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COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

Health home model has flexibility for 'social determinants of health' 124

NY case management programs find enrollment obstacles. 126

Has the needlestick problem been solved? AOHP study says 'No' 127

Steps toward bundled payments 129

Copy/paste in EMRs should be used carefully. 130

NOVEMBER 2016 Vol. 27, No. 11; p. 121-132

As Demand for Case Managers Rises, Educators Meet the Need

Training is crucial to the case manager role

Healthcare organizations nationwide recently have increased hiring of case managers and care coordinators as they respond to the Affordable Care Act's push toward a population health model.

One of the chief obstacles to scaling up on care coordination and case management programs is the limited supply of experienced and trained case managers. However, this is beginning to change as new education programs are helping registered nurses and others transition to this role.

"Training new case managers is critical when you think about population health, Medicare, Medicaid, commercial insurers, who are all driving toward a more value-based climate," says **Kathy Parrinello**, RN, PhD, chief operating officer at Strong Memorial Hospital, University of Rochester Medicine in Rochester, NY. The university's school of nursing has a certificate program with up to six modules geared toward registered nurses. It includes a supervised mentor experience for care management.

"And now with physician

EXECUTIVE SUMMARY

Case management positions and hiring are on the rise as healthcare organizations respond to changes brought by the Affordable Care Act.

- Supply of experienced care coordination and case managers is limited.
- Organizations increasingly are sending a group of employees to take case management training.
- Young nurses are drawn to the contemporary case management role because of its emphasis on working with patients.

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reimbursement conditioned on meeting certain metrics, physicians are very anxious to get involved in new models because it provides them with an easier pathway," Parrinello says.

In the last decade, the passage of the Affordable Care Act (ACA) and the Institute of Medicine's report on the future of nursing suggested the need for increasing training programs for case managers, says **Kelly Kruse Nelles**, RN, APRN-BC, MS, faculty and co-director of the National Registered Nurse Case Management Training Center in Blue Mounds, WI.

"They were a strong impetus for us to really look at what was available for experienced registered nurses in practice who were going to move into these case management roles and would need a strong framework to impact successful care coordination," Nelles says.

Awareness of the changes led Nelles and her co-director, **Mary Jo Borden**, RN, APRN-BC, CCM, MSN, to focus on training the next generation of case managers.

"We were both faculty in Madison, Wisconsin, and identified the need for this to happen quickly," Borden says.

Nelles and Borden's training program provides online, on-demand courses with interactive learning tools, as well as matching content in a classroom setting for students who prefer this educational venue. Students receive a contemporary case manager's certificate of completion when they finish the course.

"One of the key components of active interest in enrolling in the course has occurred as a result of the shift to quality in payments," Borden says.

Health systems are struggling with improving patient satisfaction and need to raise the bar to improve their quality of care, she adds.

"We're moving from a sustainable growth rate to a value-based macro program, and it's resulted in a lot of health systems finally understanding they can't wait and need to implement changes to become patient-centered," Borden explains.

"We have a couple hundred students take the program each year," Nelles says. "We're starting to see a definite increase in those numbers."

Other educational organizations also are seeing increased interest in case management and care coordination classes among healthcare organizations.

"What I see increasing is organizations wanting to train lots of people all at one time," says **Elizabeth C. Shaid**, MSN, CRNP, advanced practice nurse and clinical education core leader at the University of Pennsylvania School of Nursing in Philadelphia. The university has a continuing education seminar on the transitional care model.

"That's been a real change in the last year," Shaid says. "I'm getting calls from either organizations or insurers, or I had a state health agency that was putting together a program for a whole region of the state, and we trained 15 people all from that region."

From a hospital or community nurse's perspective, case management training is a way to bridge the gap between their clinical knowledge and experience, and the skills they'll need to be care coordinators and case managers.

"What I hear from a lot of people trying to move from the nursing field to case management is a lot of places aren't hiring because of the lack of experience in case management," says **Robin Sullivan**, RN, BSN, CCM, team leader for case management at

Deaconess Hospital in Evansville, IN. Sullivan is an instructor for an online certificate course in case management and care coordination, offered at the University of Southern Indiana in Evansville.

"The suggestion I give people is that the more education, the better," Sullivan says. "I tell them to go and take certification courses that prepare them to take the certification exam because that's a huge step."

Many healthcare organizations are requiring employees to be certified. Also, the need for case managers has increased as a result of the Medicaid expansion and the ACA, which are increasing the numbers of people eligible for health insurance, Sullivan says.

"Nurses on the floor truly want to broaden their horizons and start something new, so they'll take courses in case management as a first step to preparing themselves," she adds.

The university's case management program is one of 17 online healthcare certificate programs the university offers. The program's enrollment was fairly small until the last few years, when it's grown to more than 100 students in the last session, says **M. Jane Swartz**, DNP, RN, ACNS-BC, interim director of continuing education at the University of Southern Indiana.

Young nurses are attracted to the case management roles emerging and being reinforced in the post-ACA era, case management educators say.

"Younger nurses are attracted by the contemporary RN case manager role," Nelles says. "They desire to be in a direct relationship with patients, caregivers, and families."

Younger RNs also want to work with healthcare teams and are committed to moving into leadership positions within organizations that prioritize case management, she adds. "They see so many things happening in their organizations that they know they can contribute to."

All RNs are involved in some type of care coordination, so the case management role is not alien to their experience, Borden notes.

Still, nurses will need some additional training when taking on the case manager role. Education plays a huge role, and students hopefully gain through training a better understanding of what case management is and the importance of the care continuum, Borden says.

"YOUNGER NURSES ARE ATTRACTED BY THE CONTEMPORARY RN CASE MANAGER ROLE; THEY DESIRE TO BE IN A DIRECT RELATIONSHIP WITH PATIENTS, CAREGIVERS, AND FAMILIES."

Some case management educational programs, such as the online transition of care training offered at the University of Pennsylvania School of Nursing, can be easily scaled up to handle greater numbers of students, Shaid says.

"There's no reason why it couldn't educate more people," she says.

"The foundation of transitional care seminar offers 20 units of continuing education with only one hour live per week," she explains. "There are four hours of somebody doing the work on their own, so there is no reason it couldn't be scaled up."

Also, the training can be brought to any organization's workplace for onsite education, she adds. "Last year we had several additional seminars set up specifically for an organization."

Currently, the seminars are held five or six times over eight months with about 15 to 20 people attending each seminar, Shaid says.

For other educational programs, it would be more challenging to increase class sizes. For instance, the University of Southern Indiana's web-based training is designed to be interactive with discussion boards, posted comments, questions, and feedback, Sullivan and Swartz say.

"I encourage my instructors to have interactions with the students, and you can't do that when you have too many students," Swartz explains.

The case manager instructors report that students gain more confidence, as well as knowledge about the continuum of care, when they complete these courses. They also gain training they can use to improve their workplaces and careers.

Nurses taking case management and care transition training just want to do a good job, Nelles notes.

"Over half our students pay their own tuition because they know they need the information," Borden says.

The organizations that enroll staff in the sessions also find that care coordination training can make a difference.

"It's not unusual for organizations to contact us to send a cadre of nurses to take the program together," Nelles says. "When they take the program together, they are actively engaged in identifying strengths of existing practice, barriers, things they can improve on the practice level by themselves, as well as things that require system improvements and changes to improve patient care." ■

Health Home Model has Flexibility for 'Social Determinants of Health'

Homelessness is obstruction to health

CMA SERIES: NEW YORK CASE MANAGEMENT MODEL THE LEADS WAY

This is the second of a two-part series on how the health home model works and seeks to improve healthcare coordination and case management services for at-risk Medicaid patients. This issue includes articles about the model's reliance on helping people with social determinants of health and the program's enrollment obstacles.

The state of New York's health home model of care for Medicaid patients has built-in flexibility for organizations to handle patients' socio-behavioral needs, including mental illness, homelessness, and other social determinants of health.

For example, a patient can be referred to the program because of a mental illness, such as depression, and a chronic illness like diabetes. Many organizations involved with health home have long expertise on connecting the dots between patients' poor health outcomes and their social determinants of health, which are also called social-behavioral issues.

"We're primarily a care coordination model, providing medical and behavioral care," says **Amanda Semidey**, LCSW, director of Coordinated Behavioral Care (CBC) Health Home in New York City.

"We engage clients and address social determinants of health," Semidey says. "We strongly believe health can improve significantly over time when an individual is not struggling with homelessness and food insecurity."

Organizations like Onondaga Case Management Services of Syracuse, NY, have provided case management for people with mental health issues for years and were well-positioned to continue the work when the state changed the way case management would be delivered, says **Molly Stuttler-James**, CASAC, coordinator of adult care management services.

"Years ago, our focus was primarily on mental healthcare, and we were known in the community for providing case management for mental health," she says. "Now the shift is to behavioral health, dual recovery, and the new emphasis for us is to physical healthcare."

Health home-eligible patients are Medicaid recipients who have a diagnosis of a severe mental illness or a chronic condition, including substance abuse or a physical illness.

"The idea was to look at better integrating services within the community for clients," Stuttler-James says. "There's more of a focus on helping clients become self-managing."

The clients the program reaches are people who use the ED often, but no one has had the resources to find out why or to follow up with the patient to make sure he or she does not get sick again.

The health home program seamlessly integrates behavioral and medical health case management, says **Margaret Leonard**, MS, RN-BC, FNP, vice president for Medicaid government and community initiatives for MVP Healthcare in Schenectady, NY.

"This can only be a win-win for everyone, but especially the member, as you'll no longer have someone looking at you and saying, 'Well, I'm going to send in the social worker,' because that person is coordinating it for you," Leonard says. "Many more behavioral health facilities are taking on medical care, and medical facilities are taking on behavioral healthcare."

The key is to get people to visit their providers when needed.

Under the health home model, case managers work with community providers and care providers to identify what is happening with a client, to identify barriers, and get

EXECUTIVE SUMMARY

"Social determinants of health" greatly affect some patients' health, leading to worse outcomes unless those issues are resolved.

- New York's health home model of care for Medicaid patients includes case management to address social and behavioral health issues.
- Case managers identify barriers and work to resolve them.
- Patients with health issues that could be cured sometimes fail to take medication because of a mental health challenge.

services in place to help the person better manage his or her health, Stuttler-James says.

"We may meet with the person and learn they're in the hospital all the time because they're not managing their diabetes and not taking their medications," she explains. "Or we meet with the client and see there are housing issues, so it doesn't make sense to work on all of their health issues if they're concerned about housing."

Social determinants of health drive ED visits, Stuttler-James adds.

Care coordination relies heavily on communication and collaboration between providers, case managers, and patients. "We encourage doctors to talk with each other and collaborate," Semidey says.

"We have care coordination across a network of providers, involving them throughout the engagement process," she adds. "Doctors and therapists need to share information to figure out how to help a person live longer and better, which are the goals of the health home."

Addressing patients' social problems has a twofold benefit. First, it helps to build a trusting relationship with care managers and providers. Secondly, clients are more likely to engage in their own care if someone shows them how they'll benefit from care coordination, Semidey explains.

"You have to answer the question of, 'What's in it for me?'" she says. "This often means we have to address the social determinants of health at the same time we address the health and behavioral health needs."

The reality of healthcare with Medicaid enrollees, and perhaps with most people, is that a social problem or mental health issue can overlap or exacerbate a medical problem. "There may be a confluence of factors that exacerbate a mental health condition," Semidey says.

"For example, there is a lot of research finding that individuals with chronic or acute medical conditions are often impeded from receiving life-sustaining treatment because of untreated behavioral health disorders, including unaddressed trauma."

When it comes to homeless patients, their social issues have a huge effect on their health outcomes.

For instance, a diabetic patient who is homeless might not have the means to take insulin or other diabetes medication and cannot maintain a healthy diet. Add to those obstacles the likelihood that the person is depressed and using alcohol or other substances, and the person's healthcare suffers, Semidey notes.

When a care manager helps the homeless patient find stable housing, regular meals, and transportation to doctor's appointments, the person's healthcare utilization increases in a positive way. The person is seeing a doctor regularly and taking prescribed medications appropriately, instead of having episodic and unnecessary ED visits.

"If you have a well-coordinated care coordination team that is nimble, you are walking toward better engagement with the provider and also addressing a member's priorities and chronic health needs," Semidey says. "Oftentimes, we need to meet with members when they're in an acute crisis and initiate coordination at that time."

The homelessness issue has become important enough to result in a new Medicaid program in which a person who qualifies for the health home program also can receive assistance in finding housing, says **Karlo Francis**, LMSW, deputy director of care coordination for the Community Healthcare Network's (CHN's) Health Homes Program in New York City.

"We assist them with interviews once they go for housing, help them complete a form, and when we get to the shelter, we escort the person," Francis says. "That's proven to be very successful, and we hope to expand that."

Very few traditional case management programs could provide the in-depth kind of help people receive from New York's health home model.

For example, CHN had one patient who was diagnosed with hepatitis B, diabetes, and who was homeless. He also had post-traumatic stress disorder (PTSD) after a fire destroyed his house. Because of his PTSD and fear of enclosed spaces, he lived on a train platform alone. He refused to live in any building or shelter, Francis says.

"We worked with the corner store, the family, and other people who knew him when he was vibrant in the community, and they helped him manage his medication, having it delivered to the corner store," he says. "Whenever we needed to find him, we would ask people at the store, 'Have you seen him today?'"

The man began to see a therapist to treat his PTSD. After a year of this kind of support, the man agreed to live in a shelter. The case management team continued to visit him, and helped him enroll in a program that provides apartment vouchers.

"We partnered with a foundation that helped the patient with furniture, and he now is living in his apartment and comes to the clinic, bringing us candy and thinking of us as part of his family," Francis says. "It's a fantastic story, and he's almost done with this hepatitis B treatment and will be cured soon." ■

NY Case Management Programs Encounter Enrollment Obstacles

Even the title 'Health Home' is an issue

One of the major challenges of a sweeping care coordination management program that targets people with the trio of medical, behavioral, and social problems is that this very population is among the most difficult to enroll in any kind of sustained healthcare effort.

The New York State Health Home Program has the triple aim of improving healthcare for its target population, reducing costs, and redesigning the current Medicaid system. Enrollment criteria include having significant, ongoing, chronic mental health or behavioral health and physical conditions, says **Molly Stuttler-James**, CASAC, coordinator of adult care management services at Onondaga Case Management Services in Syracuse, NY.

"Referrals can come from community providers, therapists, treatment centers, or self-referrals — someone walking in the door," she says. "The first point of contact is the referral source."

Once a referral is made, the case management organization starts outreach services including visiting a person in the hospital or calling the patient to schedule a first intake appointment, Stuttler-James says.

"We ask them if they understand why they've been referred and how our service can help them," she explains.

"Our services are entirely voluntary and they can opt out," Stuttler-James says. "But our hope is that we engage very quickly with people and get them in to see an assigned primary care manager, who helps them identify their personal goals."

The health home program's goal is to collaborate with the state and community partners to develop services that will help high-risk patients stay out of the hospital, says **Tara Costello**, MSW, CASAC, vice president of behavioral health services at Upstate Cerebral Palsy in Utica, NY.

Enrolling patients through community referrals is taking longer than hoped, Costello says.

"The conversion rate has not been the most successful," says **Karlo Francis**, LMSW, deputy director of care coordination for the Community Healthcare Network's (CHN's) Health Homes Program in New York City.

"That is something where we are working with the state to figure out ways to change it," Francis says. "Across the state there is a 12% to 14% conversion."

One of the chief obstacles to enrollment is the program's "health home" name, he says. "It connotes a place where people think they'll be placed, so there's that confusion."

Another problem is that the people following up on referrals often have to show up at someone's home without a prior phone call, and it unnerves clients to learn that someone they don't know has their name and information. This creates distrust, Francis says.

CHN has invested many resources into integration and care coordination, Francis says.

For example, CHN receives a list of patients in the city, including those who do not have a primary care provider. The organization conducts community outreach and embeds people in the clinic to educate patients about the New York State Health Home Program's services. The next step is to enroll patients and assist providers by taking the new patients to doctor's appointments when needed, Francis explains.

"That has helped our conversion rate significantly because these are people that can relate to how we're working with their providers and are seen as part of the team," he says. "We're also embedded in some of the shelters in the city with outreach and

EXECUTIVE SUMMARY

People who have mental health issues and social problems are difficult to enroll in a healthcare program, even if it would greatly benefit them.

- Enrollment criteria in the New York State Health Home Program includes people with ongoing chronic mental health or behavioral health and physical conditions.
- Referrals come from doctors, therapists, treatment centers, and other sources.
- Case management teams meet with people about the health home program, but have found it difficult to convince a large majority to enroll.

care managers who are connecting with patients to make sure they get primary care."

CHN's system includes having interdisciplinary team members meet with providers and assign a care manager to each patient. Physicians set health goals, and care managers help patients meet those goals. For instance, if a physician decides a diabetic patient's blood glucose level needs to be reduced, the care manager follows up with the patient to make sure he or she is checking sugar levels, engaging in healthy activities, meeting with a nutritionist, and visits the patient at home as needed, Francis explains.

Keeping people enrolled in the program also is challenging. For instance, one community provider planned to discharge a client because she did not show up for appointments. The patient's medication caused sleeping problems, so the case management team met with her, her doctors, and family members and set up a new plan, Stuttler-James says.

"We had a collaborative meeting, solved the problem, and had the client continue on a recovery path," she adds. ■

Has the Needlestick Problem Been Solved? AOHP Study Answers a Resounding 'No'

Gains plateau, fear of complacency

Bloodborne pathogen exposures to healthcare workers were higher than expected and not declining in incidence rates, according to the latest results from the Exposure Study of Occupational Practice (EXPO-STOP)[1].

The ongoing study of members of the Association of Occupational Health Professionals in Healthcare (AOHP) ascertains blood exposures (BE) to healthcare workers via percutaneous sharps injuries (SI) or mucocutaneous (MC) exposure such as a splash to the eyes.

A 16-item electronic survey was distributed to AOHP members to ascertain BE incidence and denominator data for their hospitals. Participants were asked to report the annual number of SI and MC exposures for all staff. The annual SIs were reported separately for surgical procedures, for nurses, and for doctors. The denominator metrics included 100 occupied beds (OB), full-time equivalent (FTE) staff, FTE nursing staff, and adjusted patient days (APD).

Responses from 84 hospitals in 28 states were included in the analysis. In 2013, 7,158 BEs were reported and in 2014, 6,954 BEs were reported. In both years, 73% of BEs were SIs and 27% were MC exposures. The SI incidence rates in 2013 were: 33.0/100 OB; 2.6/100 FTE; and 0.54/1,000 APD. In 2014, the SI incidence rates were: 33.3/100 OB; 2.7/100 FTE; and 0.56/1,000 APD.

Time of Fear

There was a time beginning in the 1980s when healthcare workers were literally at risk of death if they seroconverted for HIV following a needlestick. Awareness of the risk of exposures led to the federal Needlestick Safety and Prevention Act in 2000. With implementation of the act, there was a drop off in blood exposures, which are now beginning to edge back up as a certain level of complacency sets in.

"It did drop right after that legislation took place, but over the years since then it has continued to creep up," says **Linda Good**, PhD, RN, co-author of the study and director of Employee Occupational Health Services for Scripps Health in La Jolla, CA. "I think a lot of people saw the initial drop and said, 'Good, we took care of that problem.' But the takeaway from this study is that legislating this is not enough to take care of it. It's something that needs continued attention."

For one thing, hepatitis C virus — the most common chronic bloodborne infection in the country — threatens healthcare workers with severe liver problems if infected. Then there is the threat of Zika and whatever follows it as a novel bloodborne pathogen. The effectiveness of post-exposure prophylaxis for HIV — and the development of antiretroviral drugs that drive virus counts to levels that are scarcely detectable — may have contributed to a sense of complacency.

"That was one of the things that motivated the AOHP to commission

this study," Good says. "We were concerned that there might be an assumption out there that this problem had been solved. This is an ongoing issue and it won't just go away without sustained focused attention."

Even if the cold calculus of potential infection and exposure outcomes has shifted to somewhat safer footing, armchair analysts should walk a mile in a nurse's shoes before dismissing the emotional trauma that follows a needlestick. A study that looked at this issue concluded that "enduring psychiatric illness" can result from needlesticks, but swift delivery of source-patient test results may reduce duration of depression and anxiety.[2]

Drill Down

Among the case vignettes are this one, summarized as follows:

"A 36-year-old healthcare worker in an emergency department was emptying a clinic bin. She was replacing a bag when a needle, which had been incorrectly disposed of, pierced her leg. She was immediately shocked and worried and tried to make it bleed. She talked to the doctor on duty and he tried to reassure her that they had not had any knowingly infected patients in, but she was not reassured. She was worried that she had been exposed to an infectious disease such as HIV or hepatitis or another disorder, and underwent a course of injections over the next week, which gave her diarrhea. The injections then moved to monthly. She also had to have regular blood tests to check on whether she had seroconverted and was suffering from hepatitis B or C or HIV. She received the all-clear from blood tests approximately six months later. Her anxiety gradually subsided thereafter."

As part of the EXPO-STOP study, Good interviewed some of the sites that had successfully driven needlesticks and exposures down and kept them there.

"The hospitals that have been very successful are not complacent about this at all," she says. "They have a goal of achieving zero, so they don't consider any bloodborne pathogens exposure as acceptable. That's kind of remarkable. So anytime it happens, they really drill down with the employee that has been injured, their manager, and they investigate any unsafe practices. They look for a root cause rather than make an assumption about it."

> "ANOTHER HALLMARK OF SHARPS-SAFETY HOSPITALS IS THAT THEY HOLD EVERYONE RESPONSIBLE. THEY DON'T SAY IT'S EMPLOYEE HEALTH'S JOB TO CUT DOWN ON NEEDLESTICK INJURIES. IT'S EVERYONE'S JOB."

"Effective reduction strategies in the low-incidence hospitals included prevention through education, data-driven communication, immediate root cause investigation of all exposures, adoption of safer safety engineered devices, engagement of staff on all levels, and acceptance by staff that safety is their responsibility," the authors reported.

Low-tech Interventions

For example, one hospital picked up a trend that blood draws interrupted by visitors or other healthcare workers could be at higher risk of resulting in a needlestick. As a result, they placed a sign or symbol on the door indicating a procedure was in progress and developed a script to explain and alert the patient to the moment of needle puncture.

"Sometimes it's just something very simple — low-tech interventions — [which were possible] because they paid attention to what was causing their exposures," Good says. "Another hallmark of sharps-safety hospitals is that they hold everyone responsible. They don't say it's employee health's job to cut down on needlestick injuries. It's everyone's job."

Another example cited from a low-exposure hospital was a team of safety advocates, which includes members from front-line staff, employee health, department directors, and hospital administration. The group meets regularly for breakfast and to discuss injury rates and identify key problems. ■

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Step Toward Bundled Payments

The IPPS rule could easily be retitled "Get Ready for Bundled Payments," says **Susan Nedza**, MD, MBA, senior vice president of clinical outcomes management with MPA Healthcare Solutions, a healthcare analytics consultancy in Chicago. An emergency medicine physician, Nedza previously was a regional chief medical officer at CMS and a senior executive at the American Medical Association. She says the final rule is similar to the Medicare Access and CHIP Reauthorization Act (MACRA), but with a great deal more complexity.

"For the folks in the quality area, the link between the hidden quality metrics and the financial bottom line of the institution is where you need to focus," Nedza says. "It's clear that if you miss certain targets, a health system can be at risk for 1% of its Market Basket Update, which can be significant dollars, based on the Medicare volume and the patient population they serve."

Several metrics can play into that risk, including targets for hospital-acquired conditions, value-based purchasing, and avoiding hospital readmissions. The more direct ties to financial outcomes will generate more interest from finance leaders at the hospital than quality professionals have ever seen, Nedza says. She says that could be a challenge for many hospitals.

"It's a challenge because it's not an area where there are a lot of linkages at this point. Most of the quality metrics have been more compliance-based, where you had a minimum to submit and there was either an upside or no penalty," she says. "But now we're talking about these metrics being tied more directly to finances, with a real possibility of a negative effect."

That increased scrutiny from financial executives ties into the move toward bundled payments, Nedza explains. She sees substantial alignment in the final rule with what CMS is doing in its bundled payments program, including more administrative- and claims-based quality metrics. With acute myocardial infarction, for instance, Nedza notes that the IPPS final rule includes metrics that are also being proposed in the bundled payments program.

"What that means is that this becomes almost a transition point, where to meet the stated goal of transferring risk the metrics are going to be more administrative-based and usable in a bundled structure," Nedza says. "That's different from what most of who grew up in the quality world are used to. We're more used to process measures. The linkage is going to continue to increase."

One of the most talked-about changes is a welcome change to the Two-Midnight rule, imposed in 2014 in response to patients staying in observation status for three or four days when they should have been inpatient. The rule was supposed to prompt a decline in the number of long observation stays and an increase in the number of inpatient admissions, and CMS tried to offset the cost through a 0.2% reduction in inpatient payments. That reduction was strongly opposed by hospitals, including some that sued CMS. As a result, CMS gave in and removed this adjustment for 2017 and also retroactively eliminated the reductions back to 2014.

Nedza says compliance with the Two-Midnight rule was difficult from a practical standpoint and unfairly threatened a hospital's finances.

"It became increasingly more complicated to try to fix this, and we almost lost sight of what the original intent was," Nedza says. "In a bundled payment model, none of this matters because the hospital and physician will be held responsible for the costs. You can put them in inpatient or you can put them in observation status, but what really matters is the aggregate costs for that patient."

There are similar points regarding the quality metrics. The 30-day readmission metrics are going to be extended to 90 days in the bundles, so the risk will be transferred to the providers, Nedza says. That puts more emphasis on quality and less on the data gathering and reporting metrics, she says.

"This is an example of moving from a regulatory requirement to a real quality improvement model," Nedza says. "For quality professionals, this means expanding the scope to partners outside the hospital. You're going to have financial risk associated with what happens to patients after discharge, and a significant portion of the potential for improvement is going to be in that post-acute care space."

Nedza advises quality professionals to start considering how current metrics can be used in a bundled context and measuring a 90-day period. That can show the infrastructure you will need and the stakeholders you need to convene, she says.

She also suggests developing

closer ties with the finance department, particularly with the goal of understanding the financial effect of the patients who failed to meet quality measures in the past. Who were the patients that caused the 30-day readmission measure to be suboptimal or optimal?

"We've seen over the years that a lot of quality improvement programs increased perceived quality on performance measures, but also resulted in reduced costs," Nedza says. "You need to do an inventory with physician leadership and hospital leadership of what they are currently collecting and try to identify the things that are actually allowing them to save money while not compromising quality. It's a paradigm shift." ■

Copy-and-Paste Should Be Used Carefully

Anyone who uses a computer or other device routinely takes advantage of the copy-and-paste feature to save time and effort, but how appropriate is that when you're working in an electronic medical record (EMR)? It can be done safely, but only if you are aware of the potential risks and use the feature wisely, experts say.

The use of copy-and-paste in EMRs was the focus of a recent work group at ECRI Institute in Plymouth Meeting, PA. Experts from healthcare organizations studied how copy-and-paste is used and the potential effects on quality, patient safety, and legal risks. The group determined that there are significant risks, says **Lorraine Possanza**, DPM, JD, MBE, senior patient safety, risk, and quality analyst for ECRI.

"One of the biggest problems is when you are copying incorrect, outdated, or inappropriate information into a chart," Possanza says. "Even if you're going back into the patient's record and pulling information that was valid at that time, you have to ask if the information is still accurate and relevant. It's one thing to copy the past surgical history — a fairly static list — but quite another to copy an assessment from when the patient presented with a similar condition two years ago."

Copying an assessment or similar material creates a cognitive bias in all clinicians using that record afterward, presenting the information as current when, in fact, it may be from years ago, Possanza explains.

Both Risks and Benefits

The ECRI task force identified several risks and benefits of copy-and-paste. The risks included producing notes with internal inconsistencies; creating more queries or work to determine if information is correct; erosion of confidence in the documentation either for provider or the health record in general due to outdated, inaccurate, or misleading information; interfering with effective communication among providers because important findings and problems are intertwined with normal patient information; producing overwhelmingly long charts and notes; and the perceived need to "fill" the note for billing and regulatory requirements. *(The report is available online at: http://bit.ly/28YYlnU.)* The ECRI work group developed four recommendations for the safe use of copy-and-paste.

But as serious as those problems are, copy-and-paste should not be eliminated because it offers valuable benefits as well. ECRI points to these positive results from the prudent use of copy-and-paste, saving time by allowing for information that does not readily change to be easily transferred, efficiently capturing complex information, improving tracking of multiple problems for complex patients by providing an easy way to continually document care, improving continuity of care by allowing a simple way to transfer important information to other providers, reducing transcription errors, and reducing the risk of neglecting important issues.

Possanza points out that copy-and-paste is different from cut-and-paste. Copying text can be efficient and safe when done properly, but cutting text in a medical record is never acceptable because it amounts to altering the record, she explains. That is not only bad medicine, but also exposes the hospital and clinician to legal liability, she says.

"That is an important distinction the work group made," Possanza says. "There is a big difference, and the work group was clear in saying that cut-and-paste has no place in working with a medical record."

Most Lack Policy

Another significant risk from copy-and-paste is that the medical record can be cluttered with repetitive or unneeded information, Possanza says. Lab results, for instance, may be lengthy and detailed when just a few values are important for the patient's care. If the clinician copies and pastes the entire lab report instead

of entering just the pertinent data, the next person using the record will have to wade through the entire lab results. That increases the chances that vital information will be overlooked, she says.

"It makes the note exceptionally long, and you cause the reader to lose the train of thought, and maybe forget what you opened the record to look for in the first place," Possanza says. "It makes decision-making more difficult and clogs the communication between providers."

Possanza notes that a recent survey by the HHS OIG found that only 23% of hospitals had a policy on cut-and-paste, so the issue is still mostly overlooked.

"Individuals who have grown up in an electronic environment expect to use copy-and-paste, and they don't understand why it can be such a problem," she says. "Copy-and-paste also leads to a bloated medical record because you very easily take a big chunk of text and duplicate it elsewhere, whereas the doctor probably wouldn't have taken the time to write that much if it had to be entered manually. The longer and more complex the chart is, the more likely that something will be overlooked."

Educating people about the risks and safe ways to copy-and-paste is the first step in addressing the issue, Possanza says.

"There are inherent risks and we have seen incidents where copy-and-paste led to patient harm," she says. "In one case, the record incorrectly indicated that the person had received anticoagulant prophylaxis and that got carried forward for several days. The person ended up getting deep vein thrombosis, and that probably would not have happened if the error wasn't copied and pasted into the record over and over." ■

CE INSTRUCTIONS

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CE QUESTIONS

1. Some case management educators say enrollment for care coordination and case management training and educational courses is on the rise. To what do they generally attribute the increase in interest in case management training?

A. A national survey said that case management jobs pay 44% greater on average than typical RN jobs.
B. Merging hospital systems have a glut of RNs on staff and some are looking at trying a new career path.
C. In the last decade, the passage of the Affordable Care Act and the Institute of Medicine's report on the future of nursing suggested the need for increasing training programs for case managers.
D. All of the above.

2. What are social determinants of health?

A. Social-behavioral issues that affect a patient's ability to maintain good physical health.
B. A person's educational status and income level.
C. A person's social skills and emotional quotient.
D. None of the above.

3. When case managers in the New York Health Home program learn of a patient's social determinants of health, what often is a first step in working with that patient?

A. The case management team will conduct directly observed therapy (DOT) to make certain the person takes his or her medication.
B. The case management team will work with the patient to resolve the social and behavioral issues, and either simultaneously or after the social-behavioral problems are handled, help the patient maintain better health.
C. The case management team will refer the patient to state social services to manage social and behavioral issues.
D. All of the above.

4. Which of the following are the enrollment criteria for the New York State Health Home Program?

A. Person is eligible for Medicaid and has a significant, ongoing, chronic mental health or behavioral health and physical condition.
B. Person is eligible for Medicare and has a substance abuse problem combined with a chronic physical disease.
C. Person is homeless and either sick with AIDS or diabetes.
D. None of the above.

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