate, such as physical therapy, occupational therapy, speech therapy, nutrition services, financial advisors, and pharmacist. A home health liaison, skilled nursing facility liaison, and palliative care leaders are invited to attend via live conference calling.

A set time, day meeting space are reserved on a weekly basis so team members know to build this into their schedule. Invitations are sent to all participants a day or two before the discussion via email. Timeframes are identified for efficiency, so key players know when they are scheduled to present. In the electronic record, a shared list includes the patients targeted for discussion. Anyone with a need to know can access this electronic list to prepare for a thorough discussion several days ahead of time.

The meeting usually lasts an hour, depending upon how many patients are discussed. The actual presentation of each case only takes about five to 10 minutes. As the patient's situation is presented, those in position to resolve barriers "swing" into immediate action. Consults are ordered, interventions are revised, social and financial plans are made. One example was as easy as getting bedside nursing to use a Hoyer lift to mobilize the patient, allowing them to sit in a bedside chair.

Once team members are all on the same page, family conferences can be called where goals of care discussions take place and code status is addressed. As a result of multidisciplinary complex case discussions, our extended lengths of stay patients have been greatly reduced. In 2012 we would have as many as 47 patients who were in the hospital 15 days or longer. Now in 2013 our numbers are in the teens and low 20s. Our readmission rate is also down to 10.1 percent, far below the national average. Table 1 shows some data supporting our findings. The sidebar "Complex

Table 1

Date	Total # Extended Length of Stay patients	15-30 Day Length of stay	> 30 Day Length of Stay Adult (Pediatric)
April 2012	47	20	27(9)
May 2012	39	16	23(8)
June 2012	34	14	21(5)
July 2012	29	12	16(2)
August 2012	31	14	17(5)
Sept 2012	31	11	20(7)
Oct 2012	21	5	16(7)
Nov 2012	20	8	12(5)
Dec 2012	22	7	15(8)
Jan 2013	22	9	13(6)
Feb 2013	23	12	11(6)
March 2013	20	10	10(5)
April 2013	18	9	9(1)
May 2013	15	9	6(3)
June 2013	16	10	6(3)
July 2013	18	9	9(6)

Complex Case Discussions

GENERAL STATEMENT

A Complex Case Discussions meeting is defined as a regularly scheduled meeting of the patient care coordinators (PCC), RM management team, MSW management team, and a RM/UM physician. RM staff will identify complex ELOS (extended length of stay) patients who are in the hospital 15 days or longer or fewer than 15 days, but with current/anticipated complex medical/psychosocial issues. Complex Case Discussions are designed to address and/or develop plan of care for each Complex Case patient. All participants of the Complex Case Discussions work collaboratively to ensure appropriate treatment plans and utilization of resources. The application of professional medical judgment and specific case considerations by the responsible providers determines the plan of care and the management of the patients' specific needs.

KEY POINTS

- OMC RM Complex Case Discussions are scheduled every Friday at 11:00–12:30.
- Each PCC presents his/her identified in advance patients.
- Discussion is patient- and family-centered.
- Complex Case Discussions participants are expected to use UM criteria/guidelines in conjunction with clinical judgment, and case specific consideration:
    - **a)** Member needs, such as age, comorbities, complications, home environment, psychosocial/cultural issues, patient safety and community resources.
    - **b)** The capabilities of the local delivery system, clinical criteria/ guidelines.

ROLES AND ACCOUNTABILITIES

- **PCC:** PCC identifies the case history, payer source (member, non-member, benefits, etc.). The Five Whys are addressed: who, what, why, when and where. For example:
    - **a)** Who is the patient, why he/she is here, baseline function, where did patient come from
    - **b)** What is the level of care (LOC); is LOC appropriate? IQ/met/not met for IP/OBS?
    - **c)** Readmission history
    - **d)** What care/tests being done that requires IP care? Could this care be provided at another LOC?
    - **e)** What are barriers to discharge? (PCC must address actual or anticipated delays in provision of treatment/ services and actions taken to mitigate them).
    - **f)** What interventions are planned to help remove these barriers?
    - **g)** What referrals are needed: High Risk CM, Transition CM, CCM, Palliative Care, etc.?
    - **h)** What is the anticipated discharge disposition (ADD)? What is the expected discharge date (EDD)?
    - **i)** What is absolutely needed to be done in order for patient to go to another LOC? What has not been addressed yet: pain, mobility orders, bowel/bladder function, oxygen, restraints/sitter, psychosocial issues, transportation, etc.
- **COCSD/RM Manger/Assistant Manager:** Shepherds the care coordination rounds; serves as a resource to support problem solving; partners with RM chief or UM physician to resolve system issues impacting efficient delivery of care; navigates Health Connect to provide additional information.
- **RM Chief/UM Physician:** Acts in an advisory capacity to the team; intervenes to facilitate care without delay; partners with leadership to resolve recurring system issues; navigates Health Connect to provide additional information.
- **Medical Social Work Manager/Assistant Manager:** Addresses psychosocial factors that may impact the plan of care or discharge plan; addresses the advance directive status of each patient; communicates the outcomes of patient/family conferences about goals of care; identifies and intervenes to meet spiritual needs of patient/family; addresses and follows up on the referrals that are needed: Medi-Cal, community resources, benefits advocate, MFA, residential care facilities placement, transportation.
- **All participants:** Shall agree on each presented patient plan of care, what information needs to be communicated to the patient/ family, who will communicate the message to the patient/family, what other disciplines need to be consulted.

All members of the rounds shall be actively involved in the discussion. Team ends discussion of each case by clearly identifying:

- a) Patient's plan of care.
- b) Barriers to discharge.
- c) Follow-up items and who is responsible for follow up.
- d) Expected discharge date and anticipated discharge disposition.

Case Discussions" provides a blueprint for getting underway with these helpful team-based care meetings.

IN SUMMARY

Returning to our baseball analogy, the lesson learned is that you only reach home plate by first touching first, second and third base. By covering all the bases in complex case discharge planning, you can better ensure a safe, long-term plan that will support the patient in the community. As you round the bases of clinical stability, social and financial support, and community-based resources, outcomes will improve. Multidisciplinary teams are like base coaches that assist and encourage you to transition forward to the next level of care. Anticipating the "pitch" is a skill case managers have developed. When you put it all together, you have a better chance at hitting a home run with the bases loaded, and achieving a true grand slam. CIP

Julie Adams, RN, MSN, PHN, currently works as a manager in the resource management department at Kaiser Permanente, Oakland Medical Center, in Oakland, Calif. She presides as president of CMSA San Francisco/Eastbay Chapter, and is active in public policy. Contact: juliel94@msn.com

Accelerating Cystic Fibrosis Quality Improvement on the Frontlines: Survey of Cystic Fibrosis Stakeholders

BY LES C. MEYER, MBA AND DONALD E. LIGHTER, MD, MBA, FAAP, FACHE

Cystic fibrosis (CF) represents one of modern healthcare's incomplete success stories. Much has been learned about the genetics, comorbidities and efficacious treatment options over the past four decades, and the number of children with diagnosed CF living into adulthood is at all-time highs. Taking CF care to an even greater level of efficiency and effectiveness will require constant attention to factors in healthcare delivery that emphasize continuity of care and assurance of access to care for this complex population. A telephone survey was conducted with 20 leaders and frontline staff in CF care from March to June 2013 to examine the following issues:

1. What clinical and financial needs exist in the marketplace for CF services?
2. What measures and benchmarks are of most importance in providing CF care and ensuring that CF centers address value-based purchasing objectives?
3. How are CF centers finding and sharing best practices?
4. What sources of information do CF providers use to affect improvements?
5. What supports and barriers exist to achieving higher performance?

CURRENT NEEDS FOR CF SERVICE DELIVERY

Of the nearly 30,000 people with CF in the United States, virtually all are treated or followed at a CF Care Center accredited by the Cystic Fibrosis Foundation (CFF). The Foundation provides a number of services, including development of clinical practice guidelines and maintenance of a clinical registry, that support physicians and other caretakers who are trying to provide high-quality care.

CF services are chronically underfunded, including important programs that support home care and pharmaceutical financial assistance. The high cost of delivering multidisciplinary care, combined with the dependence on high-cost medications and technologies, creates a financial challenge for both pediatric and adult health systems, although the need appears to be more pronounced in pediatrics because of the variation in Medicaid reimbursement across the states.

Although accountable care organizations (ACOs) will put increasing pressure on CF centers, with changing payment systems like bundled payments and capitation, along with increased requirements for quality metric reporting, the changes may also prove to be advantageous. For example, properly structured bundled payments can remove some of the uncertainty in cash flow for CF centers that adopt efficient and effective practice methods based on evidence. Some CF centers appear to be adopting these practices and will be well positioned in an era of consolidation and integration of healthcare services.

A corollary issue faced by some CF suppliers is the inability to have a close relationship with patients because of payers' reluctance to allow suppliers to become providers in the payers' networks. Traditional views of network providers generally do not include equipment or medication suppliers, but this older perspective inhibits the ability of some of these suppliers to support CF care through value-added services. For example, one pharmaceutical provider has developed educational and care management services, which are not reimbursed by payers because the pharmacy is not recognized as a provider by payers in a number of states. Although the organization continues to provide these services, it contends that the services could be more robust, even helping to reduce costs, if supported by third-party payers.

Nutrition has become increasingly important for both children and adults with CF. Body mass index (BMI) has been shown to be an important predictor of pulmonary function and ultimately survival, and the CF practice community has adopted an aggressive approach to ensuring adequate nutrition through vitamin and nutritional supplements for all age groups. In spite of these clear recommendations based on scientific evidence, financial support for these crucial therapies remain insufficient in many parts of the country. Some vendors provide assistance with these supplements, but there is no consistent approach at this time to ensure that people with CF receive the nutritional support needed for improving outcomes.

> "CF SERVICES ARE CHRONICALLY UNDERFUNDED."

A number of additional opportunities became apparent during the telephone interviews. Discussions with staff members at CF centers seemed to confirm that time for innovation and improvement initiatives continues to be limited by the patient load that most clinicians must manage to ensure that the center has enough funding to survive. However, some respondents indicated that they lacked knowledge of how to engage in quality improvement activities, indicating that quality improvement (QI) education may be beneficial.

Additionally, a few comments were made regarding the evolution in care from inpatient to outpatient treatments for CF patients, and the need for developing and disseminating best practices for outpatient care appeared to be important to practitioners. Finally, at least one respondent noted increased interest in genomics and implications of newer genetic diagnostic and treatment modalities for CF as one of the most exciting aspects of improving the health of CF patients in coming years.

Finally, a major challenge for making specialty medications available is the difficulty for specialty pharmacies to qualify as network providers with pharmacy benefit managers (PBMs), primarily due to the high cost of the medications required for effective treatment. In many cases, this failure of coverage makes medications less available or copays so high that the medication becomes unaffordable and thus functionally unattainable. Payers are particularly averse to allowing these relationships in several states across the U.S. Interestingly, some pharmacy providers include case management services that help ensure appropriate use of expensive and complex medications.

CF MEASURES AND BENCHMARKS

The CFF measures were most frequently cited as being used for evaluating CF care both for individuals and as aggregates for CF centers. The significance of these measures is captured in the goals articulated in the CF patient registry annual data report. Each of the goals has associated measures, for which the CF centers are accountable. A list of the goals and measures is included in Table 2. Of the measures listed in the table, those most frequently mentioned in the interviews with CF center staff were the BMI, FEV1 and oral GTT. However, the CF centers also mentioned a number of other metrics that included operational, as well as clinical parameters (See Table 1.)

In addition to the CF center measures, other stakeholders had a number of measures that are important for their work in CF. For example, specialty pharmacies utilize typical business metrics such as sales, but they also include patient-centered measures that add to clinical understanding, like medication adherence rates, prescription fulfillment tracking and customer satisfaction with pharmacy services.

Another stakeholder group interviewed included care management company staff and executives who appeared to have a much more robust series of measures to assess performance:

- **Financial performance.** Payer rate of acceptance of patient treatments, copays, deductibles.
- **Capture rate.** Referral rates, referrals on specific drugs, time from referral to drug or provider, length of time clients were on the care management program, adherence rates.
- **Patient metrics.** Patient satisfaction, patient quality of life, exacerbation rates, adverse event rates.

Interestingly, one care management executive noted that physicians were hesitant to receive information from the company, as they worried about potential liability if they had the data.

QI APPROACHES: IDENTIFYING AND SHARING BEST PRACTICES

The CFF has a centralized program for performance improvement that involves Learning and Leadership Collaboratives (LLCs), development of clinical practice guidelines, collection of clinical and operational data through the patient registry, and other QI activities that started in 2002 as a result of the QI strategic plan. The LLCs include approaches to promote the sharing of improvements with other CF centers. Additionally, the CFF works with Dartmouth University to support listservs that allow collaboration among CF providers, including some that are specific for subspecialties.

However, interviews with staff members and leaders in some CF centers indicated a different picture at the local level. Systematic QI programs do not appear to be widely deployed at the centers and the LLCs seemed to be appreciated for bringing some structure to QI efforts. Since most centers are consumed with patient care, the time required for QI initiatives is limited. However, this issue is not universal.

Centers that have integrated a QI approach into their workflow have achieved standardization of care processes, an environment that fosters innovation and a measure-driven culture that supports high performance. One center has undertaken a significant effort toward standardization that they term “intentional consensus” by adopting evidence-based clinical guidelines and even recruiting physicians into the center who are inclined to collaborate in a standardized environment. Those efforts have helped the center make substantive strides toward achieving the triple aim and provide value-based care. The center does rely on the CFF for some direction and credits the Foundation for initiating interest in the QI domain, but it was clear that the center had internalized the QI approach and honed it to a high level of efficacy.

Another opportunity for improvement across the CF centers appeared to be a lack of background and education in the field of quality improvement. The CF Foundation provides just-in-time education for LLC programs, but many CF professionals have not had much other background in the science and practice of QI. Without this base of understanding, many health professionals feel that QI initiatives add to the daily workload, and the design of QI initiatives fails to achieve the goal of improving efficiency as well as effectiveness.

Methods of sharing improvement results and providing supporting information are diverse, but most CF centers report that they rely on the Foundation for a substantial portion of the resources they use. However, opportunities for improvement exist to make resources more available. For example, the development of smartphone applications has expanded greatly in the past few years, but knowledge of these apps was relatively limited across the stakeholders polled in this survey. Another example is the relative lack of experience and education in quality improve-

Table 1

Operational measures:	Clinical measures:
o Admission rates	o Mid-parental height
o Patient and staff satisfaction	o Growth chart values
o Total clinic visits per year	o Forced Vital Capacity (FVC)
o Emergency department use	
o Specialists seen at each visit	
o Billing and collection rates	

ment in some of the centers, which may be amenable to new outreach programs.

The Foundation's performance improvement initiatives emanate from the QI strategic plan, which was first formulated in 2002. The program includes the Leadership and Learning Collaborative program, as well as several other initiatives focused on improvement of FEV1 levels, BMI, screening for CF-related diabetes, and access to care measured by the number of patients with the recommended four clinic visits per year, one respiratory tract culture per year, and two pulmonary function tests (PFTs) per year. A key resource in that effort is the patient registry, which was mentioned in nearly every provider interview. The annual registry report and ad hoc queries provide centers with aggregate performance on these key indicators, as well as a number of others, and compares the measures with mean performance in other centers. According to some of the survey respondents, however, the reports do not provide high performance levels (e.g., the 90th percentile) for benchmarking, and apparently do little case mix adjustment for adequate comparisons.

The Foundation also provides a patient/caretaker toolkit that helps families and patients understand and optimize interactions with CF centers to help all stakeholders in the treatment axis. Additionally, the Foundation website contains several webcast videos that explain the function of CF center teams and the importance of data in care management, as well as several other useful videos. The Foundation partners with the Institute of Healthcare Improvement and Dartmouth for several of its initiatives.

SOURCES OF INFORMATION FOR CF

The survey included three questions to determine the most important and trusted resources for information about the disease, and the most highly rated sources included:

- **Conferences** – especially national conferences focused on cystic fibrosis.
- **Webinars** – particularly those at convenient times (noon, evenings).
- **Literature reviews** – monographs, compendia, and review articles.
- **Discussions with colleagues** – team members, other experts in cystic fibrosis.

On the other hand, several sources of information were rated low, including:

- Pharmaceutical literature (except product inserts) – pharmaceutical literature is generally perceived by practitioners as being more marketing-oriented, rather than designed to provide meaningful scientific information.
- Visits by pharmaceutical representatives – many institutions have eliminated these visits, but among those that still allow for the practice, these visits were rarely valued.
- Government resources – with the exception of specific resources like the Centers for Disease Control (CDC) and the Agency for Healthcare Research and Quality (AHRQ), government resources were not highly rated.
- Consultations with experts – responses to the question about consulting with experts in cystic fibrosis showed substantial variation, with some respondents ranking the approach very high, while others ranked these interactions quite low. Overall, however, this method of getting information was less appealing.

The most trusted sources followed the same pattern, with colleagues, experts and medical literature being most trusted, and pharmaceutical sources least trusted. Government resources, particularly the CDC and AHRQ, were generally trusted, but perhaps not accessed very frequently.

SUPPORTS AND BARRIERS FOR HIGHER PERFORMANCE

Almost universally, respondents identified funding and the related factor of time availability was the biggest barrier to higher performance. Lean staffing patterns and the volume of patient care required at the CF centers has led to significantly reduced time available for QI activities, and clinical research funding cuts have decreased the funds available for clinicians to participate in studies that may lead to substantive advances in care. Since volume of services has become the de facto driver of CF center survival, this time factor is unlikely to change until the Affordable Care Act fully impacts the population receiving CF care.

Discussions with organizational leaders (e.g., chief executive officers and divisional leaders) uncovered the conundrum of the orphan disease, i.e., although these conditions are important, they usually comprise a small proportion of the patients cared for by an institution while consuming a disproportionate share of resources. Thus, CF centers that are part of a larger system (as nearly all are) remain cost centers and often are considered loss leaders for pediatric health systems. The effect of this impact on margin is to drive volume to mitigate the costs as much as possible, leading to the current time availability barrier to higher performance faced by CF practitioners.

Another major barrier to care is the classic medical challenge of patient/caregiver adherence to recommended care. The CF centers and practitioners all mentioned this issue as one of their major problems for achieving high performance. Although discussed in the context of CF care, the problem is universal and longstanding. Some patient issues include financial considerations like copayments and deductibles, but these issues were generally of less importance than problems with the discomfort caused by the nature of the therapy and the inconvenience of dosing schedules. One practitioner, for example, opined that changing treatment frequency schedules to once or twice daily, rather than current four to six treatment-per-day regimens, would dramatically increase adherence to treatment recommendations.

One CF clinical leader noted that electronic clinical data systems are inadequate to support care for complex patients. If these systems could support workflow and standardize data collection, the information emanating from the resulting data repository could help improve care. However, current barriers involve the relative clumsiness of many EHRs in supporting workflow and standardizing data collection to provide the information infrastructure that can be used to perform clinical outcomes research studies on clinical data.

Finally, transition of care from pediatric to adult providers remains a challenge for many centers. A number of CF centers have both pediatric and adult teams, which helps expedite and formalize the process, but for those that do not have both types of services, the challenge remains. Although many centers have effectively dealt with the transition process, these solutions may not be translatable to every other program because of lack of availability of adult

Table 2: Cystic Fibrosis Foundation Goals and Measures

Goal	Measures
1. People with CF and their families will be full members of the care team. Communication will be open so everyone can be involved in care decisions. Care will be respectful of the person with CF's needs, preferences, and values.	Guidelines to be met every year: • 4 or more clinic visits • 4 or more respiratory cultures • 2 or more pulmonary function tests if >6 years of age and physically able • Influenza vaccine if > 6 moa • Fat soluble vitamin (A, E, D) levels measured • Oral GTT if > 10 yoa • Liver enzymes
2. Children, adolescents, and adults with CF will have normal growth and nutrition.	Body mass index (BMI) with percentile
3. People with CF will receive appropriate therapies for maintaining lung function. Pulmonary exacerbations will be detected early and treated aggressively to return people with CF to their previous levels of lung function.	Forced expiratory volume at 1 second (FEV1) Smoking status Secondary smoke exposure status
4. People with CF, their families, and CF care center staff will be well-informed and active partners in reducing the spread of germs, particularly Ps. aeruginosa (Pseudomonas) and Burkhoderia cepacia (B.cepacia) complex.	Respiratory tract culture results: • Pseudomonas aeruginosa, including multiple drug resistant strains • Staphylococcus aureus, including MRSA • Hemophilus influenza • Stentrophomonas maltophilia • Achromobacter xylosoxidans • Burkholderia cepacia
5. People with CF will be screened and managed aggressively for complications of the disease, particularly CF-related diabetes (CFRD).	• Diabetes (CF related diabetes) • Bone disease (arthritis, arthropathy, osteopenia, osteoporosis • Depression • GERD • Asthma • Distal intestinal obstructive syndrome • Liver disease
6. People with CF and their families will be supported by their CF care center when facing decisions about transplantation and end of life care.	• Lung transplantation
7. People with CF and their families will have access to appropriate therapies, treatments, and support regardless of race, age, education, or ability to pay.	• Insurance coverage ○ Private ○ Medicare ○ Medicaid ○ Indian Health Service ○ Tricare/Military ○ Other ○ None

practitioners with interest or expertise in CF. The opportunity in this area appears to be cultivation of practitioners, particularly internal medicine subspecialists, throughout the country who are willing and capable of caring for adults with CF and associated comorbidities. Focused training programs for these specialists may enhance their capability in caring for these complex patients.

Very few supports for higher performance were identified, but leadership certainly became evident as a major encouraging factor. One center in particular had a clinical leader who was highly engaged in quality improvement and had implemented the Foundation/IHI approach to collaborative quality improvement that had salient effects on the center's measures.

KEY RECOMMENDATIONS

A number of inferences can be made for stakeholders in several healthcare sectors, including pharmaceutical companies, biotechnology and life sciences organizations, medical technology suppliers, and CF researchers, who are interested in supporting CF care:

- Support for quality improvement initiatives, either through grants to specific centers or through the Foundation, or by providing ancillary staff to augment center staff capabilities, will assist CF centers that have limited time and resources to engage in these activities.
- Research into methods of improving patient adherence to care recommendations will not only help patients achieve better outcomes, but also can help providers ensure better performance on quality measures that will soon be crucial for reimbursement.
- Development of information system approaches to support workflow and standardize workflow in the EHRs in use in CF centers would be an effective way of not only making the work of the centers more cost-effective, but it would also allow the clinicians to improve patient care through the use of a data repository that could be used in QI research. New technologies in health information technology, e.g., health information exchange systems, could be leveraged to achieve these goals, and experts in each of the EHRs in use throughout the industry might assist in creating templates for standardized data collection.
- The CF Foundation is providing substantial infrastructure for quality improvement at the CF centers.
- Although pharmaceutical companies may have little influence on funding issues, supporting efforts by the CF centers and CFF to improve efficiency and effectiveness will help enhance margins to support the intense care needs of the CF population.
- Payer coverage of required treatments needs to be more uniform and easier to negotiate. Work with payers and providers should determine ways of reducing the administrative burden for both patients and providers in accessing the required treatments and diagnostic tests, e.g., by removing prior authorization requirements for drugs that are specific for CF and unlikely to be abused.

With all of the challenges faced by CF providers and patients in the next few years as healthcare reimbursement changes from fee-for-service to more prospective payment programs, opportunities abound. Stakeholders within the

continued on page 35

A Step Closer to Diabetic Foot Care Improvements

BY IRISH PATRICK WILLIAMS, PHD, RN, MSN, CRRN, CFS AND ROCHELLE WARD SMITH, MSN, RN, FNP-C, FNP-BC

Diabetes continues to be a major cause of morbidity and mortality related to foot complications, such as ulcerations, which can lead to potential amputations. Currently, more than 85 percent of lower extremity amputations in patients with diabetes are preceded by foot ulcers.[1] According to the American Diabetic Association (ADA), all individuals with diabetes should receive an annual foot examination to identify high-risk foot conditions. Those with one or more high-risk foot co-morbidities should be evaluated more frequently.[2] The examination should include a visual foot inspection with monofilament with each visit.[3] In addition, nail, corn and callus care should be performed when warranted.

With the impact on medical cost related to premature amputations, primary care providers must address the occurrence of diabetic foot ulcers and should insure foot care education and regular foot examinations.[2] Over the years several studies have been conducted to determine if healthcare professionals are providing adequate foot inspection with monofilament along with the assessment and management of co-morbidities that may decrease the risk of limb loss.

“ALL INDIVIDUALS WITH DIABETES SHOULD RECEIVE AN ANNUAL FOOT EXAMINATION.”

Rayman et al., (2004) conducted a study of diabetic patients with foot complications that were assessed by a nurse and or a podiatrist. Data was collected from the hospital database and records. The study concluded that developing a systematic assessment modality would decrease the risk for lower extremity amputations.[4]

Lavery et al., (2006) conducted a study of 1,666 diabetics to investigate the risk factors for lower extremity complications. The study findings indicated that foot infections occur frequently in diabetic individuals almost always following trauma, therefore increasing the risk of amputation.[1]

Bell et al., (2005) assessed foot self-care performed in 699 rural, multiethnic adults to identify factors associated with foot self-care. Study participants were asked to identify the number of days within a week that they had performed positive foot care practices (dried between their toes after washing, checked their feet, inspected the inside of their shoes) or negative foot care practices such as soaking their feet. The study found that 23 percent of the participants reported not checking their feet at all, while 54 percent did not inspect their shoes before wearing them. The findings suggested encouraging patients become more engaged and educated about better foot self-care practices.[5]

A more recent study was conducted in 2011 to investigate relationships of diabetes, comorbidities and care provided by healthcare professionals associated with potential loss of limb. The research involved collecting data from 400 medical records of diabetic patients in two central Mississippi primary care clinics. Demographic information, clinic location (urban or rural) and associated comorbidities were collected. Medical records were also reviewed to determine the type of healthcare professional providing the service, i.e. medical doctor (MD), nurse practitioner (NP), diabetic foot care specialist registered nurse, podiatrist and if the patient received a visual foot inspection along with monofilament. One hundred and ninety-seven medical records were reviewed from a rural clinic and 203 medical records were reviewed from the urban clinic.

Of the 400 diabetic patients’ medical records reviewed, 50.8 percent of the patients were located in the urban clinic, while 49.3 percent were seen in the rural clinic. The largest group seen in both clinics was female, with 81.6 percent from the rural clinic and 73.9 percent from the urban clinic. In the urban clinic, 49.3 percent of the patients were between the ranges of 41-60 years of age while 48.5 percent were in the 61-80 ages range at the rural clinic.

The findings further revealed that the majority of patients from both clinics had obesity and hypertension as comorbidities. Females from both clinics had higher incidence of smoking, obesity and hypertension than their male counterparts. However, a larger number of females were seen in both clinics. The urban clinic reported 50.9 percent receiving a visual and monofilament exam while the rural clinic reported 49.1 percent receiving at least a visual. Therefore the majority of patients are not receiving a visual along with a monofilament examination/treatment.

In the rural clinic, 22.4 percent were examined by a medical doctor, 32.1 percent by a diabetic foot nurse specialist while 45.5 percent were seen by the nurse practitioner. In the urban clinic, 52.5 percent of the patients were seen by the NP, while 22.4 percent were seen by the MD and 25.1 percent were seen by diabetic foot nurse specialist. In conclusion, the majority failed to receive an appropriate diabetic visual inspection and monofilament from either clinic, with neither clinic utilizing podiatrists. However, diabetic visual inspection and monofilament, including callus and corn care were more consistent (80 percent), performed in both clinics when the patient was either seen by the NP or diabetic foot nurse specialist.

HEALTHCARE PROVIDERS’ IMPROVED OUTLOOK

Based on these study findings, efforts should be made to enhance physician education related to the necessity for visual/monofilament inspection with each clinic visit in an effort to decrease the probability of amputations. Additionally, podiatrists should play a more active role in the initial and continued assessment.

Since the study indicated that the majority of diabetic patients seen in the clinics were females with a high rate of obesity and hypertension, it is important that primary and secondary prevention strategies are gender-specific, therefore increasing the likelihood of compliance. Since the majority of patients’ ages range from 61 to 80, which span across a large range of working diabetes and those who are elderly, it is important to avoid any disability that would render an individual nonproductive. For the elderly, an amputation most likely would impact their ability to provide activities of daily living, resulting in the need to become dependent on family members and/or a failing

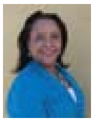
continued on page 35

continued from page 34

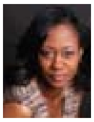
healthcare system.[2] Accordingly, efforts should be made to ensure that all diabetic patients receive a visual foot assessment inspection and or monofilament with each visit. Primary and secondary prevention strategies should be related to decreasing comorbidities, therefore decreasing the incidence of diabetic-associated amputations.

REFERENCES

1. Lavery, L., Armstrong, D. G., Wunderlich, R. P. Treadwell, J., Boulton, A. (2003) Evaluating the prevalence and incidence of foot pathology in Mexican Americans and non-Hispanic whites from a diabetes disease management. ***Diabetes Care***. 26:1435-1438.
2. Wraight, P. R., Lawrence, S.M., Campbell, D. A., Colman, P. G., (2005) Creation of a multidisciplinary, evidence based, clinical guideline for the assessment, investigation and management of acute diabetes related foot complications. ***Diabetes Care***. 22: 127-136.
3. Steed, D., Hinger, C. A., Brem, H. Colaizi, T., Crossland, M. Franz M. (2008). Guideline for the prevention of Diabetes Ulcers. Wound Healing Society. 16:169-174.
4. Rayman, G. Singhman, T. M., Baker, N. R. et al. (2004). Are we underestimating Diabetes related lower extremity amputation rates? ***Diabetes Care***. 27:1892-1896.
5. Bell, R., Arcury, T., Snively, B. Smith, L., Skelly, A., Wetmont, L., Quandt, S. (2005). Diabetes foot self-care practices in rural, tri-ethnic population. ***The Diabetic Educator***. 31 (1):75-83.



Irish Patrick Williams, PhD, RN, MSN, CRRN, CFS, teaches at Hinds Community College Nursing Allied/Associate Degree Nursing Program, located in Jackson, Miss. In addition, she is a diabetic foot specialist contracting with some local clinics providing foot care to diabetes. Contact: ipatrick@bellsouth.net



Rochelle Ward Smith, MSN, RN, FNP-C, FNP-BC, works at Jackson Hinds Comprehensive Health Center in Jackson, Miss. Contact: rsmithfnp@gmail.com

---

continued from page 33

healthcare industry need to adjust to these changes to ensure access to high-quality care for patients and their families.

This article, including the industry research on which it is based, was created with the support of Aptalis Pharma.

Les C. Meyer is a seasoned healthcare strategist and CEO of HPI Advisors LLC, a Delray Beach, Florida-based corporate strategy and disruptive innovations firm. Additionally, he is chairman of the Informed Opinion Leadership Action Group (IOLAG) and senior fellow, Jefferson School of Population Health, Thomas Jefferson University. Les is also a board member of the Professional Patient Advocate Institute (PPAI) and founder Taos Brain Injury (TBI) Institute. Contact: les.meyer@healthandperformance.info

Donald E. Lighter, MD, MBA, FAAP, FACHE, is a nationally recognized quality improvement (QI) opinion leader, book author, Baldrige Performance Excellence Program Judge, Professor at The University of Tennessee in Knoxville, Quality Improvement HPI Advisors/ Informed Opinion Leadership Action Group (IOLAG), and Director, The Institute for Healthcare Quality Research and Education (HQRE). Contact: dlightermd@ihqre.org

---

continued from page 20

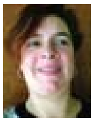
4. Use the media, where possible, to promote your project and keep it fresh and in the public eye. Remember also to notify your stakeholders prior to any announcements or changes, so they will have plenty of time to digest the information and provide feedback to you. Be open and accept feedback graciously. Discuss controversial points with stakeholders and come to a resolution that is acceptable to the majority.

5. Hold a launch and commitment meeting (invite the media to come) to generate excitement and communicate with the public. Remember to schedule follow-up meetings with goals to be accomplished. Create reassessment and feedback loops utilizing your timeline. Allow the vision to mature and grow.

By identifying, through data, the need for and the design of the program, you can build the processes that implement your program. By monitoring your program and measuring the outcomes, case managers can establish best practices resulting in positive change. By reaching out and facilitating new relationships, efforts can be aligned to improve health and decrease readmissions. Case managers are instrumental in this process, establishing a comprehensive community program for improved healthcare that is achievable, replicable and sustainable, while decreasing length of stay and readmissions .

REFERENCES

1. Dunphy, L. M. (2006). Florence Nightingale's legacy of caring and its applications. In M. E. Parker (Ed.), Nursing theories & nursing practice (second edition ed., pp. 39-57). Philadelphia, PA: F. A. Davis Company.
2. Loyo, H. K., Batcher, C. A., Wile, K., Huang, P., Orenstein, D., & Milstein, B. (2013, January). From model to action: Using a system dynamics model of chronic disease risks to align community action [Peer review journal]. Health Promotion Practice, 14 (1), 53 - 61. Doi: 10.1177/1524839910390305



Dr. Karina Loyo is a stress reduction and healthy aging expert. She is owner of MiBoHe Wellness where she focuses on helping people archive mind body heart wellness. Dr. Loyo uses a hands-on, full body approach to helping consumers achieve optimal health naturally. She is available for consulting and speaking engagements. Contact: karina@drkarina.com

Cynthia Batcher, RN-BC, MSN, CCM, is an active case management leader in both small and large academic, community and healthcare organizations. Contact: cbatcher@gmail.com

Join the Case In Point Learning Network!

Join the Professional Learning Network and you'll get:

- 12 monthly issues of Case In Point delivered to your inbox the first Monday of every month.
- 48 total pre-approved continuing education credits – never before has it been this easy to get your continuing education units!
- A PDF of the magazine delivered via email and available on www.dorlandhealth.com.
- Access to an enhanced digital edition of the magazine presented in a portable, searchable format on www.dorlandhealth.com.

Join the Premium Level of the Learning Network and you'll get all of the above plus the opportunity for even more CEs – amounting to 66 total – through:

- Two select Dorland Health webinars from the Learning Library – a $660 value and 3 CEs.
- Two select Dorland Health special reports from the Learning Library – a $400 value and 8 CEs.
- A 30% discount to the Care Coordination Summit – a $270 value and 7 CEs.

Because of case management's position as a linchpin in the ongoing effort to achieve effective care coordination, improve quality and control costs, Case In Point will continue to provide you with the latest trends in patient-centered care, resource utilization, transitions of care, federal regulations, new models, and more.

Join the Learning Network today!
www.dorlandhealth.com/subscriptions

DORLAND HEALTH
a division of Access Intelligence

4 Choke Cherry Road, 2nd Floor | Rockville, MD 20850 | www.dorlandhealth.com | 1-888-707-5814

19949