CASE MANAGEMENT ADVISOR™

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INSIDE

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Care Transition Program Targets High-risk Patients With Data

One call can be all it takes

Good data and a quick phone call sometimes are all it takes to keep at-risk patients well and out of the hospital.

A care transition program, often consisting of a single care manager's call, has reduced readmission rates at one health system. The program uses data to identify the most at-risk patients. The program also has anecdotal evidence of patients who have changed their behaviors, despite many obstacles.

"We've seen a reduction in readmission rates in all lines of business," says **Sandra M. Mitchell**, RN, assistant director of Network Care Management at Montefiore Care Management, part of Montefiore Health System in Bronx, NY.

"Our seven-day readmission rate dropped 3.9%," Mitchell says. "Our 30-day readmission rate went from 16.6% to 13.3%."

> "OUR SEVEN-DAY READMISSION RATE DROPPED 3.9%, AND OUR 30-DAY READMISSION RATE WENT FROM 16.6% TO 13.3%."

The program cannot measure the nurse care manager's empathy for patients, but this emotional connection — combined with the motivational interviewing technique — has made a big difference, Mitchell adds.

"We have anecdotes of patients who change their behavior," she says.

"The whole purpose of the program is to ensure safe and effective care transitions, to identify barriers to healthcare management including access to care, ER visits, and to overall ensure a positive patient experience," Mitchell says.

The care transition program began as a pilot project in April 2009. The goal was to maximize the care areas and reduce readmissions, Mitchell says.

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"The pilot became a program, starting with four RNs," she says.

Now, the care transition team consists of Mitchell, three LPNs, five RNs, and one RN clinical manager. Longitudinal teams manage patients with heart failure and diabetes. People with complex needs might receive help from an integrated behavioral medical health team.

The care transition team helps to identify barriers that might prevent patients from taking care of themselves safely at home, and to ensure appropriate follow-up care, Mitchell says.

Turning care transition into a more efficient process required better data. "We had a rudimentary way of categorizing patients," Mitchell says.

For instance, the program initially targeted patients who were 70 years or older or who had home care services after returning home.

After receiving input from data analysts, the program's risk assessment evolved. It now looks at patients' comorbidities, readmission risk scores, length of stay, acuity, and number of ER visits over a six-month period.

Data show that the targeted patients have multiple issues. "We know that 44% of the patients we assess have needs regarding medication issues; 25% are referred to other programs including behavioral health," Mitchell says.

The program places the highest-risk cases with RN care managers and others with LPN care managers.

"Each morning, the RNs and LPNs get a daily report that divides up patients for each staff member, based on scores," says **Veronica Chepak**, RN, BSN, MPA, clinical coordinator for the care transitions team at Montefiore Care Management.

"Once we get that report, we start making phone calls, and I will call the person I see there who will have high or moderate risk, and I'll call the high-risk patients first," she says. "I'll look at when patients were discharged, and if they were discharged four days before, I'll call them right away."

The initial calls inquire about the problem that sent them to the hospital and what their discharge instructions are, Chepak says.

"They get a lot of calls at home, so we tell them we're there to support them and to advocate for them, and help them stay healthier," Chepak says. "We ask if they understand the discharge instructions because most of the time they're so overwhelmed, they didn't hear all the discharge instructions given to them or understand the paperwork given to them."

The care manager discusses their symptoms, why their medications were changed, and what their follow-up should be, she says.

"I call it triage case management," Chepak says. "I feel the RNs and LPNs have to be thinking, 'What does

EXECUTIVE SUMMARY

A care transition program achieves readmission rate reductions through data-driven analytics to identify the most at-risk patients for care managers to call.

- Often, care managers can make just one call to the patient and improve outcomes.
- The program's purpose is to ensure safe and effective care transitions.
- The 30-day readmission rate dropped from 16.6% to 13.3%.

this patient need? What will keep them from coming back in the hospital?'"

For instance, care managers could consider the following questions:

- Would the patient benefit from having a pharmacist call?
- Would the patient benefit from long-term case management and follow-up?
- Does the patient need additional services, such as transportation assistance?

Most of the time, one phone call will be all the extra help the patient needs, Chepak notes.

When a case does need more attention, Chepak can make extra calls for assistance.

"I may call the doctor's office to get them an appointment or, if something is urgent with home care, touch base with the home care agency," she says.

"I'll touch back to tell them the outcome of that call and to move them on to a case management team or home care team or whatever team is best to meet that patient's needs," Chepak adds. "The call can take from 15 minutes to an hour, depending on what's going on."

Developing trust with the patient starts with the phone introduction. "I say, 'My name is Veronica from Montefiore Care Management. I'm calling to see how you're doing. We want to make sure you're doing okay at home,'" Chepak says.

People who have just been discharged from the hospital often want to feel that someone cares for them and they weren't just discharged and forgotten, she notes.

"Then I listen to what brought them into the hospital and what they think they need," she adds. "If there's something they think they need — even if I don't think they need it — I'll deal with whatever their pressing need is."

By helping the person with his or her main concern, Chepak builds rapport.

The call might end with the care manager giving the person phone numbers and reassurance that someone from the home care team soon will call.

"In most cases, this is the first touch for the patient to get them along the care continuum," Mitchell says. "We try to ensure patients have primary care visits scheduled with the doctor within seven to 10 days of discharge."

One other aspect of the care transition program is that it keeps care managers' time free from some of the scheduling and other details.

"The nurse is freed to make connections with the next patient and coordinate the next care plan, but she is not bogged down to do all of the little things," Mitchell explains.

For instance, a patient might need a referral to a community-based organization like Meals on Wheels. The nurse care manager can send that referral to a case management team that will follow the patient over a longer term, she adds.

"So if a patient needs transportation, the nurse doesn't have to make arrangements for transportation," she says. "Patients who are on anticoagulation therapy and who can't afford their medications or don't understand how to take their medications, or who need medication reconciliation, are sent to the pharmacy team." ■

Remote Monitoring Can Enhance Case Management and Reduce Costs

Complex cases benefit

Remote monitoring can support case management and disease management programs by providing real-time, data-analyzed medical information of complex patients at home.

One of the drawbacks of telephonic case management is that case managers are limited to information from healthcare provider visits and the most recent symptoms patients report. Patients might gloss over symptoms or be reluctant to report aches and pains. But a remote monitoring device reports objective data, telling a true story of the patient's health changes.

"We do remote monitoring on a co-management basis," says **Kevin Jacoby**, MSW, CCM, CCP, manager of case management at Geneia of Harrisburg, PA. Jacoby is scheduled to speak about integrated remote monitoring at the 2017 Annual Conference & Expo of the Case Management Society of America (CMSA), June 26-30,

2017, in Austin, TX.

One study found that a patient remote monitoring pilot saved $8,375 in costs per monitored patient over a one-year period.[1] The study highlighted case studies, including one of a 75-year-old man who was diagnosed with heart failure, hypertension, chronic obstructive pulmonary disease (COPD), and diabetes. His reliance on continuous oxygen kept him homebound and increased his fall risk. As a result of remote monitoring, he no longer needed continuous oxygen, his blood pressure normalized, his doctors decreased his medications, and he had no ED visits or hospitalizations. From the patient's perspective, his quality of life was greatly improved, as he was no longer homebound and could even attend a family wedding.[1]

"Not everyone needs this equipment," Jacoby says.

"What we do is enroll people and screen for case or disease management," Jacoby adds. "And if we feel the member would benefit from this monitoring equipment, we will have them enroll in a disease management program and offer extra support through the home monitoring program."

The typical patient who benefits from remote monitoring is someone who has complex medical needs. These patients also need many supportive services.

"If you're just doing home monitoring, it's not as effective unless you're supporting other areas," Jacoby says.

Remote monitoring programs work by enrolling patients based on their diagnoses. Nurses deploy the equipment, teach patients how to use it, and establish a relationship. The nurses also assess the patient's ability to use the equipment. The remote monitoring equipment might include screening devices that check heart rate, respiratory rate, weight, blood pressure, glucose levels, and oxygen saturation. Patients use the screening technology each day and their results are sent wirelessly to a portal monitored by care managers. "Nurses look at the values and see if there is anything of concern," Jacoby says.

"Right now we're focused on congestive heart failure, but we're looking to expand it," Jacoby adds. "Some patients have comorbid diagnoses of diabetes."

If clinicians notice a value that is higher than the patient's typical range, it's left to the professional to decide whether the reading could be a legitimate concern or is an outlier.

"If the nurses know patients are heading in a bad direction, then they can head it off," he explains. "Or the nurse might call and say, 'Your blood sugar was a little high today; what was going on last night?'"

When there is a problem revealed by the remote monitoring, nurses can contact the patient's physician to suggest a change in medication, he adds.

"If it's a major concern, they might advise the patient to go to the emergency room," Jacoby says.

Or if data show that a patient is stable and doing well, the information is sent to the doctor at least monthly to let he or she see over time how the patient is managing.

Occasionally, the data will indicate a major change. When this occurs, case managers can troubleshoot to see if there is something wrong with the equipment or how it is being used.

Case managers find that they can focus on a comprehensive picture, using the monitoring data to adjust and improve patients' care, Jacoby says.

"Patients feel so much more in control because they know when they're veering in the wrong direction, they get immediate feedback," he says. "They love getting feedback about how their diet and activities are impacting their health."

Their positive daily actions result in positive health changes that they hear about immediately, rather than having to wait months for a doctor's visit. ■

EXECUTIVE SUMMARY

A remote monitoring program can save thousands of dollars per patient by giving case managers and providers real-time data and trends of vital signs and other health information.

- Monitors can measure blood pressure, glucose levels, weight, oxygen saturation, and other vital signs.
- If a case manager notices a sudden change or problem, he or she can contact the patient's physician or advise the patient to head to the ED.
- The daily data provide reassurance and encouragement to patients for their efforts to improve their health.

REFERENCE

1. Geneia study finds remote patient monitoring could save more than $8,000 per patient annually. Published June 15, 2016: http://bit.ly/2np88uC.

Under MACRA, Keep Two Goals in Mind: Quality and Managing Costs

MACRA replaces a system that hasn't worked

The Medicare Access and CHIP Reauthorization Act (MACRA) likely will enhance the value of care coordination services, focusing on decreasing readmissions.

Since CMS released the final rule on Oct. 14, 2016, healthcare organizations have learned that the push toward population health, which makes case management more prominent, is a chief objective. But whether this focus changes with the new presidential administration is unknown.

"There has been so much focus on post-discharge, and now it's focused on decreasing readmissions, managing the social determinants of health, and care coordination prior to an event," says **Susan Nedza**, MD, MBA, FACEP, senior vice president of clinical outcomes management with MPA Healthcare Solutions, a healthcare analytics consultancy in Chicago. Nedza previously has worked for CMS and is an adjunct assistant professor in the department of emergency medicine at Northwestern University in Chicago.

"MACRA was put in place as a way to provide incentives for physicians to improve quality and impact cost," Nedza says. "It's a replacement for a system that hasn't worked for a number of years: the sustainable growth rate."

The sustainable growth rate (SGR) formula was very flawed, she notes.

"Spending kept going up on physician services, and the government didn't cut physician fees," Nedza says.

The SGR concept was that Medicare spending would grow at no more than 2-3% per year, but it never worked, says **Gary Pritts**, president of Eagle Consulting in Cleveland. Eagle Consulting works with hospitals and physicians on MACRA and other healthcare issues.

"The growth was way beyond that, and the formula called for a pretty substantial chop to physician reimbursement each year over the past 15 to 16 years," Pritts says. "It was so substantial that Congress negated it each and every year."

Finally, Congress decided to eliminate the SGR and passed MACRA to fix the problem, he says. MACRA's two goals are quality and managing costs.

MACRA's value-based Quality Payment Program (QPP) consists of the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (AAPM).

Physicians have a choice between MIPS and the AAPM, which is where the big opportunities are for case managers, Pritts says.

The AAPM is like an accountable care organization (ACO) and Medicare shared-savings program. Physicians in an AAPM will have risk related to their patients' financial outcomes of care, including hospital admissions, ED visits, hospital readmissions, and anything else that increases healthcare costs, she explains.

"By participating in these alternative payment models, they are eligible for a higher rate of reimbursement," Nedza says. "So the whole system is set up now to encourage and reward financially participation in a system that really focuses on not just quality, but efficiency."

Physicians will save Medicare money, but also streamline care, he says.

"In general, the alternative payment models — and to a lesser extent, MIPS — are going to encourage hospital systems and some physician practices to do things smarter and better than they have

EXECUTIVE SUMMARY

The Medicare Access and CHIP Reauthorization Act (MACRA) changes Medicare reimbursement to align it with goals to cut costs and decrease readmissions.

- Under MACRA's Merit-based Incentive Payment System (MIPS), providers earn a payment adjustment based on evidence-based and practice-specific quality data.
- With the Advanced Alternative Payment Model (AAPM), providers are reimbursed under a model that is similar to accountable care organizations.
- The AAPM is more likely to increase reimbursement and need for care coordination and case management.

before, and this is where a nurse case manager can come in," Pritts says. "For example, in the case of a bundled payment model, good case management can potentially reduce the overall cost of what a hip replacement costs and nursing home costs."

MIPS lets providers earn a payment adjustment based on evidence-based and practice-specific quality data.

From a care coordination perspective, there are opportunities in both MIPS and the AAPM models, but more in the AAPM.

Healthcare costs continue to rise well beyond the rate of inflation. In 2015, healthcare expenditures increased by 5.8%, a rate that's not sustainable and suggests a problem with Medicare solvency, Nedza says.

"The whole system has to figure out incentives for hospitals and make sure everyone is getting appropriate care, but not overutilizing services," she says. "Avoiding unnecessary care is going to be critical, no matter what happens with the Affordable Care Act and what changes."

President Donald Trump's administration could make some changes that would make the MACRA programs voluntary.

The U.S. Department of Health and Human Services (HHS) under the leadership of Secretary Thomas E. Price, MD, likely will not favor a mandatory AAPM, Nedza says.

"Dr. Price was a firm opponent of the mandatory AAPM, and he wrote a letter about comprehensive care for joint replacement and forced bundled payments," she explains. "So most people are betting that he'll continue those programs, but make them voluntary."

But there is so much momentum in the direction of quality-based and cost-savings-based incentive programs that the Trump administration may not be able to change the industry's movement in that direction, he notes.

If MACRA's incentive programs become voluntary, then many physicians and healthcare organizations may choose to not participate, slowing the shift to what health systems call a value-based or quality-based healthcare payment system, replacing the fee-for-service model. Most experts in the healthcare industry acknowledge that fee-for-service is costly and leads to medical cost inflation.

> "THE WHOLE SYSTEM HAS TO FIGURE OUT INCENTIVES FOR HOSPITALS AND MAKE SURE EVERYONE IS GETTING APPROPRIATE CARE, BUT NOT OVERUTILIZING SERVICES."

For private payers, this possible MACRA change could be problematic as one of the ways they've saved money is through the use of alternative payment models. "Medicare sets the stage, and everyone else follows," Nedza says.

"If you participate and have some skin in the game, you'll be part of the solution and not part of the problem, and that's the link between MACRA and the ACA," she says. "What's at the core is how do we, at a national level — Medicare, Medicaid, private/public payer — manage increasing costs through more efficient care?"

MACRA's focus on reducing readmissions likely will continue, and this is where case management and care coordination takes center stage.

"The idea is to have someone help you post-hospitalization," Nedza says.

Case management can make sure patients keep follow-up appointments, receive the therapy and other services they need, and have no medication adverse events.

"As more people age into Medicare, you need more people to manage them and to serve in a care advocate role," Nedza says. "Case management could expand borders, going into prevention."

For example, if an elderly person has mobility issues, a case manager can help the person manage mobility around the home prior to hip replacement.

"It really does expand the role of care coordination. I call it care advocacy across the care of a person's needs," she says.

MACRA bundled payment and accountable care organization programs will pay for case management and home visits by care management specialists who might not have nursing degrees, Nedza predicts.

If MACRA and its focus on moving away from fee for service is undermined, then healthcare organizations still will use case management but there won't be adequate reimbursement for it, she says.

"There may not be additional dollars allocated at the federal level for it," she adds. "Care coordination will continue, but who will pay? What is the extra value of having a RN case manager?" ■

Care Managers Can Improve Communication With Physicians

Key is SBAR

Patients' chronic conditions increasingly can be managed at home, but it requires highly effective communication between providers — and this is where case managers can help.

"We can manage patients' chronic conditions in their home environment — the least restricted environment — and keep them in an optimal state of wellness, enhancing their quality of life and managing costs," says **Patricia Hines**, PhD, RN, managing director for care management transformation at Novia Strategies in Poway, CA.

A key strategy in improving communications is the SBAR, which was created by clinical staff at Kaiser Permanente in Colorado:

S = Situation;
B = Background;
A = Assessment;
R = Recommendation.

SBAR is a communication framework between healthcare team members. It gives clinicians a way to focus expectations and attention to particular issues.

"Using SBAR, when a physician comes to the phone, the case manager can give the information that's needed, providing a good assessment around what should be done next," Hines says.

The SBAR toolkit can be found on the Institute for Healthcare Improvement's website. "Take that toolkit and learn about SBAR," she says. "Write out what's a situation, background. Writing it out helps to think about it."

Communication strategies should be directed to particular physicians and disciplines. For instance, case managers in the hospital environment often are working with hospitalists, so their communication plans should be directed to hospitalists.

"It's typical that each is seen by a case manager who will identify what the patient's plan of care is, know what the patient's payer source is and the benefits associated with that, and from a social worker perspective, understand what's going on in the home environment," Hines says.

"I think it's all around the communication style, and it's a way in which you present to the physician," she adds.

Instead of saying, "Don't you think we should do X?" a case manager could say, "I noticed the last time the patient had this situation, you did Y. Do you think that would work again at this point?" Hines suggests.

"If you have a suggestion or recommendation, then you can bring that information forward and engage with the physician in a way that's helpful and not aggressive," she adds.

Handoffs are where clear communication is especially important.

For example, when the hospitalist is discharging the patient to the skilled nursing facility (SNF), then communication between the hospital and SNF should include the next level of care requirements. These go to the medical director or whoever is caring for the patient. The handoffs are important in terms of medication reconciliation, Hines says.

"Case managers dealing with physicians at the hospitalist level could engage in daily bed huddles or rounds with the multidisciplinary teams," Hines says. "The way the team engages with the hospitalist is being able to be there as a team and collectively talk about what the patient's plan is for care treatment, discharge barriers."

Case managers could find out how a particular physician likes to receive communication and contact them with the preferred method. "Some physicians are more open to electronic communications or want to receive phone calls," she says.

Some physicians will include case managers on the team, so communication is direct.

"When we get into primary care physician [PCP] offices and if we have an embedded case manager, the case manager is helping the physician manage the patient's care," Hines says. "So if the patient has comorbidities and is being seen by the PCP, then the case manager might do weekly or biweekly calls to the family to talk about how care is being provided."

The case manager calls also involve weekly or biweekly family calls to discuss how care is being provided. "They make sure they're doing well and have the medications they need, so we don't end up with the patient having exacerbated chronic obstructive pulmonary disease on Friday morning and ending up back in the ER," she adds. ■

OB Risk Reduction Focuses on Nurses, Detailed Timelines

Obstetrical malpractice claims make up only a portion of all cases, yet they demand an undue amount of attention from risk managers and defense attorneys. The tragedy of an injured child can pose a challenge to defending or settling the case, one reason the payouts can be far higher on average than other claims.

While much of malpractice prevention efforts focus on physicians, nurses can be at risk of malpractice charges in this specialty.

Obstetrics is the one nurse specialty consistently experiencing the highest financially severe payments in both past and present Nurses Service Organization (NSO)/CNA closed claim reports, says **Jennifer Flynn**, CPHRM, manager at Aon Affinity Healthcare Risk Management. The most recent report, published in 2015, includes an analysis of obstetrics-related claims and injuries. The authors studied a five-year view of closed claims with an indemnity payment of $10,000 or greater made on behalf of a nurse to an injured third party.

Obstetrics-related claims accounted for 9.8% of all claims, Flynn notes. On average, NSO & CNA paid $397,064 for OB-related claims, which is more than double the overall average paid indemnity for all nurse closed claims of $164,586.

The high severity of OB claims reflects the lifelong medical cost for patients in a persistent vegetative state, who require ongoing nursing care, Flynn explains. Of all obstetrical injuries, fetal/infant birth-related brain injuries had the highest percentage of closed claims, representing 72.5% of all OB claims.

In all these cases, the patients argued the claims involved one or more of the following nursing errors:

- failure to timely report a complication of pregnancy/labor to the practitioner;
- failure to monitor and timely report the mother's and/or baby's vital signs;
- failure to identify and report observations, findings, or changes in condition;
- improper or untimely nursing management of an OB patient and/or complication;
- failure to invoke the chain of command.

Risk Reduction Tips for Nurses

Flynn notes that obstetrics, like some other specialties, involves unique nursing skills that create additional risks. She offers the following risk management recommendations for nurses working in higher-risk clinical areas:

- Follow established policies, procedures, and clinical protocols regarding the assessment and management of each patient's labor and delivery.
- Attain and maintain up-to-date knowledge and skills in the interpretation of electronic fetal monitoring tracings.
- Agree on and utilize common language and interpretation of electronic fetal monitoring tracings among all members of the patient care team, including, among others, physicians, nurses, and technicians.
- Maintain fetal and maternal monitoring during transport to diagnostic test locations or operating room and during the patient's preparation for a cesarean section.
- Document communication with other members of the healthcare team throughout the patient's labor and delivery.
- Understand and follow the nursing scope of practice requirements related to management of medications for cervical ripening and labor induction or augmentation.
- Know and follow the chain of command, as needed, to ensure timely and appropriate nursing and medical care.
- Utilize the chain of command to address medical orders outside the standard of care as defined by nursing and medical staff policies and protocols, professional guidelines, and/or the state nurse practice act.
- Participate in drills for the management of obstetrical emergencies, including uterine hemorrhage.
- Document in a timely manner all patient assessments, fetal tracing assessments, patient care services, and contacts with other healthcare professionals, as well as the patient's symptoms, responses to treatment, and complaints.

Fetal Monitoring Often at Issue

Fetal monitor strips feature prominently in many OB malpractice cases, Flynn notes.

"Nurses must carefully review fetal monitor strips throughout labor

and delivery to monitor the health of mother and baby. If the nurse fails to properly monitor the mother's and baby's vital signs or fails to act swiftly once the fetus begins showing signs of distress, serious injury may occur, ranging from mild to traumatic," she says. "In the most severe cases, the baby may suffer brain damage from oxygen deprivation."

When a birth injury has occurred, the fetal monitor strips can be invaluable pieces of evidence — either in the defense of the defendant nurse or for use by the patient to show harm was done, Flynn says. They will show when the fetus went into distress and for how long. This information may be used to show that the nurse acted or failed to act to the distress in a timely manner. Additionally, fetal monitor strips become part of the medical record, therefore becoming part of the malpractice lawsuit, Flynn explains.

Zika Claims May Be Coming

Risk in OB cannot be properly addressed until a system is in place for tracking and recording unusual occurrences, Flynn says. The most common method for describing untoward events is the incident report form, which should capture relevant, objective information regarding the event and surrounding circumstances, notify management of a potentially serious or litigious situation, and facilitate gathering of information that tracks and trends adverse events.

"Incorporating good, consistent risk control strategies and habits into your practice can help reduce or eliminate those risks," Flynn says. "Some of these recommendations made may seem like 'no-brainers,' but many times we see cases where these simple steps are not done at all or not done consistently across an organization, which leads to poor patient outcomes."

The future may bring obstetrical malpractice claims related to the Zika virus, says **David E. Richman**, JD, a partner in Medical Malpractice Defense Practice Group with the law firm Rivkin Radler in Uniondale, NY. Zika is spread by mosquitoes in some areas and can be passed from a pregnant woman to her fetus. Infection during pregnancy can cause severe birth defects.

"We may see cases coming out of patients with Zika, most likely related to the diagnosis and what advice is given to the parents in regards to potential termination of the pregnancy," he says. "There are a lot of issues with false negative and false positive results, and the histories being taken of patients. I think the risk management community needs to be aware of this cutting-edge issue and take steps to communicate with the clinical staff."

Richman also cautions that providers still must be on guard for one of the worst challenges: the obstetrical patient with little or no prenatal care, who now becomes the physician's responsibility at time of birth. It can be worthwhile to support community intervention programs for these patients to educate them about the need and availability of prenatal care programs, he says.

Cesarean sections are another common point of contention, but not always just whether the procedure was clinically necessary, notes **Bobbie Moon**, JD, shareholder with the law firm of Sandberg Phoenix & von Gontard in St. Louis. She recently worked on a case in which neither of the plaintiff's expert witnesses would say the standard of care required a cesarean section, but they were critical of the defendant physician for not explaining the risks and benefits enough, implying that the patient may have chosen to undergo an elective cesarean section if she had fully understood.

"I think that argument went over the jurors' heads to some degree, but the informed consent issue is an angle that works around what you absolutely had to do," she says. "Some plaintiffs' attorneys are getting around the idea that doctors can't predict the future with absolute certainty by saying you needed to let the mom know. We're seeing more and more detail on that. Did you tell the mom she was having decelerations and this might mean a problem in the future? They ask, 'Doesn't the mom deserve that information?'"

Moon worked on another case in which the plaintiff's attorney questioned why the mother was not informed about certain alarms being turned off during her labor.

"It's all about what did you tell the mom," Moon says. "There's not a very good documentation often about physician or nurse discussion of risks and benefits. Pitocin is always a nightmare, so it would be helpful if your protocol had the nurse take time to document that she discussed the risks with the patient and the patient understood the doctor thought this was best for her at that time."

Texting also is becoming an increasingly common element in malpractice cases, says **Maureen Barnes**, vice president of risk management and patient safety at Cassatt Insured Group, a captive insurance group in Malvern, PA, that provides risk management and patient safety programs to its member hospitals and physicians.

With the timeline so crucial in

most OB cases, plaintiffs' attorneys often obtain text records to prove their case or dispute testimony about the timing of events, Barnes says. The texts sometimes lead the plaintiff's attorney to segue into the audit trail for the electronic medical record (EMR).

"If this physician is going to say he was called away to another delivery at a certain time, the metadata for the EMR ought to be able to support that," she says. "It creates a behind-the-scenes story of who entered what in the record at what time. Sometimes, that is good for us, showing the physician was acting on available information at the time, that the lab result everyone is focusing on actually wasn't available to the physician at that critical time." ■

SOURCES

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ANA Prepares for Return of Ebola – or Anything Else

Nursing groups work with CDC, APIC to teach infection prevention

It seems like only yesterday — and we can certainly be thankful it wasn't — that many U.S. hospitals and healthcare workers felt unprepared to deal with a potential incoming case of Ebola linked to the outbreak in Western Africa.

The 2014-2015 outbreak spread to some 28,000 cases and caused more than 11,000 deaths. One of them was a patient admitted to a hospital in Dallas in October 2014. He died, but infected two nurses, who survived. There was considerable confusion about the case, and some initial speculation that the nurses must have had a break in infection control technique. While the exact route of transmission was not determined, a report by an expert investigative panel described a chaotic scene where any number of factors could have led to the occupational infections. Healthcare workers were confused and "lost confidence" trying to protect themselves with PPE guidelines that were in flux at that critical time, the expert panel concluded.

As a result of the Ebola outbreak, the American Nurses Association has entered into training and resource collaborations with both the CDC and the Association for Professionals in Infection Control and Epidemiology (APIC).

> "THROUGH THESE PARTNERSHIPS, WE WANT TO ENSURE THAT NURSES ARE PREPARED FOR ANY INFECTION THAT MAY BUBBLE UP."

"The ANA has been involved in infection prevention and control for quite some time, ranging from antibiotic stewardships to preventing HAIs, but after the Ebola outbreak in 2014 we wanted a more formalized collaboration between ourselves, the CDC, and APIC," says **Seun Ross**, DNP, MSN, CRNP-F, NP-C, NEA-BC, director of nursing practice and work environment at the ANA.

"Through these partnerships, we want to ensure that nurses are prepared for any infection that may bubble up."

The nurse-patient relationship is arguably the most critical aspect of care delivery, and the ANA is particularly proud that nurses are consistently ranked as the most ethical of all professions.

"We have ranked number one in that category for the past 15 years and that is a position we don't want to concede," Ross says. "We want to continue that trust [in nursing as an ethical profession]. We want to make sure that nurses are knowledgeable to handle anything that comes their way. Certainly, emerging infectious diseases are in that category and may involve at any time a different understanding of [infection control

recommendations]. We want to do everything we can to minimize any concern or hesitation on the part of the nurse."

One result of this effort is the creation of the ANA/APIC resource center, a website for nurses with a wealth of information on all aspects of infection prevention *(http://www.nursingworld.org/ANA-APIC)*.

In addition, the ANA has collaborated with CDC to form the Nursing Infection Control Education (NICE) Network. The plan is to present CDC training materials at conferences and meetings of nursing specialty groups.

"The CDC is developing a basic training program and we are going to take it and gear it more toward nurses for ANA and some 20 other nursing associations," Ross says. "We will do it in collaboration with them at each of their conferences so we can reach a broader range of [nursing specialties]. After nursing school, once you get your first job, every hospital does basic infection control. With the NICE Network we plan on teaching hand hygiene, PPE, fundamental principles, and prevention of infection transmission. We will use all of that as a baseline and expand on that and talk more about emerging infections like SARS, MERS, Ebola, etc."

The training will be conducted at meetings of key nursing groups that include the:

• American Association of Critical-Care Nurses;

• American Association of Occupational Health Nurses;

• Association of periOperative Registered Nurses;

• Emergency Nurses Association.

The NICE initiative with ANA will address the challenges of emerging infections like Ebola, but will go beyond the widely reported problems with PPE during the outbreak.

"This is about a lot more than PPE," says **Michael Bell**, MD, an epidemiologist in the CDC Division of Healthcare Quality Promotion. "A lot of this is about recognizing risk. This is not another review of hand hygiene. It is more about explaining risk — the 'why' in infection control. It's also not just infection preventionists. It's for all nurses. Preventing infections across the board is huge."

The ANA will serve as the primary contractor for the project, which runs through May 31, 2018. Key aspects include developing educational tools and outreach materials for both registered nurses and nursing-related professionals, including licensed practical nurses (LPNs) and certified nursing assistants (CNAs), the ANA reports.

Nurses are the on the front line of patient care, but the ANA reminds that they may also be involved as need warrants in environmental cleaning and disposal of hazardous waste. Of course, as workers protect themselves though PPE and infection control measures, the other critical area of emphasis is to prevent cross-transmission between patients.

In additional Ebola education efforts, the federal government has awarded $12 million over the next five years for training development at three hospitals that all cared for infected patients in their respective biocontainment units during the outbreak.[1] The facilities participating in the collaborative training and education effort are Emory University in Atlanta; the University of Nebraska Medical Center in Lincoln; and Bellevue Hospital Center in New York City. Training will include rapid suspect or confirmed case identification and immediate isolation as well as appropriate donning and doffing of PPE.

Editor's note: "The Expert Panel Report to Texas Health Resources Leadership on the 2014 Ebola Events" is available at: http://bit.ly/1R7j0oP. ■

REFERENCE

1. Cummings KJ, Choi MJ, Esswein EJ, et al. Addressing infection prevention and control in the first U.S. community hospital to care for patients with Ebola virus disease: Context for national recommendations and future strategies. *Ann Intern Med* 2016;165:41-49.

CE OBJECTIVES

After completing this activity, participants will be able to:

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

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CE QUESTIONS

1. **A care transitions program achieved success in reducing readmission rates, partly through identifying and targeting the most at-risk patients. Which patient factors contributed to the risk assessment data?**

   a. Comorbidity, readmission risk, length of stay, acuity, and ER visits
   b. Hospitalization rate, congestive heart failure, gender, age
   c. Fall risk, nutritional status, frailty, culture
   d. None of the above

2. **Which of the following is an advantage to remote patient monitoring?**

   a. It can provide patients with quick medical fixes through the technology left in their homes.
   b. It can send vital signs and other results electronically to care managers, monitoring their health trends.
   c. It can replace home care services.
   d. All of the above

3. **Which of the following provider payment models was included in the Medicare Access and CHIP Reauthorization Act (MACRA)?**

   a. Merit-based Incentive Payment System (MIPS)
   b. Advanced Alternative Payment Models (AAPM)
   c. Sustainable Growth Rate (SGR)
   d. Both A and B

4. **What does the healthcare communication strategy known as SBAR stand for?**

   a. Summarize, bullet-point, abbreviate, relate
   b. Strategy, belief, acceptance, recognition
   c. Situation, background, assessment, recommendation
   d. None of the above