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INSIDE

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Designers of Collaborative Behavioral Health and Primary Care Models See Growth in Future

Care management funding by payers is key

Some of the major designers of collaborative or integrated behavioral health and primary care models have spent years creating tools and models that will work in communities across the nation.

A review of 79 studies, including 24,308 patients, found that collaborative care increases the number of patients adhering to their medication regimens and can improve mental health.[1]

Integrated behavioral healthcare also can help improve healthcare spending. One study found that adults with multiple chronic diseases and high needs related to social-behavioral issues, had nearly three times greater healthcare costs as adults with only multiple chronic diseases.[2]

"We've come to realize that 5% of the population accounts for 50% of healthcare expenditures," says **Garrett E. Moran**, PhD, project director at the Agency for Healthcare Research and Quality (AHRQ) Academy for Integrating Behavioral Health and Primary Care. Moran also is vice president at Westat in Rockville, MD, which contracts with AHRQ to operate the academy.

"WE'VE COME TO REALIZE THAT 5% OF THE POPULATION ACCOUNTS FOR 50% OF HEALTHCARE EXPENDITURES."

"That's widely known, and it's a focus of a lot of case management activity," he says. "There are a lot of folks trying to take those high-cost, high-need patients and work with them to improve their engagement and activation and to help

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them avoid costly, unnecessary, and inappropriate utilization of healthcare services."

More recently, health scientists and others have realized that behavioral health disorders are major drivers of healthcare costs and problems, Moran says.

It's not that people with comorbid conditions spend more because they seek behavioral health services, he says. When all physical ailments are the same, the people who also have depression or anxiety or another behavioral health disorder spend more on their medical care and treatment. Their costs are higher because they'll head to the ED to be hospitalized for physical flare-ups more often than do people without a behavioral health disorder.

Studies that show this financial effect have received the healthcare industry's attention, Moran notes.

"When research made a financial case for addressing behavioral health disorders, people started paying attention," Moran says.

Now that Medicare provides funding for care/case management in these programs, there is cautious hope that more health systems and communities will embrace integration.

"I think we have made progress and are making progress," Moran says. "We have new medical codes to pay for collaborative care, but not many insurance programs have adopted [them]. It's still difficult to pay for integrated care in a fee-for-service environment, with Medicare being the exception."

The Medicare funding codes for care management will have an effect to the extent that other insurers, including Medicaid, follow Medicare's example, Moran says. "In that case, it can really make a difference."

So far, CMS's change, made less than a year ago, has shown promise. But the world has not yet changed, he adds. *(For more information, see related article on page 123.)*

"The rationale for integrated care is that it's so important that we not only treat people's physical concerns, but we also treat their mental health needs, and this is done in the primary care setting," says **Sherri Branski**, RN, MSN, deputy director of AccessCare in Morrisville, NC. Branski is one of the authors of a poster presentation about enhanced roles for care managers in integrated health models.

"Medicare increasingly is

EXECUTIVE SUMMARY

Recent Medicare funding for care management services, related to integrated behavioral health and primary care, has provided more incentives for healthcare organizations to use this approach.

- The Agency for Healthcare Research and Quality (AHRQ) Academy for Integrating Behavioral Health and Primary Care provides free online information, models, and tools.
- The AIMS Center at the University of Washington in Seattle also provides free online tools, definitions, and other information about collaborative care.
- The focus of these models often is on care/case management that helps patients meet their behavioral health disorder needs, as well as maintain their health while coping with comorbidities.

generating new codes to allow practices to bill for the kind of integrated care that many people with mental health disorders need," Branski says.

The AccessCare poster featured the collaborative care model, formerly called the Impact Model, which originated at the University of Washington in Seattle. The model involves a behavioral care case manager working in a primary care setting, whose services are billed by a primary care physician, she says.

AccessCare's poster and integrated/collaborative care model initiative were created to help primary care practices become more integrated, Branski says.

"We do Medicaid case management across the state of North Carolina, and we work closely with providers to help them build capacity to do behavioral health services and meet patient needs," she explains. "The whole nation is working on building capacity for managing mental health needs for patients."

From a case management perspective, collaborative care is the future. "We're always looking for opportunities to utilize case managers in different capacities and different settings," Branski says.

The collaborative care model involves identifying patients that are struggling with multiple comorbidities, including behavioral health issues such as anxiety and depression, says **Anne Shields**, RN, MHA, associate director of the AIMS Center at the University of Washington.

"It's a vicious cycle," Shields says. "Families and patients are dealing with a lot, and it's hard to deal with your diabetes when you're feeling low and struggling in other ways in your life." Substance abuse, depression, and anxiety all contribute to poor health, she says.

Organizations like the AIMS Center have been working on the collaborative care model since before the Affordable Care Act (ACA) was passed. However, the ACA has helped promote the model through some funding and pilot programs as part of its population health and preventive care focus. Even with the ACA's help, organizations need grants to provide a funding stream for sustaining integration program efforts, Shields notes.

Now, with the Medicare codes for care management, there is a possibility that more healthcare organizations could start care collaboration initiatives. And when they do, AIMS and the AHRQ Academy are there to help with free, evidence-based strategies and tools.

For example, AHRQ developed the Playbook, an interactive online guide to integrating behavioral health in ambulatory settings. The Playbook is available online at: http://bit.ly/2ydvFrq.

The Playbook starts with a checklist for organizations to

Medicare Payment Codes Related to Care Management

Starting in 2017, the Centers for Medicare & Medicaid Services (CMS) provided new Healthcare Common Procedure Coding System (HCPCS) codes for care management payment.

Here are the codes and descriptions:

- G0502: Initial psych care management, 70 minutes.
- G0503: Subsequent psych care management, 60 minutes.
- G0504: Initial/subsequent psych care management, additional 30 minutes.
- G0507: Care management services, minimum 20 minutes.

The G0507 must include:

- Initial assessment or follow-up monitoring, including use of applicable validated rating scales.
- Behavioral healthcare planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes.
- Facilitating and coordinating treatment, such as psychotherapy, pharmacotherapy, counseling, and/or psychiatric consultation.
- Continuity of care with a designated member of the care team.

Source: AIMS Center, University of Washington; aims.uw.edu.

determine their level of integration. There also is a section on developing a game plan and the folllowing six examples of common integration approaches:

1. Collaborative Care. This focuses on tracking identified patient populations in a registry, using a care team of a primary care physician, a mid-level care manager on site, and a consulting psychiatrist.

2. Combined Federally Qualified Health Center — Community Mental Health Center. A generalist behavioral health provider addresses a wide range of behavioral health problems and provides rapid access to behavioral interventions.

3. Federally Qualified Health Center and Community Mental Health Center Partnerships. Characterized by close collaboration between behavioral health and primary care, this model has whole-person care in both settings. Patients move between settings, depending on acuity.

4. Comprehensive Primary Care. A team-based approach, this includes behavioral health in primary care settings.

5. Integrated Comprehensive Health Systems. Such systems assume responsibility for all patient care and feature whole-person approaches with inpatient, outpatient, and specialty care.

6. Massachusetts Child Psychiatry Access Project. This project works to improve access to child psychiatry services when fully integrated care is unavailable. It includes universal behavioral health screening, telephone child psychiatry consultations, in-person child psychiatry appointments as needed, and support for primary care providers and families.

The AIMS Center offers a number of free tools and information, including a two-page sample job description for a behavioral healthcare manager. The following are sample items from the list of duties and responsibilities:

• Support the mental and physical healthcare of patients on an assigned patient caseload. Closely coordinate care with the patient's medical provider and, when appropriate, other mental health providers.

"COLLABORATIVE CARE IS A GREAT STRATEGY TO GIVE PATIENTS A WHOLE LOT MORE SUPPORT FOR A PERIOD OF TIME, AND MOST ARE IN THE PROGRAM FOR AROUND SIX MONTHS."

• Screen and assess patients for common mental health and substance abuse disorders. Facilitate patient engagement and follow-up care.

• Document patient progress and treatment recommendations in the electronic health record and other required systems to be shared with medical providers, psychiatric consultation, and other treating providers.

• Develop and complete a relapse prevention self-management plan with patients who have achieved their treatment goals and are soon to be discharged from the caseload.

"We have a plethora of free resources on our website that push integrated and proven practices out to the world," Shields says. "We work diligently with some organizations on a limited or more extended basis to train their staff and design their model of integrated care."

One of the more popular approaches among healthcare organizations that are employing a collaborative care model is to take a stepped approach, she notes.

"They try to match the right level of integrated resource to the patient's needs," Shields says. "Some patients might do well under the care of just their primary care provider or a specialty provider — without need for additional resources."

Other patients will need more help, including therapy and other support, to help them return to their usual levels of function, she adds.

"Collaborative care is a great strategy to give patients a whole lot more support for a period of time, and most are in the program for around six months," Shields says. "Studies suggest that at least two contacts by a care manager within those early months of care is very important." ■

REFERENCES

1. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety. *Cochrane Database Syst Rev*. 2012; Oct. 17. Available at: http://bit.ly/2xLdS9r. Accessed Oct. 3, 2017.
2. Hayes SL, Salzberg CA, McCarthy D, et al. High-need, high-cost patients: Who are they and how do they use health care? A population-based comparison of demographics, health care use, and expenditures. *Issue Brief* (Commonwealth Fund). 2016; Aug. 14:1-14. Available online at: http://bit.ly/2xEx0Xk. Accessed Oct. 3, 2017.

Orthopedic Nurse Navigator Helps Surgery Patients Stay Healthy

Initiatives for total joint replacement

The role of orthopedic nurse navigator ramped up when CMS rolled out initiatives for total joint replacement.

Under the Trump Administration, the Comprehensive Care for Joint Replacement (CJR) initiative has been curtailed, decreasing the mandatory sites and canceling its expansion. However, changes in the process and patient focus have improved outcomes and collaboration across the care continuum, says **Pamela A. Cupec**, BSN, MS, RN, ONC, CRRN, ACM, orthopedic nurse navigator at the University of Pittsburgh Medical Center (UPMC) Passavant in Pittsburgh.

The program helped UPMC Passavant reduce the percentage of total joint replacement patients who are discharged to a skilled nursing facility (SNF) instead of home from about 35% to 22%, Cupec says.

"We have also reduced our LOS [length of stay]," Cupec adds. "Several years ago, a total hip or total knee replacement involved a four-day length of stay, and the team implemented several changes to decrease length of stay. Some of our hip replacement patients have been discharged safely to home the following day. On average, these patients return home after a two-to-three-day LOS."

The LOS decline was due to the navigator program, as well as to changes made by physicians and surgeons, she notes.

Applying a case management/care continuum approach to handling total joint replacement surgery makes a great deal of sense from both a quality of care perspective and a cost of care perspective, Cupec says. "Total joint replacement is an expensive surgical procedure, with cost of care disparity across the nation. Part of the CJR initiative is to rein in costs while delivering high-quality outcomes and patient-focused care."

EXECUTIVE SUMMARY

The Comprehensive Care for Joint Replacement (CJR) program helped the University of Pittsburgh Medical Center Passavant reduce the percentage of total joint replacement patients who are discharged to a skilled nursing facility instead of home.

- The program also helped to reduce the hospital's length of stay among those patients.
- Applying a case management/care continuum approach in handling total joint replacement surgery helps with both quality of care and cost-effectiveness.
- Patients with diabetes, obesity, and comorbidities are referred to nutritional counseling and other programs to help them improve their health before surgery.

One of the changes that the program promoted was deferring surgery when patients' health might lead to poor outcomes.

Patients with diabetes, obesity, and comorbidities were referred to programs — such as nutritional counseling — that could help them improve their health before surgery.

The role of the orthopedic nurse navigator varies and can be practice-based or facility-based. Practice-based navigators assist patients prior to surgery, providing education related to surgery and post-op care.

"Some practices would have a navigator in the surgical office, who would meet with patients prior to scheduling surgery and give [them] education," Cupec says. "I don't have that luxury. I call patients before surgery and invite them to join a class and start to develop a discharge plan."

During a phone call with the patient, the nurse navigator assesses the patient's current support system, as well as the feasibility of the patient returning home after surgery and whether he or she will need a skilled nursing facility stay for post-acute care, she adds.

"The navigator, who may also have a strong case management background, can discover barriers to discharging patients home," Cupec says. "They can start working with the patient in forming a discharge plan and alternatives, such as having a family member take off time, or perhaps move into a child's home if they have a better home set up."

For patients who are unable to attend a live class, navigators can

review key points in educating that patient prior to surgery, leading to better understanding and preparation, she says.

Postponing surgery to give patients time to improve their health can result in fewer complications with infection, she adds.

The following is how the orthopedic nurse navigator works with total joint patients:

• **Before, and day of, surgery:** The hospital case manager and Cupec work closely together. For instance, there might be a high-census, high-volume day in which TJR patients are kept in the recovery room longer than necessary because there are no hospital beds available. Cupec will try to use that time efficiently by sending a physical therapist to start a treatment session with a patient who is stable.

This helps with the hospital's LOS because that patient won't be delayed in discharge due to a late start to therapy. "If they go up to the unit late, they will miss their session of therapy until the next day," Cupec explains. "If they don't get in two sessions, then they have to stay in the hospital another day, and that doesn't make anyone happy."

For example, one staff nurse's husband underwent knee surgery, and Cupec noticed he was walking around the unit when he should have been resting in the recovery room.

"I said, 'Your husband is walking around the unit. Did they cancel the surgery?'" she says.

Post-surgery, he was working with a physical therapist within eight minutes of entering the recovery room.

This kind of solution helps. "It's all part of case management, where you don't back up people and extend the LOS, but you help keep that process moving," Cupec says.

• **Post-surgery:** The morning after surgery, Cupec gives patients her contact information and says, "I will be the person following you for the next couple of months."

Having one person they can contact and rely on can help them feel less overwhelmed. "If they say they are having trouble getting therapy scheduled, it's my job to intervene," she says.

When Cupec sees patients, she discusses their discharge plans and asks how they're doing.

"I say, 'Hey, I hear you're doing great,'" she says. "We talk about what kind of progress that patient has and whether there are medical complications."

Cupec makes rounds every other day, and she'll stop to speak with patients when she sees them in the hall, emphasizing that she is there for them.

• **Long-term follow-up:** Cupec uses a spreadsheet to track patients post-surgery. She also checks therapy notes about them and reviews a daily list of those who return to the ED.

UPNC produced an app that sends information to physicians after hospital and ED visits. "If a patient comes to the ED with drainage in the leg, the app sends out an alert," she says.

This triggers a request to the physician to determine whether the doctor could see the patient the next day to avoid admitting the patient to the hospital.

After 90 days, Cupec stops following patients.

"We reach out to patients in the last nine or 12 months to do a survey, and patients report outcomes," Cupec says. ■

Organization Expands Case Management for North Carolina Sickle Cell Population

Patient engagement improved

North Carolina patients with sickle cell disease are a small population that experiences repeated and costly ED visits and hospitalizations.

"That's why we started looking at them to see what we could do to help them," says **Debbie Murray**, RN, CPN, CMAC, CHC, manager of telephonic support program at Community Care of North Carolina (CCNC) in Raleigh. Murray authored a poster about the Sickle Cell Disease Initiative and presented it at two case management conferences. She is scheduled to speak about sickle cell disease and care management at additional conferences in the fall of 2017.

CCNC has 600 care managers statewide. They work primarily with Medicaid patients, matching them with 14 networks and care managers across the state.

Sickle cell patients who have commercial insurance or no insurance receive assistance from the

North Carolina Sickle Cell program, which collaborates with CCNC, Murray says.

CCNC formed a task force in 2013 to find solutions for the sickle cell population. After reviewing Medicaid data and consulting with providers and the public health sickle cell program, the task force learned that they fail to visit their primary care physicians (PCPs) and hematologists regularly. This was due to lack of insurance, living far from specialty centers, and having limited local resources, according to the report. Plus, EDs had trouble managing pain medication for sickle cell disease patients.[1]

The Sickle Cell Disease Initiative's objectives were to enhance co-management between hospitalists, specialists, care management, PCPs, and public health programs and to decrease the fragmentation of care. The program resulted in improved patient engagement.[1]

Here's how it worked:

• **CCNC convened a state work group**. Working with the North Carolina Emergency Nurses Association and the North Carolina College of Emergency Physicians, CCNC Pediatrics and the state work group developed a Vaso-Occlusive Crisis Management algorithm.[1]

When sickle cell patients are in pain with their disease flaring up, they need immediate treatment, Murray says.

The algorithm helps identify those crisis moments. It is designed in an oval flowchart with patients heading either to their PCP or the ED. The PCP can refer patients to a hematologist and coordinate care with the sickle cell program educator counselors. The ED can refer patients to the CCNC call center, which also will refer them to the educator counselors. Network care managers can be referred by PCPs, the CCNC call center, and the educator counselor.[1]

"Part of the algorithm is to make a referral for someone to work with patients to figure out what kind of barriers they're facing," Murray says.

• **ED staff use checklist referral form.** "We look at the reasons they're in the emergency department, and what they need," Murray says.

"WE WORK WITH THREE OF THE MAJOR HOSPITAL SYSTEMS HERE, AND WE'RE WORKING TO SPREAD IT ACROSS THE STATE TO OTHERS, USING GRANTS WITH DUKE UNIVERSITY."

Sickle cell patients often have financial and emotional needs. "We see a lot of emotional needs, like anxiety and depression," Murray says. "Some people have difficulty getting their prescriptions."

Using a checklist referral form, ED staff checks off answers to questions about the patient's access to transportation, relationship issues, prescriptions, pain, and emotional or mental health needs, Murray says.

This patient information goes to CCNC staff, who make appropriate referrals.

"We work with three of the major hospital systems here, and we're working to spread it across the state to others, using grants with Duke University," Murray says. "We'd like for the program to be completely across the state."

• **Care managers reach out to patients.** When patients need an in-person visit, a care manager will visit their homes or meet them at their primary care physician's office.

"At the first meeting, they work with patients and assess patients' needs," Murray says. "They see whether they have a provider and transportation to get there."

Patients sometimes live in areas without access to hematologists. Or, they might have financial needs that lead to missed medication doses. The care managers can educate patients to watch for signs and triggers of a health crisis, she says.

Care managers also can be patient advocates. They talk with providers about patients' needs and connect patients with specialists.

"It's a multidisciplinary plan to work with them," Murray says. "Care managers, social workers, and health coaches in call centers all can touch base with patients regularly."

• **Refer to health coaches as needed.** Care managers have the option of referring stable patients, who have some health issues, to health coaches, Murray says.

Health coaches can teach patients about stress management, weight management, tobacco cessation, and how to better maintain their sickle cell disease.

"Health coaches can touch base with patients to see if they're taking their medications and whether they're experiencing any issues," Murray says.

Care managers work with patients during acute phases, but can hand them off to health coaches for follow-up and to learn about prevention.

"They can continue to work

with patients for a longer period of time," Murray says. "If the patient gets back into the acute phase, the health coach lets the care manager know. We call the care manager and say, 'This patient is going through a crisis, can you help him?' That's another piece of great collaboration."

• **Pharmacists also assist care managers.** CCNC has community-enhanced pharmacies that provide patients with education, blister pack medications, and medication delivery when needed, Murray says.

"If we thought there was a problem with opioids, we call the pharmacy for help with that," she says.

Since starting several years ago, the sickle cell program has made more than 800 referrals and sent more than 500 patients to the CCNC networks, Murray says.

"Last year, we had teams from hospitals across the nation that came to find out how we're doing this," she says. "Most states don't have a CCNC or networks that extend across the state, so the key is to figure out how they can replicate it using the resources they have." ■

REFERENCE

1. Murray D. Cross-sector system improves continuum of care for sickle cell patients. Poster presented at the Case Management Society of America conference, held June 26-30, 2017, in Austin, TX.

Bundled Approach to Handoff Communication Delivers Significant Safety Dividends

With an estimated 80% of the most serious medical errors linked to communication failures, handoff processes are a rich target for improvement. There are numerous tools designed to help providers remember to convey the most important information when transitioning a patient to another provider, but one approach in particular has demonstrated in multiple studies that it can reduce medical errors and preventable adverse events substantially.

Called the I-PASS bundle, the approach originally was devised for use in pediatric hospitals, but has been adapted and modified since for use in many different types of hospital units, including both pediatric and adult EDs. In fact, such efforts have been so successful and widespread that the I-PASS Study Group has been awarded this year's John M. Eisenberg Award, an honor bestowed annually by The Joint Commission to recognize national-level innovation in improving patient safety and quality.

"I-PASS" stands for: illness severity, patient summary, action list, situation awareness and contingency planning, and synthesis by receiver. However, the bundle includes several other elements, too, including a handoff document, training, faculty observations and feedback, faculty development, and an awareness campaign. Although the approach has delivered impressive results, reducing handoff-related errors by as much as 30%, proponents acknowledge that reaping such gains requires considerable effort and ongoing commitment.

Christopher Landrigan, MD, MPH, the research director of inpatient pediatrics at Boston Children's Hospital, the principal investigator for numerous I-PASS studies, and co-founder of the I-PASS Institute, a group formed to help guide institutions interested in implementing the I-PASS approach, explains that while the tool was developed and used in children's hospitals first, there are themes that carry across all healthcare settings.

"There are some common principles in structuring and organizing handoffs," he explains. "The reason we started at Boston Children's Hospital is because that is where I am, and it is a place where, from my own clinical experience, I could see there was a problem, and we began to try to design a solution."

In fact, initially in 2008, I-PASS was just a resident physician initiative that focused specifically on change-of-shift transitions as residents began to work shorter shifts, resulting in more handoffs, Landrigan says. "When we put the I-PASS bundle into effect, there was a very substantial reduction in medical errors," he observes.[1] "And that initial effort served as a foundation for the multicenter I-PASS study where we were in nine children's hospitals, and again focused primarily on that transition between residents and interns at the change of shift."[2]

Beginning in 2010, the study group began to make adaptations to the bundle for nurses, finding that they could achieve similar levels of improvement in the quality of communication during transitions.

"Since 2013, we have really been focused on wide-scale dissemination

across different settings, including internal medicine services, the ED, surgical perioperative handoffs, and all kinds of transitions involving doctors and nurses," Landrigan says. "This includes transitions within services at change of shift as well as between services when patients are moving around in the hospital."

The I-PASS bundle has continued to deliver good results. For instance, Landrigan notes that one study nearing completion involves 32 hospitals that have begun to adapt the bundle for different settings. "We are seeing similar results to what we saw in the original I-PASS studies where we saw reductions in both medical errors and injuries due to medical errors," he says.

Prioritize Training, Feedback

Landrigan acknowledges that there are all kinds of mnemonic-based tools published in the literature that provide reasonable organizational frameworks for the information that needs to be conveyed in a handoff.

"What makes the I-PASS bundle unique is that it is not just about the mnemonic," he says. "We have bundled together a training program for residents and later for nurses and others, with discrete changes to the handoff process." For instance, there is a written handoff tool that is integrated into the electronic medical record (EMR), and investigators have expended considerable effort thinking through how hospital administrators can achieve the cultural changes needed to sustain the I-PASS approach, Landrigan explains.

"A critical piece of this is workplace-based learning and assessment so that when clinicians are using this, they are getting feedback on what they are doing and constant reinforcement on what a good handoff looks like," he says. "That requires really building a core of faculty that can provide this feedback."

Further, when making modifications to the I-PASS bundle, individual units must account for how it is going to integrate with their EMR systems as well as the workflow of physicians and nurses. "It has to be something that is easy for them to use, and ideally is sitting on the same [EMR] system or is accessible from that system so that it feels natural for them," Landrigan notes. Working with IT specialists, hospitals often can arrange for the electronic handoff form that is part of the I-PASS bundle to be populated automatically with information that exists elsewhere in the EMR, which saves time and effort, Landrigan says.

"WE HAVE BUNDLED TOGETHER A TRAINING PROGRAM FOR RESIDENTS AND LATER FOR NURSES AND OTHERS, WITH DISCRETE CHANGES TO THE HANDOFF PROCESS."

In fact, Landrigan relates that investigators have taken pains to accurately measure the time required to use the I-PASS bundle when transitioning patients, and they have found that it does not add any time at all to the process.

"It does lead to some reorganization in the way that handoffs are handled ... but in the aggregate, it does not add any time," he says.

For the past several months, **Catherine Perron**, MD, the director of physician quality assurance and compliance in the department of emergency medicine at Boston Children's Hospital, has been focused on implementing I-PASS in the ED after an earlier attempt failed.

"We had an experience back in 2011 where we did a lot of I-PASS training because the hospital was promoting it, but it went still in the water because we never backed it up with any real-time observation," she explains.

This time, Perron made implementation a top priority, first modifying aspects of the I-PASS bundle so that they integrate well within the emergency setting. For example, she developed her own I-PASS training videos, using patients more representative of those treated in the ED.

"We quickly created five or six patient [examples] so that when we went to do training, it looked like an ED sign out and not an [inpatient] floor sign out," she explains.

Perron explains that she turned to the most vocal naysayers in the department to prepare video examples of both poor handoffs and good handoffs, using the I-PASS approach. This helped to get buy-in from some of the most resistant staff, she explains. The videos then were sent to all the staff so they could see examples of how the approach works with typical emergency patients.

Another modification of the I-PASS approach involved the written handoff tool because while

handoff paperwork for inpatients often involves hefty documents, the ED sees a wide variety of patients, some of whom require very little documentation.

"We as a group troubleshooted what we were going to do about the written handoffs and we left that fairly loose," she explains. "We provided people with a template they could use in our charting area, but we didn't actually require people to use a certain template for the handoff. That was probably our quickest modification."

Identify Champions

With the kickoff for the implementation slated for Jan. 1, 2017, Perron spent much of the fall leading up to that date holding workshops and focus groups and identifying I-PASS champions who would conduct observations and provide feedback to staff once the rollout began.

"We made a plan to get to every provider with two observations, so all attending physicians and nurses, which for us was about 300 observations," Perron notes. "We were going to do that within six months. We were going to be a presence in the department so that people felt like their behavior was being reinforced, and if we got to everybody, people would reinforce each other."

The department also launched a marketing campaign so that the I-PASS method was reinforced constantly as a priority.

"The amount of information that providers got — I am sure they are seeing I-PASS in their dreams," Perron notes. "There was signage, emails, staff meetings, safety stories — this has been a constant presence."

Prior to the I-PASS rollout, administrators collected data showing that the department would handle a handoff-related safety issue every two to three days. That was the baseline, Perron says.

"Our intent was to reduce our handoff-related safety events by at least 20% at the six-month mark following the start of the initiative," she explains. "We just ran our numbers; we are down by roughly 30% in handoff-related and reported safety events."

Going forward, Perron is hopeful that with other units in the hospital also implementing I-PASS, there will be added reinforcement to keep the practice in place. "We have already started to notice that if you call [another unit that is using I-PASS], you don't have to prompt them to synthesize," she explains. "They will actually say 'let me synthesize back to you,'" she says.

Certainly, implementing I-PASS is a big lift, and you have to keep at it, Perron shares.

"You really have to have a multidisciplinary group take this on and make it happen," she adds. "What we learned a few years ago is you can train everybody, but if you don't reinforce the behavior, you can't make it stick."

Intrigued with the potential and the published results of the I-PASS approach, **James Heilman**, MD, medical director of the transfer center, telemedicine, and continuous quality improvement for the department of emergency medicine at Oregon Health & Science University (OHSU) Hospital in Portland, led the effort to study, modify, and implement the I-PASS bundle in the ED.[3]

"We started investigating and did focus groups [on the I-PASS approach] in the fall of 2014," he explains. "The major modification we made was to the patient summary ... because it is a lot different in the ED than in an inpatient setting." The main issue is time, Heilman observes. "On the inpatient side, oftentimes there are more things to follow up, but they are not as time-sensitive," he says. "There may be multiple consultants managing a lot of different things over a longer period of time, whereas in the ED it is a matter of managing fewer things, but in a much more condensed time period."

To accommodate for this difference, the patient summary must be brief and to the point, Heilman observes.

"It has to be tailored to how much work the oncoming team is going to have to do with that patient," he says. "It is a challenge with emergency medicine handoffs because of the time pressures that we have. It takes experience to be able to know when you need to talk more or less, so the I-PASS tool helps with this, but it doesn't solve all the problems."

Before adopting the I-PASS bundle, the ED used the standard SBAR (situation, background, assessment, recommendation) mnemonic, but the department did not have a standardized EMR template.

"It was loosely used by people to organize their handoff, and that was helpful, but I think the advantage of I-PASS is that it has 'illness severity' first," Heilman notes. "Having that at the beginning is helpful because it really cues the oncoming team if there is someone that they need to worry about ... if you are receiving someone who is unstable, then you are going to want to know more information."

With SBAR, the stability of the patient is not always communicated, says Heilman, so being prompted to identify whether the patient is stable

or unstable helps because it cues the oncoming team to any high-risk patients up front. "It is surprising how [illness severity] can get missed sometimes with handoffs because there are so many other details," he adds.

The OHSU team also modified the instructions for the second "S" in I-PASS, which stands for synthesize. "In the ED, it is different from an inpatient ward where clinicians have more time to be able to repeat everything back, so we modified it for the ED," he explains.

Instead, this synthesis is shortened to one sentence on each patient. "It achieves the same thing. It is still a synthesis by the receiver," Heilman notes. "It is not the whole presentation back, but rather a one-liner so everyone is on the same page."

It is tough to quantify the effect the I-PASS bundle has made on the ED because other changes were integrated at the same time, says Heilman, but he believes it has made a difference.

"I think the important thing is to have a standardized process and a standardized tool to help guide that process," he says. "Having a standardized EMR template was critical ... and it was important to the way our work flows here."

Also key to the successful adoption of the approach was empowering residents to take a leadership role in driving the implementation.

"Different academic programs have different ways that they do sign outs and handoffs. Ours is resident-directed, so having them buy into the idea ... and getting them interested in it was important to our culture here," Heilman notes.

The I-PASS bundle offers structure to the handoff process as well as to the process for implementing the approach, but putting in the required resources and time is important, Heilman observes.

"Putting the investment up front solves a lot of problems downstream," he says. "It is a way your department can demonstrate that you are staying up with the current times and the safety literature."

REFERENCES

1. Starmer AJ, Sectish TC, Simon DW, et al. Rates of medical errors and preventable adverse events among hospitalized children following implementation of a resident handoff bundle. *JAMA* 2013;310:2262-2270.
2. Starmer AJ, Spector ND, Srivastava R, et al. Changes in medical errors after implementation of a handoff program. *N Engl J Med* 2014;371:1803-1812.
3. Heilman JA, Flanigan M, Nelson A, et al. Adapting the I-PASS handoff program for emergency department inter-shift handoffs. *West J Emerg Med* 2016;17:756-761.

CE QUESTIONS

1. Which of the following is a major driver of healthcare costs and problems?

a. Behavioral health disorders
b. Overstaffing in hospitals
c. Population health initiatives
d. All of the above

2. Which of the following is included in the AIMS Center's two-page sample job description for a behavioral healthcare manager?

a. Support the mental and physical healthcare of patients on an assigned patient caseload.
b. Screen and assess patients for common mental health and substance abuse disorders.
c. Develop and complete relapse prevention self-management plans with patients who have achieved treatment goals and are soon to be discharged from the caseload.
d. All of the above

3. Applying a case management/care continuum approach to handling total joint replacement surgery works from a quality of care perspective and from which other perspective?

a. Cost of care perspective
b. Staffing efficiency perspective
c. Surgeon satisfaction perspective
d. Healing speed perspective

4. Which of the following is a common emotional need of sickle cell disease patients?

a. Obsessive-compulsive disorder
b. Fear of crowds and open spaces
c. Anxiety and depression
d. Feelings of insecurity and discrimination

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