



COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

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AHC Media

TelePain program provides CM model to rural, underserved areas

Program's impact reaches far

A new study shows success with a case management-style model in treating chronic pain. The program incorporates collaboration, assessment, care coordination, and advocacy for services for people suffering from disabling pain that interferes with their function and quality of life.

“Chronic pain can lead to despair, hopelessness, and loss of productivity, and it is unbelievably expensive — a \$650 billion a year industry,” says

David Tauben, MD, chief of the division of pain medicine at the University of Washington in Seattle.

“Pain care can include drugs, devices, surgeons, and hospital admissions,” Tauben says. “It’s complex and requires specialized knowledge skills and access to resources that usually are not available.”

This TelePain program gives patients and their providers options far beyond what traditionally would be available, suggesting broader possibilities of case

EXECUTIVE SUMMARY

Chronic pain is a \$650 billion a year industry that leads to loss of productivity and 18,000 deaths per year from prescription opioid use. A group of healthcare professionals in Washington created TelePain to address the need for better pain management options for people in areas where pain specialists are not available.

- The model provides patients and providers with expanded options for treatment.
- An interdisciplinary panel of experts listens to individual cases and offers advice.
- Case managers, physicians, and other healthcare professionals can virtually attend the weekly meetings, which include an educational segment and a case study segment.

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management of chronic pain in
other areas.¹

The program reaches medically
underserved and rural communities
through a case management-
style community of practice. It
incorporates interdisciplinary care
plans for complex pain patients,
using case study discussions and
evidence-based pain management
strategies. It connects providers
with experts via computer
teleconferences.¹

"This is a mission-driven
program," Tauben notes. "We give
away the services because it's the
right thing to do."

Since March, 2011, the TelePain
program has had more than 500
healthcare providers participating
with an average of 30-50 people
attending each session, says **Ardith
Z. Doorenbos**, PhD, RN, FAAN,
professor in the department of
anesthesiology and pain medicine in
the School of Medicine and School
of Nursing at the University of
Washington in Seattle.

"We reach more than 100
different clinics and hospital systems,
and some of these have an onsite
case manager," Doorenbos says. "We
also have advanced practice nurses
who do case management on our
side."

The program was launched after
several problems converged: "In
primary care, one of the challenges
that primary care providers face
involves patients with pain,"
Doorenbos says.

"Pain patients rank highest
in dissatisfaction with healthcare
services, and they are very, very
challenging patients," she adds.

Generally, primary care doctors,
nurses, pharmacists, and nurse
practitioners receive almost no
education on how to treat chronic
pain, Tauben says.

"In the context of total
educational programs, it's seven
to eight hours total in four years
of medical school," Tauben adds.
"There's a similar paucity of
training and sense of competency at
graduation."

Published surveys of primary
care providers, asking about how
competent they feel in treating
pain, typically find that providers
acknowledge having too little
knowledge in this area, he says.

"Two percent of pain is treated
by pain specialists, and 98% is
treated by folks with no training in
it," Tauben says. "Thirty percent of
clinical interactions of primary care
providers are the management of
chronic pain; it's one of the most
common problems."

So what happens is that providers
who have little to no education in
chronic pain and who have little
experience treating it with non-
pharmaceutical strategies rely on
opioid management, which has not
been shown in studies to work in the
long term, Tauben says.

"Around 18,000 people die from
prescription opioids each year, and
others are switching over to heroin,"
he says. "It's a structural mess due to
geographic, political, educational,
and other problems, including the
lack of access to proper specialists."

The need for a case management
outreach approach to dealing with
the problem was apparent, and
Washington was an ideal place
to launch the TelePain model,
Doorenbos notes.

"We became known as one of
the states in the country with more
deaths related to opioids than
to car accidents," she explains.
"For that reason, the state of
Washington passed a law so that
anyone who was prescribing over
120mg of opioids needed to

consult with a pain specialist.”

The problem was that there are far too few pain specialists in the state, and most of them are located in Seattle, she says.

“Patients out in the country had to travel a long distance, and wait times at clinics were three to six months,” Doorenbos adds. “For those reasons, we started to think about what was a good way we could provide case management for chronic pain in primary care clinics.”

Even urban areas have long wait times for chronic pain treatment, which exacerbates the chronic nature of the problem because outcomes are far better when the pain is treated effectively early on, Tauben says.

“An urban area could benefit from this program, as well,” Tauben adds.

They began with an educational series, didactic presentations with pain topics for clinical providers, and then they started case consultations, Doorenbos says.

“It morphed into 1.5 hours of a TelePain session, held twice a week on Wednesdays and Thursdays, from noon to 1:30 p.m.” she says. “They don’t have to be there for the entire

session, and they receive continuing education credits as a benefit.”

Direct outcomes of the program include greater satisfaction among primary care providers involved with TelePain, Doorenbos says.

“We can’t directly attribute a decrease in opioid deaths only to our program, but in counties where TelePain has been more active, there has been a greater decrease in opioid deaths than in counties where it’s not active,” she adds. “It’s really, really exciting.”

Community providers who are in areas underserved by pain management services can fill out a referral form with survey questions when they have patients with troubling chronic pain.

“This survey helps us organize our care and prioritize patients,” Doorenbos says. “Then the community provider presents the case, and we have 30 to 50 community providers dialing into the session.”

Besides having on hand a provider certified in pain medicine, the program’s community of practice includes a panel of experts in

anesthesiology, rehab, addiction medicine, psychology, pharmacy, and nursing, she adds.

“It’s great to get so many specialties and experiences in the room at the same time,” says **Alexa Meins**, PhD(c), research assistant, biobehavioral nursing and health systems at the University of Washington.

“This can create comprehensive pain management strategies all in one setting instead of trying to coordinate care from different providers,” she adds.

When TelePain experts make recommendations, these are evidence-based pain management strategies, Meins notes. (*See story below on how the program works.*)

The program addresses case referrals from Washington and additional states, including Wyoming, Alabama, Montana, Oregon, and Idaho.

REFERENCE

1. Meins AR, Doorenbos AZ, Eaton L, et al. TelePain: A community of practice for pain management. *J Pain Relief*. 2015;4(2):1-4. ■

Here’s how the TelePain program reaches patients

CMs, others can listen in

The University of Washington in Seattle addresses the need for pain management experts to reach underserved communities through a TelePain program that incorporates case management practices and a community of practice.

Here is how it works:

- **Ask providers to complete a referral form/survey.** The form’s purpose is to give the panel of experts a better idea of what’s going on in a particular patient’s life. Providers

whose patient cases will be discussed email their responses 24 hours in advance of the meeting, says **Ardith Z. Doorenbos**, PhD, RN, FAAN, professor in the department of anesthesiology and pain medicine in the School of Medicine and School of Nursing at the University of Washington.

It asks questions about the patient’s pain, including these types:

- Where is the patient’s pain located?

- How does the pain affect the patient’s enjoyment of life?

- Does the patient have difficulty with sleep?

- How is the patient’s mood?

- What kind of medication is the patient using?

- Is medication controlling the pain?

- How many bad days has the patient had?

- How satisfied is the patient with the pain treatment?

• **Healthcare professionals connect via technology to weekly sessions about pain management.**

The program is designated for health professionals, and any health provider can connect to it, says **David Tauben**, MD, chief of the division of pain medicine at the University of Washington.

“We prefer a video connect, and all they need is a laptop computer with a camera,” Tauben says. “There’s also an opportunity to connect through the telephone or Adobe if you don’t want to be on the camera as you eat lunch.”

Although connecting with the program is free, health providers who wish to earn continuing education credits for their attendance are charged a \$40 annual fee, he adds.

“The information is evidence-based and high quality with internationally known experts, many of whom are doing research on pain,” Tauben says.

• **Provide educational content first.** “The first 30 minutes of the session is didactic, covering important issues related to pain management,” says **Alexa Meins**, PhD candidate, research assistant in biobehavioral nursing and health systems at the University of Washington.

“And then the session is translated into a PDF and put on YouTube, so people who arrived late can refer to the educational piece at a later time,” Meins adds. “A lot of times, the specialist panel will refer to certain citations and resources that the provider then can look up after the session.”

An example of the educational content includes a review of motivational interviewing, Doorenbos says.

An expert discusses how to do motivational interviewing with

patients, following evidence-based techniques, she adds.

• **Have community providers present their case studies.** “Other providers can see on their screens the pain tracker, so everyone gets information about the patient’s pain intensity, the impact of pain on their lives, physical activity impairments, mood impairments, and how well the pain is managed with medications,” Doorenbos explains.

“IT’S VALUE-BASED CARE, AND THE VALUE WE ADD IS COST-AVOIDANCE AND FULFILLING THE GOAL OF REDUCING THE TOTAL EXPENSE OF PAIN CARE DELIVERY.”

They do not show X-rays or medical chart information, and they rely on the community provider to present important details, she adds.

These case presentations typically take 10 to 15 minutes. Here’s one example: “There was a fisherman who was referred to us from Alaska,” Doorenbos says. “The man, who was an owner-operator, was having trouble doing physical labor on his boat because of pain, and he was having trouble with taking pain medication because they caused a lot of nausea.”

The nausea was most acute when he was standing on the moving boat, so he’d stop his pain medication when he went out to sea. This resulted in his returning to land

in acute pain. A nurse practitioner sought the TelePain expert panel’s advice for how to treat his pain while respecting his lifestyle/work decision.

“Our rehab specialists said to give the fisherman information on how to lift equipment correctly, and the anesthesiologist, who is board-certified in acupuncture/acupressure, gave advice on using acupuncture to control nausea,” Doorenbos says. “And the pharmacist gave advice on how to control the medications.”

The provider hadn’t considered any of these pain strategies before the teleconference and decided to try all of them, she notes.

“We ask for a follow-up in six to eight weeks, and in this case it worked really well,” Doorenbos says. “The fisherman was able to manage his pain much better while on the boat.”

The TelePain program’s benefits extend beyond the single cases that are heard at a particular session, Tauben says.

For individual patients and families, there are immediate benefits to their pain management, and they can achieve this help from the community provider they trust, he says.

It also saves healthcare costs because patients do not have to travel to distant hospitals and providers to find relief from their pain, and their treatments typically are more effective, requiring fewer medical resources, he adds.

But there also are benefits to all of the healthcare providers who are listening in to the sessions. They can learn tips that they can use with their own patient populations. “It’s value-based care, and the value we add is cost-avoidance and fulfilling the goal of reducing the total expense of pain care delivery,” Tauben says. ■

Senior initiative reduces admissions by 50%

Three-year program's results are positive

As America's aging population increases, there's pressure on the nation's healthcare industry to develop care models and best practice programs that will improve seniors' health.

One initiative by Sharp Rees-Stealy Medical Centers of San Diego resulted in a 50% reduction in admissions for seniors engaged in the program. Also, seniors reported a 40% increase in their confidence, knowledge, and skills for self-management.

The health system joined more than 20 other health systems in a program that started July 1, 2012, and recently completed its three-year period for a grant from the Centers for Medicare & Medicaid Services (CMS), says **Scott Heimer**, project coordinator at Sharp Rees-Stealy Medical Centers.

"We enrolled our first patient in May 2013," Heimer notes. "It took a year to get everything up and running."

Sharp Rees-Stealy has had a robust care management program that focused on patients with chronic illnesses, including diabetes, coronary artery disease,

and chronic obstructive pulmonary disease (COPD), says **Christine Tedeschi**, MS, RN, CDE, manager of ambulatory disease management programs at Sharp Rees-Stealy Medical Centers.

"This opportunity focused on the senior population and created a care model for seniors in order to determine, number one, what their needs were, and, two, what type of patient-centered changes took place to increase their efficacy and quality of life," Tedeschi explains.

The program looked at whether seniors had depression and how the team could connect with them to improve their overall health status, she says.

"This fit in well with Sharp Rees-Stealy's philosophy," Tedeschi notes. "Our leadership wanted us to integrate these ideas into our existing programs, and we had a mandate of not increasing resources, so we couldn't hire anybody extra to manage and take care of this program."

The challenge proved to be a wonderful experience, she says.

"The overseeing organization was an outside organization of medical

groups, and we took their guidelines and incorporated them into what we already had in place," Tedeschi says.

The health system's team would meet with the other participating medical groups in collaborative sessions, Heimer says.

"We'd share our experiences and learn a lot from them, as well," he notes. "We had the key players in our organizations figure out how to best implement and layer it into what we're already doing to have as little disruption as possible and to make it easier for nurses to keep track of what needed to be done for this particular program."

The following are some of the steps they took:

- **Define the program's focus.** "Our program focused on senior patients, including those with chronic medical conditions and individuals who were thought to be at high risk," Tedeschi says. "We already had disease management in place, so our high-risk seniors in those programs became eligible for this program, as well."

Since the health system had a successful disease management program with complex case management, patients in this additional initiative were able to be part of an existing structure, she notes.

"We also had high-risk seniors who didn't fit into any other programs who could come over and have their care managed by an RN and social worker who were devoted to that senior population," she adds.

The program required a face-to-face visit, which was integral to its requirements. "It also taught us a lot

EXECUTIVE SUMMARY

A new initiative addressing healthcare needs of an aging population has resulted in a 50% reduction in admissions for enrolled seniors, according to those in charge of the program.

- The program is a collaboration by health systems and has recently completed a three-year period for a grant.
- In starting the robust care management program, project leaders worked to not use more than existing resources.
- The program targeted seniors with chronic medical conditions or who were considered at risk.

about how people engaged and how they saw patients on a face-to-face basis to gather consent,” Tedeschi says.

Nurses also called patients and some people were seen in the hospital, but home visits were a part of the program, she says.

• **Focus on connecting with patients.** “During those face-to-face visits, we worked hard to identify — especially in conversations — how to make a connection with patients to establish what their immediate needs were,” Tedeschi says. “There also was a requirement that we continue to have an engagement with patients and have at least a monthly contact.”

Even the most thorough assessment by phone or in a healthcare setting might miss the patient’s underlying issue, such as the patient’s worry about a family member, she notes.

“It’s all about identifying the immediate needs,” she says.

“For this particular population, these small requirements were helpful over time, so that if a patient needed something, even something as small as a medication refill, we could help,” Tedeschi adds. “This began to be seen by the patient as a special connection.”

There was one patient who would tell her family, “These are my people calling me,” she recalls.

“She was engaged with the care and able to move forward,” Tedeschi says. “All of us were focused on the total care of the senior patient.”

• **Assess for mental health and social support needs.** “Assessments included clinical and psychological needs, and we used an activation measure and quality of life and depression measure, as well,” Tedeschi says.

“Many patients would be connected with mental health

services,” Tedeschi says. “These included depression screening and connecting patients to other programs that might help them.”

For instance, there was one man who needed knee surgery. He lived on a boat, so the nurses worked with him to find housing on land. They were able to find a place for him to live, making it easier for him to have the surgery, she recalls.

“He couldn’t have had the surgery and lived on a boat,” Tedeschi says.

EVEN THE MOST THOROUGH ASSESSMENT BY PHONE OR IN A HEALTHCARE SETTING MIGHT MISS THE PATIENT’S UNDERLYING ISSUE, SUCH AS THE PATIENT’S WORRY ABOUT A FAMILY MEMBER.

“Those were the kind of issues identified over and over again.”

• **Use the right staff.** “We learned early on that it made a difference who we had making phone calls and outreaching to patients,” Tedeschi says. “We have case managers and care specialists — unlicensed staff members who assist case managers in their work on a daily basis.”

Care specialists can reach out to patients and obtain informed consent by telephone, Tedeschi says.

While the actual assessment was done by the care manager, they found that there were individuals who had a gift for connecting with

patients, whether on the phone or in person, Tedeschi says.

“These are the individuals who just have a knack for engaging with patients in person and telephonically,” Tedeschi says.

“We think these people are very vulnerable.”

“One of the stars on the staff is able to help with patients who need to reconnect with the medical group,” Tedeschi says. “She has a knack for making that person feel accepted and embraced, and she is very, very engaging; we look for the warmth to come through for every level of outreach.”

• **Measure results.** “The patient population improved across the board — quality of life scores, depression, as well,” Tedeschi says.

“It was very interesting to look at data and see if the patient was moderately depressed,” she notes. “We were really surprised to find that in both measures having to do with quality of life, we had increases in health-related quality of life.”

They’re refining the process to re-evaluate the patient activation measure, Heimer notes.

“Right now, it’s really subject to the care manager’s opinion whether people need to be challenged,” he says. “It makes sense if you have seniors with multiple chronic conditions, then some will need help for the duration, but the outcomes were positive.”

The key to the program’s success has been the philosophy and regular contact with the patient, Heimer says.

“They develop relationships with their nurse or social worker,” he explains. “It goes back to patient-centered care and how sometimes they’re worried about their cat, and until their cat is okay, you can’t worry about other things.” ■

Adjusting CM services in a transition-focused world

ACA era is “exciting time” for CMs

Healthcare transitions have always been critical in case management, but the Affordable Care Act (ACA) has pushed transitions to the top of the priority list for many healthcare providers.

“ACA’s penalties surrounding readmission rates and a lot of other forces have brought it to everyone’s attention,” says **Cheri Bankston White**, RN, MSN, director of clinical advisory services at Curaspan Health Group in Newton, MA.

“When we drill down to it, the reasons for readmissions are inappropriate discharge planning or discharging patients that were not necessarily prepared to manage themselves after discharge,” White says. “Everyone is starting to recognize that the case manager holds the keys to the kingdom.”

This ACA era is an exciting time for case management, White notes.

“We’re just in the middle of everything right now,” she says. “Even though we are super busy, we need to embrace the change and start to reach out to community partners, taking

the initiative to engage the payers and providers.”

Case managers now have more of a role after discharge and into the community, she adds.

Another change has been increased communication between hospital case managers and case managers in other settings, White notes.

Pre-ACA, acute care case managers were satisfied with managing their own cases, but were less concerned with following up on patients post-discharge. That’s changed with Medicaid and Medicare incentives to prevent readmissions, she says.

“So case managers need to be in touch with payers and post-acute providers to understand the best way to handle moving patients from one level of care to the next,” White explains.

Communication between hospital and community CMs can take place automatically and electronically, but it has to happen, she adds.

With everyone invested in better outcomes, CMs need to pay attention to relationship-building. “We need to

build this into our orientation process and do things creatively,” White says.

“I recommend that new case managers shadow people in different settings and learn about the regulatory pressures and criteria that community partners are dealing with,” White says.

For instance, the following are some of the things new CMs need to learn:

- what it takes to make a smooth transition,
- which information is crucial for each health provider partner to receive, and
- what the CM needs to know about the community partner to be successful.

CMs also can learn about the contracts providers have with payers, information that helps CMs direct staff to necessary tasks, White adds.

“If I have a contract with an insurer and that contract states that I’m going to call and deliver a review every day, regardless of the diagnosis, then my staff needs to understand that expectation,” she says.

The case management world — while always requiring broad knowledge of community services — has gotten even bigger. CMs now need to know of community transport companies and care coordination organizations, as well as home health agencies and skilled nursing facilities. So they need to reach out to these organizations, White says.

“What I find successful is to have quarterly meetings with your high volume community providers, and at

EXECUTIVE SUMMARY

Since readmissions often result from inappropriate discharge planning or discharging patients when they’re not prepared to manage themselves after discharge, one solution is to increase the involvement of case managers in the transition.

- Under the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) provides financial incentives for health systems to prevent readmissions.
- Community and hospital case managers need to communicate more effectively to ensure a seamless transition of care.
- Having quarterly meetings with high volume community partners can help.

those meetings be prepared to discuss specifics,” White explains. “They need to be on the same page with what your goals are, and you need to listen to see if there are any things that are new in the industry — anything you need to help with.”

The main idea is for CMs across the care continuum to work together

to improve outcomes for their shared patient populations. To do so, they need to share information and develop a more productive and powerful relationship, White says.

“I think sometimes we get so busy, we forget to keep on top of the latest rules and regulations,” she adds.

“So we need to educate our staff on

what’s going on out there.”

For instance, it’s helpful to give staff information in digestible formats and in easy-to-read articles, she says. “It’s our responsibility as leaders to educate our staff,” White says.

It might take effort, but it’s an investment, White adds. ■

Medicare proposes paying for advance care planning

“Good first step, but not sufficient”

Proposed changes to the 2016 Medicare Physician Fee Schedule includes a provision for two new advance care planning codes. These would be used to pay for a provider’s time discussing patient choices for advance directives and completing necessary forms.

“This wasn’t at all surprising. CMS has been working on this ever since the initial proposal was derailed by ‘death panel’ discussions,” says **David Casarett**, MD, director of hospice and palliative care at Philadelphia-based Penn Medicine.

Last year’s Physician Fee Schedule rule established the codes, but did not make them active. “The active status now means that dollar values will be assigned during the rate setting step,” explains **Judi Lund Person**, MPH, vice president of compliance and regulatory leadership at National Hospice and Palliative Care Organization in Alexandria, VA.

Joan M. Teno, MD, MS, professor of health services, policy, and practice at Brown University’s Warren Alpert School of Medicine in Providence, RI, sees the proposal as “a good first step, but not sufficient. We must create incentives to ensure

that patient preferences and goals are honored.”

Fewer end-of-life conflicts?

This proposal encourages physicians to have conversations about the patient’s goals of care — hopefully, long before an acute episode arises where the patient’s wishes and goals of care are needed for decision-making, says Person.

“It also covers advance care planning — both documents and wishes,” says Person. “When the patient’s physician knows their wishes, and they are documented, this definitely could have an impact on the number of conflicts that occur when no one knows the patient’s wishes.”

Advance care planning discussions are an ongoing process, rather than a one-time event, says Person. “We encourage conversations early and often, to cover the issues and concerns of the patient,” she says. The proposed rule accommodates the possibility of multiple conversations, with a second code to be used for additional 30-minute increments.

The hope is that earlier and better conversations will ultimately prevent many end-of-life conflicts. “But many of these discussions are going to be far in advance of any crisis — sometimes years ahead,” notes Casarett. “Although we may see a decrease in difficult end-of-life situations, the main reason to do this is that it’s simply good medical care.”

This underscores the need for better training for healthcare providers. “I’m very interested to see how health systems respond to this — perhaps by creating advance care planning clinics,” says Casarett.

Person says that the most important thing is that patients and physicians will have clarity about patient wishes, and that patients’ wishes will be followed because they are known.

CMS is also considering making advance care planning an optional element of a beneficiary’s annual wellness visit. If this is the case, says Person, “there is a better chance that there will be thoughtful ongoing discussions that become a standard part of the visit. That is the best possible outcome.”

For healthy patients, this might mean simply choosing someone

to make decisions about their healthcare for them if they were unable to, and discussing preferences in case of sudden catastrophic illness, says **Alana Sagin**, MD, an instructor for the Palliative Care Service at the

Hospital of the University of Pennsylvania. For patients who are sicker, it might mean discussing their disease trajectory, potential complications, and eliciting care preferences including preferences to avoid potentially non-beneficial

medical interventions.

“These conversations require anticipatory guidance from the medical provider,” says Sagin. “It makes perfect sense they would be a part of a visit with a patient’s primary care doctor.” ■

Choose your words carefully

Language can mislead patients

Keeping your husband on a respirator or pursuing other life-sustaining interventions appears to be futile at this point. The prognosis is guarded.”

A family member hearing these words is unlikely to understand the provider’s likely meaning; that the patient is in the dying process and that aggressive treatments are likely to do more harm than good.

“Families are in crisis, and information is oftentimes new to them. Often they don’t have the wherewithal in that moment to ask for clarification and say, ‘What do you mean by that?’” says **Thomas Foreman**, DHCE, MA, MPIA, director of the Department of Clinical and Organizational Ethics at The Ottawa Hospital in Ontario, Canada.

Foreman regularly asks family members, “What did you just hear?” “It’s surprising how many times they heard something very different from what the doctor said,” he says.

Clinicians often go out of their way to avoid the “C-word,” says **Christine Mitchell**, RN, MS, MTS, FAAN, executive director of the Center for Bioethics at Harvard Medical School in Boston.

“Patients and families are sometimes quite surprised when they learn they or their family members have cancer, even though

clinicians have used the word ‘tumor’ or ‘abnormal growth,’” she says. A mother once told Mitchell her son had “metastases” as if it were a diagnosis; it became apparent she didn’t realize he had cancer.”

“I am generally a believer in using the real words early and often, in a way that detoxifies them and allows patients and families to use them and understand what kind of cancer they have, what the doctors and nurses have said about it, how it can be treated, and what is likely to happen,” says Mitchell. At times, patients or their families are very clear that they can’t handle such talk and don’t want to hear those words.

“Out of respect, I have sometimes said, ‘Let’s talk about what we can say and how we can say it in a way that isn’t so scary,’” says Mitchell. “That at least allows us to talk about what we can’t talk about.”

This gives patients the chance to express how much they need to hope, and how they want to live in the present without an oppressive fear of impending death. “Then, it helps to explore anything they can say about what the circumstances would be when they want to hear more than they can bear to hear right now,” says Mitchell.

Sarah Goodlin, MD, FACC, FAAHPM, chief of geriatrics at the VA Portland Health Care System,

teaches both trainees and practicing clinicians to use the model “ask, tell, ask.” She starts by asking the patient or family what their perceptions are, then tells them information, and lastly, asks them to tell her what they understand and what questions they have.

Simply being asked about preferences for end-of-life care can make a patient wonder if there’s something their doctor hasn’t told them about their prognosis. Goodlin asks this question of every patient she’s meeting for the first time. “I structure it into my normal behavior so I can honestly tell them that I do this with everybody,” she says.

Goodlin tells patients, “This is something I do with every patient. I am not trying to give you a secret message. I just want to find out what you have told friends, family, or other doctors, and if you haven’t thought about it, I want to get a sense of what’s important to you.”

Foreman says it’s important for providers and ethicists to carefully consider the language they use. “Are you trying to get a message across?” he says. “It limits autonomy when we try to guide somebody in a particular direction, but we are not telling them that.”

Many ethical consults, says Foreman, “are less about actual ethical dilemmas than they are about poor

communication. Ethicists certainly have a contribution to make in facilitating a robust conversation when it's apparent people are talking through one another."

The following are some commonly used terms that can mislead patients and families, according to experts:

- **Do Not Resuscitate**

"This is a very negative message, because it communicates that you are not going to take care of their loved one," says **Edward Dunn**, MD, director of the Integrated Ethics Program at Lexington (KY) VA Medical Center. "You are only telling people what you are not going to do."

If a patient's wife is in conflict and is not ready to give up, hearing the term "DNR" can break down communication. "The patient's wife may be thinking, 'Does that mean you don't value his life as much as I do?' It fuels conflict between the family and the medical team," says Dunn. The VA now uses the term "allow natural death."

The team might say, for instance, "Mr. Jones is 90 years old and has serious medical problems and you are now his spokesperson. We believe it would be better off to allow natural death rather than charging in with a code team, because it might cause more harm than good."

"By stating, 'allow the person to die naturally,' it's implied that you are not going to call the code team," says Dunn. "Just by changing the terminology, it promotes a goals-of-care conversation."

- **CPR**

Many people have an unrealistic idea about how successful CPR actually is. For this reason, Goodlin never asks patients, "Do you want CPR?" Instead, she says, "When at the end of your life, your breathing or heart stops, we have a choice. We can allow natural death or we can try

to revive you." If patients indicate they wish to be revived, Goodlin asks, "Are there situations in which you wouldn't want your life prolonged — for example, if you couldn't leave the hospital and live independently?"

"This is framing it as a choice between two positive options," she says.

- **Failure to thrive**

Foreman has seen families get confused when providers use the term "failure to thrive," as in an elderly patient with a suspected abdominal mass. "What they really mean is that it probably isn't worthwhile exploring that too much because she'll be dead long before the cancer kills her," he says. Families sometimes wrongly assume the provider expects the patient's condition to improve.

"It is a positive way of saying something else," says Foreman. "It certainly creates challenges for families in crisis to tease out what that really means." The clinician could be trying to get across to the family that the patient is very ill and probably in the dying process.

"Physicians often say, 'I don't want to take away their hope.' But that's pretty paternalistic," says Foreman. "Patients need real information to make reality-based decisions."

Providers are challenged to balance hard truths with compassion and empathy. "Sugarcoating information may not be as ethically appropriate as we think," says Foreman. "We are denying people the ability to digest information for themselves."

- **Guarded prognosis**

Physicians sometimes use this term when they really mean the patient is dying. "But to a family member, the hidden language that we use as healthcare providers is not understood," says Foreman.

- **Futile care**

"If a patient is on a respirator

and we know they are never going to get off, we might say, 'This really is futile,'" says Foreman. A physician means the intervention can't achieve its therapeutic goal. The patient's family might look at it very differently — that the respirator is achieving the goal of keeping the patient alive.

"It is more important to understand what the patient values and to set goals for their care," says Goodlin. "Then if a ventilator will not achieve the goals, that's the message the family needs to hear."

Instead of taking about "futile" care, Foreman asks open-ended questions such as, "What is your goal?" If the family answers, "For mom to go home," the clinical team can inform the family that this isn't going to occur. The team can then move from talking about specific interventions to discussing values.

"Futile is a very value-laden and confusing word," says Foreman. "The challenge is that the family may have goals that aren't therapeutically related, which might mean it's worth the attempt anyway. It's a difficult thing to grasp."

- **Life-limiting conditions**

Patients or family may interpret this to mean that they just won't be able to do as much as they used to do. In fact, says Goodin, "we are thinking that the condition is going to end their life sooner than if they didn't have the condition. I learned to instead say 'life-ending conditions.'"

- **Life-sustaining interventions**

This gives the impression that the patient's life can be sustained indefinitely. "Oftentimes, the intervention isn't life-sustaining — it's death-delaying," says Foreman. "Although biological functioning continues, we may be just delaying the inevitable." ■

Never events usually are traced to multiple human factors, not just a root cause

Researchers at the Mayo Clinic in Rochester, MN, have confirmed what many risk managers have noted from their own root cause analyses: Most never events can be traced back to human factors rather than just a root cause.

Most commonly, the researchers found, never events are caused by between four and nine human factors.

They identified 69 never events among 1.5 million invasive procedures performed over five years, and they detailed why each occurred. Using a system created to investigate military plane crashes, they coded the human behaviors involved to identify any environmental, organizational, job, and individual characteristics that led to the never events. They found that 628 human factors contributed to the errors overall, roughly four to nine per event. The study results are published in the journal *Surgery*. (An abstract and access to the full text of the study are available online at <http://tinyurl.com/pj5nweb>.)

The never events included performing the wrong procedure (24), performing surgery on the wrong site or wrong side of the body (22), leaving an object in the patient (18), or putting in the wrong implant (5). All of the errors analyzed occurred at Mayo, and none was fatal.

The Mayo Rochester campus rate of never events over the period studied was roughly one in every 22,000 procedures, notes senior author **Juliane Bingener**, MD, a gastroenterology surgeon at Mayo Clinic. Because of inconsistencies in definitions and reporting requirements, she says, it is hard to find accurate comparison data, but a recent study based upon information in the National Practitioner Data Bank estimated that the rate of such never

events in the United States is almost twice that in this report, approximately one in 12,000 procedures.

Nearly two-thirds of the Mayo never events occurred during relatively minor procedures such as anesthetic blocks, line placements, interventional radiology procedures, endoscopy, and other skin and soft tissue procedures.

Despite increasing attention from the medical community, eradicating never events entirely remains elusive, Bingener says. The findings indicate that the never events were not often tied to “cowboy-type” behavior from physicians or staff who disdained safety efforts or casually violated protocols, she notes.

“What it tells you is that multiple things have to happen for an error to happen,” Bingener says. “We need to make sure that the team is vigilant and knows that it is not only OK, but is critical that team members alert each other to potential problems. Speaking up and taking advantage of all the team’s capacity to prevent errors is very important, and adding systems approaches as well.”

For example, to help prevent surgical sponges from being left in patients, Mayo Clinic installed a sponge-counting system with bar code-scanning to track sponges. The hospital also emphasizes use of The Joint Commission’s Universal Protocol, team briefings and huddles before a surgery starts, a pause before the first incision is made, and debriefings using a WHO-recommended safety

checklist. (The WHO checklist is available online at <http://tinyurl.com/ocofcbv>.)

To investigate the never events, the researchers used human factors analysis, a system first developed to investigate military aviation accidents, Bingener explains. They grouped errors into four levels that included dozens of factors:

- “Preconditions for action,” such as poor hand-offs, distractions, overconfidence, stress, mental fatigue, and inadequate communication. This category also includes channeled attention on a single issue. In layman’s terms, that wording means focusing so much on a tree that one cannot see the forest.
- Unsafe actions, such as bending or breaking rules or failing to understand. This category includes perceptual errors such as confirmation bias, in which surgeons or others convinced themselves they were seeing what they thought they should be seeing.
- Oversight and supervisory factors including inadequate supervision, staffing deficiencies, and planning problems, for example.
- Organizational influences such as problems with organizational culture or operational processes.

In addition to systems approaches and efforts to improve communication, attention should be paid to cognitive capacity, such as team composition, technology interfaces, time pressures, and individual fatigue, the researchers say. ■

COMING IN FUTURE MONTHS

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- CM program targets heart disease among Native Americans
- Community-based CM program reduced hospital stays
- Case management can help with chronic pain

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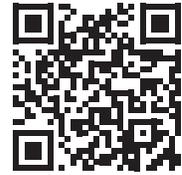
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CNE QUESTIONS

- 1. Due to chronic pain problems, Americans die from prescription opioid use at a rate of how many people per year?**
A. 5,000
B. 12,000
C. 18,000
D. 27,000
- 2. Which of the following is a good question for providers to ask and know about their chronic pain patients?**
A. How does the pain affect the patient's enjoyment of life?
B. Does the patient have difficulty with sleep?
C. How is the patient's mood?
D. All of the above
- 3. Which of the following is not something a new case manager needs to learn, according to Cheri Bankston White, RN, MSN?**
A. How to bill payers for community organization services received by patients
B. What it takes to make a smooth transition
C. Which information is crucial for each health provider partner to receive
D. What the CM needs to know about the community partner to be successful
- 4. When Sharp Rees-Stealy expanded its robust care management program that focused on patients with chronic illnesses to target a senior population at risk, why were mental health services included?**
A. It is required for case management transitions under the Affordable Care Act
B. It is a way to help increase seniors' efficacy and quality of life
C. Depression affects 90% of seniors
D. None of the above

Case Management Advisor

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report in the January 2016 issue detailing the results of this survey and the overall state of employment in case management.

Instructions: Select your answers by filling in the appropriate bubbles **completely**. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- A. case manager
- B. manager/supervisor/director
- C. vice president/president
- D. owner
- E. other _____

2. What is your highest degree?

- A. Some college
- B. Associate or 2-year
- C. Bachelor's degree
- D. Some graduate work
- E. Graduate degree
- F. Doctorate
- G. other _____

3. What is your sex?

- A. male
- B. female

4. What is your age?

- A. 20-25
- B. 26-30
- C. 31-35
- D. 36-40
- E. 41-45
- F. 46-50
- G. 51-55
- H. 56-60
- I. 61-65
- J. 66+

5. What is your annual gross income from your primary healthcare position?

- A. Less than \$30,000
- B. \$30,000 to \$39,999
- C. \$40,000 to \$49,999
- D. \$50,000 to \$59,999
- E. \$60,000 to \$69,999
- F. \$70,000 to \$79,999
- G. \$80,000 to \$89,999
- H. \$90,000 to \$99,999
- I. \$100,000 to \$129,999
- J. \$130,000 or more

6. Where is your facility located?

- A. urban area
- B. suburban area
- C. medium-sized city
- D. rural area

7. In the last year, how has your salary changed?

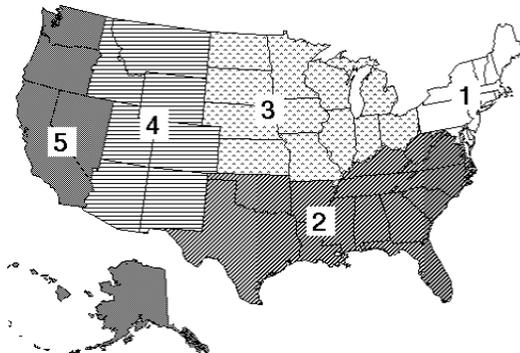
- A. salary decreased
- B. no change
- C. 1% to 3% increase
- D. 4% to 6% increase
- E. 7% to 10% increase
- F. 11% to 15% increase
- G. 16% to 20% increase
- H. 21% increase or more

8. What is the work environment of your employer?

- A. academic
- B. agency
- C. health department
- D. clinic
- E. college health service
- F. consulting
- G. hospital
- H. private practice

9. Please indicate where your employer is located.

- A. region 1
- B. region 2
- C. region 3
- D. region 4
- E. region 5
- F. Canada
- G. other



10. Which best describes the ownership or control of your employer?

- A. college or university
- B. federal government
- C. state, county, or city government
- D. nonprofit
- E. for profit

11. How long have you worked in your present field?

- A. less than 1 year
- B. 1-3 years
- C. 4-6 years
- D. 7-9 years
- E. 10-12 years
- F. 13-15 years
- G. 16-18 years
- H. 19-21 years
- I. 22-24 years
- J. 25+ years

12. How long have you worked in healthcare?

- A. less than 1 year
- B. 1-3 years
- C. 4-6 years
- D. 7-9 years
- E. 10-12 years
- F. 13-15 years
- G. 16-18 years
- H. 19-21 years
- I. 22-24 years
- J. 25+ years

13. How many people do you supervise?

- A. 0-3
- B. 4-6
- C. 7-10
- D. 11-15
- E. 16-20
- F. 21-40
- G. 41-60
- H. 61-80
- I. 81-100
- J. 101 or more

14. How many hours a week do you work?

- A. less than 20
- B. 20-30
- C. 31-40
- D. 41-45
- E. 46-50
- F. 51-55
- G. 56-60
- H. 61-65
- I. 65+

15. In the past 12 months, how has the number of employees in your company or department changed?

- A. increased
- B. decreased
- C. no change

Deadline for Responses: Nov. 2, 2015

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, AHC Media LLC, P.O. Box 550669, Atlanta, GA 30355.