CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE

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Risk Stratification Can Help in Population Health Environment

Think of risk in terms of patient needs, not cost

Risk-stratified care management is one way to provide effective and efficient care coordination/case management.

The philosophy behind relying on risk stratification is that not all patients with multiple comorbidities need the most complex care management resources. If improved data collection and risk stratification could identify precisely the patients who would benefit most, an organization can put its resources where they're most needed and effective.

"When we first started talking about risk, everyone was using the word to mean the financial risk to the organization that a patient might incur," says **Bruce Bagley**, MD, a family physician who works with Leavitt Partners on the accountable care learning collaborative project. Bagley formerly was medical director for quality improvement for the American Academy of Family Physicians (AAFP), and was the president and chief executive officer for TransforMED, a subsidiary of the AAFP, which helps primary care practices transform for success in value-based care.

> "WE TURNED THE CONVERSATION AROUND WITH A NEW VOCABULARY THAT SAYS, 'WHAT IS THE RISK THAT A PATIENT NEEDS EXTRA HELP?'"

"It was about the risk of an expensive payment," Bagley says. "We turned the conversation around with a new vocabulary that says, 'What is the risk that a patient needs extra help?'"

The goal is to identify individuals who need help managing their chronic conditions or navigating the fragmented

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care system and to provide that help in a timely way.

"If you do those two things, the money takes care of itself," he explains.

For example, AAFP developed a chart that describes examples of potentially significant risk factors in the following five different categories:

- clinical diagnoses, behavioral health, special needs;
- potential physical limitations;
- social determinants;
- utilization;
- clinician input (personal knowledge).

Each category has bullet point descriptions of conditions, ranging up to 11 bullet points. *(The full chart is available at: http://bit.ly/2z5qius.)*

"You can assign people to risk categories, determined by need," Bagley says. "Then, you must have a strategy and resources for each category."

The care plans are customized depending on a patient's comorbidities and social determinants of health.

The conceptual framework consists of six levels, beginning with healthy people with no identified diagnoses or complex treatments, and progressing through the highest level of need in which the patient has a severe illness or condition, and risk factors that might include end-of-life care or high costs with limited opportunity for improvement, according to the AAFP chart.

Each level is accompanied by recommendations, including preventive screenings, immunizations, patient education, blood sugar monitoring, care manager visits, and hospice care.

Stratifying patients into one of the risk levels provides a framework to understand their health issues and needs, he says.

"People rely on billing data to come up with lists of the most expensive patients, and that's their mindset," Bagley says. "But it obviously misses a lot of people who should be on an intensive intervention list and who are about to become more expensive."

Care management services need to address both those who need that level of attention now and patients who need more attention to prevent them from progressing to a higher level of risk.

"Only looking at the last two years of claims data is shortsighted," Bagley says. "Clinicians might know that this person's spouse just died, and now they're socially isolated and can't get around the house. Things like that don't show up in claims data."

Risk-stratified data also better inform care coordinators, helping them understand what strategic interventions might be useful. With this information, care managers can

EXECUTIVE SUMMARY

Risk-stratified care management can help bridge the distance between providing effective care and finding efficient ways to do so.

- Think of risk in terms of what a patient needs, rather than as a cost.
- Identify patients who need help managing their chronic conditions or navigating the healthcare system.
- Shift to team-based approach is essential.

determine whether patients need Meals on Wheels, home care visits, or enlisting neighbors to check in on them every week or so, Bagley says.

"It's hard to put this into computer algorithms. It has to be individualized," he says.

Using risk stratification to drive care management is part of a new trend in the healthcare industry. It is based on the team approach to care, in which the physician, physician assistant, care managers and coordinators, and other healthcare professionals work collaboratively.

"For a long time, the doctor's visit has been the central commodity in the business of healthcare," Bagley says. "That is about to change as we move to value-based care and payment reform."

Care coordinators are a key element of the new team approach. Much of what care coordinators do is organizational, providing patients the help they need and pulling in clinicians as needed, he says.

"This has to be a real team-based approach, where everybody is able to make decisions that are appropriate for their level of work," Bagley says. "I think that team-based approach, at the heart of it, is a strategic distribution of the work."

In a team-based approach, the care coordinator might call in a social worker, psychologist, or home care nurse, depending on patient need. "We need to get away from the hero model where the doctor is the source of all wisdom," he says. "We need to enlist the skills of all care team members."

This approach will require a change of philosophy for doctors, some of whom are not yet on board with case management, Bagley says.

But the team-based approach with care coordination/case management works better for patients because they receive what they need when they need it, he says.

"The team follows the individualized care plan. But once that care plan is laid out and there are problems, or things don't work out, then the team goes back to the doctor," Bagley explains. "This frees clinicians to spend more time with patients when their medical issues are not worked out yet."

Routine activities, such as flu shots, foot exams for diabetic patients, and other monitoring actions, could be part of a systematic, high-reliability approach that does not require a doctor's direct involvement, he says.

The role of risk stratification is to divide patients between those who need just an "attaboy" from those who need extra attention. "Those with multiple chronic illnesses that are not under control would need help from a professional who is trained and engaged to help them out," Bagley says.

This approach also will work in the accountable care population health world in which case managers, primary care providers, and others focus on helping patients receive healthcare that is optimal for their conditions. ■

Study Offers Puzzle Piece to Paying for Integrated Care

Depression screening only 4.2% overall

A growing national trend to better integrate mental health into primary care practice settings needs two components to make it a feasible model for healthcare organizations.

The first component is research, and the other piece involves paying for these integrated services — a challenge in America's fragmented delivery system, says **Benjamin Miller**, PsyD, chief policy officer for Well Being Trust of Oakland, CA, and senior advisor for Eugene S. Farley, Jr. Health Policy Center at the University of Colorado School of Medicine in Denver.

Because of the fragmented payment system, mental health and primary care services have evolved separately, which has been a mistake from a healthcare quality perspective. "Only 4% of primary care physicians screen patients for depression," Miller says.

He cited a study published in July 2017 in the journal *Psychiatric Services*. Researchers found that the overall rate of depression screening was 4.2%, with African-Americans being screened half as often as whites.[1]

The United States' overall major depressive episode prevalence for adults is 6.7%, with women at 8.5%, according to 2015 data by the National Institute of Mental Health.[2]

There is a disconnect between what's needed to help patients

EXECUTIVE SUMMARY

Integrating mental health into primary care practice settings needs both research and a payment structure that works.

- Primary care practices screen too few patients for mental illness, missing many cases.
- Researchers evaluated the global budget model, which is a capitated system that can enhance the integration of mental health services in primary care.
- The global budget exercise has resulted in more patients being seen by the mental health clinicians.

improve their health and the screening and services available, he says. One factor involves how healthcare is paid. The predominant system now used is fee-for-service, in which there is retrospective payment for each item of service provided, based on billing codes submitted to payers.

The Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE) model, formed by a partnership of Colorado healthcare organizations, has evaluated an alternative: the global payment model. This capitated system model pays a predetermined rate per person to healthcare organizations, allowing the organizations to determine which services to deliver.

Four years ago, Miller was part of the collaboration to test a prospective payment model that allowed mental health clinicians to perform their jobs without the constraints of fee-for-service payment.

The study involved patients from primary care settings. Each setting had an onsite mental health clinician. The study compared outcomes between two different types of reimbursement for primary care services in those settings. One type was the traditional payment model in which primary care clinicians sent patients to the embedded mental health clinician when necessary. The others used an alternative payment model in which funding was given to treat patients, including those needing mental health services.

> "THE REASON WE DON'T SEE THIS MODEL HAPPENING MORE OFTEN — ALTHOUGH IT'S ONE OF THE LEADING INNOVATIONS IN THE INDUSTRY — IS BECAUSE OF THE FINANCING."

"The facilities received a global budget that took into account the cost of the mental health clinician," Miller explains. "They didn't have to bill for their own services, but could do whatever the practice determined was appropriate to do."

Researchers wanted to know whether payment model type affected primary care clinicians' ability to treat and identify patients with mental health needs. If it proved that a global budget improved mental health screening and resulted in more patients being treated, then the next question was whether this resulted in cost avoidance.

"We didn't do any training [of primary care staff] because we wanted to see what would naturally evolve within these practices once the payment model allowed them to have what they wanted," Miller says.

"We learned a lot along the way," he adds. "There is a story, in particular, about the training that's necessary to have a successfully integrated practice, and that led us to create competencies and other projects outside the scope of the program."

They found that the the global budget exercise resulted in more patients being seen by mental health clinicians, and more patients were identified than were those under the traditional payment system, Miller says.

"Identification is very important because we don't do a good job of identifying mental health at all," Miller says."

The main mental health issues observed in the study were depression, anxiety, and substance abuse. "There was a statistical increase in these diagnoses when we removed the fee-for-service handcuffs," Miller says.

The hope was to find that treating individuals' behavioral care issues sooner would, down the road, reduce the need for costly hospitalizations, ED visits, and pharmaceutical use.

The study showed the alternative payment model resulted in cost avoidance.

"It's a little different from cost savings because we're predicting cost avoidance based upon trends that the services traditionally used are

now avoided," Miller explains. "We were able to see cost avoidance on three factors, which is actually quite profound," he adds.

The cost avoidance was more than $1 million. The research is expected to be published soon.

"This research has profound implications for anyone doing anything on delivery, financing, or policy," Miller says. "Integrating care is smart business, but it needs financial support."

Investing dollars into mental healthcare will help organizations achieve better outcomes at lower costs, he says. "To move the needle on cost, you need clinical delivery reform and, simultaneously, financial reform."

Global payments make it possible for behavioral health to become a critical facet of comprehensive healthcare. It also allows behavioral health providers to not be trapped in a volume-based payment workflow.

In the policy domain, healthcare leaders should consider dropping policies that limit patients' ability to gain access to mental health services in primary care, Miller says. Once patients have immediate access to mental healthcare, their outcomes improve and costs are avoided.

"It's a team approach to whole health. That's the model, and that's what we're trying to espouse nationally," Miller says. "The reason we don't see this model happening more often — although it's one of the leading innovations in the industry — is because of the financing." ■

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Q&A With the Nurse Who Wrote the Book on Case Management

Mullahy discusses case management patient tools

Case Management Advisor asked **Catherine M. Mullahy**, RN, CCM, president of Mullahy & Associates of Huntington, NY, and author of *The Case Manager's Handbook, Sixth Edition*, published in June 2016, to discuss case management tools and strategies:

CMA: When you talk about essential patient assessment tools and tips, what are the most important ones that you describe?

Mullahy: While there are case management software programs that have patient assessment tools, they are often a series of checklists, boxes, and drop-down menus. These tools may be helpful, but for many busy case managers, their application tends to become a rote exercise; that is, another task to be completed, rather than something that could frame or guide the assessment process.

I strongly believe that the conversations case managers have with their patients are the most meaningful type of assessments. These interactions are where the most important information is gleaned. They also help establish rapport and trust, and convey that the case manager is genuinely concerned about the individual patient and his or her family. The exchange of information that occurs during this patient assessment conversation also provides the opportunity for the patient to express his or her own words about his or her perceptions of what the diagnosis, treatment plan, and prognosis is or might be and, equally important, what the impact of all of these aspects may have on his or her day-to-day life. In my opinion, it is one of the most effective ways to gauge whether a patient fully understands [his or her] medical condition and all that entails, as well as how it is being treated.

What's most important is the discussion on how the case manager talks with the patient in the assessment process and the need to be proactive and supportive and to not make any assumptions, and to take the necessary time to lay a solid foundation.

CMA: What are some strategies and details case management leaders and staff can use for each of these assessment tools? For instance, if you had a tool that helped ensure regulatory compliance, what were the steps toward creating that tool and following it?

Mullahy: The tools we have developed over the years during which I had my case management company were, of course, mindful

of legislation surrounding healthcare and case management. They were not, however, created to ensure compliance with those increasing regulatory issues, but rather to assess patient needs, identify problems, and develop a care plan that would enhance adherence to treatment and improve outcomes.

CMA: Do you have any case studies or examples of positive outcomes after the use of tools and tips?

Mullahy: We did develop assessment tools and questionnaires that our case managers utilized and which facilitated a more purposeful assessment of each patient. Samples are included in my book, *The Case Manager's Handbook, Sixth Edition*.

These tools helped to guide the assessment process and ensure that we were able to capture all of the important elements, including clinical, medical, behavioral, socioeconomic, spiritual, vocational, financial, etc. As the assessment process evolved and the exchange of information between the patient/family and case manager occurred, problems were more easily identified. And the care plan was developed with short- and long-term goals established.

We certainly have case studies [in the book] that provide an overview of a patient's situation.

CMA: Do you have samples of some of the tools that we could include?

Mullahy: Yes. In *The Case Manager's Handbook, Sixth Edition*, a few assessment tools that we at Mullahy & Associates have created include "Initial Evaluation Guidelines" and "Initial Evaluation Worksheet."

The "Initial Evaluation Guidelines" provide direction on the assessment process and its primary stages of meeting with the claimant/patient or family, contact with the patient's primary attending physician, and contact with other key team members on the patient's care team. Case managers learn about the main goals of these stages, which are to gather as much information as possible and to establish rapport with the patient, family members, physicians, and all team members.

The "Initial Evaluation Worksheet" is a thorough intake form that facilitates a comprehensive assessment. It contains sections for a case summary, patient profile (i.e., sex, race, age/date of birth, height, weight, physical appearance, sensorium, medical history, previous medical care such as surgical history, diagnoses, medications, outcomes, etc.), current medical status and treatment, and — when appropriate — a complete body system review.

> "I STRONGLY BELIEVE THAT THE CONVERSATIONS CASE MANAGERS HAVE WITH THEIR PATIENTS ARE THE MOST MEANINGFUL TYPE OF ASSESSMENTS."

The worksheet also has sections for entering information relating to the physician-case manager meeting/consultation; the physician plan of care; family composition/dynamics, including the family's understanding of the patient's illness and treatment plan, cultural and language notes, and home and community description; to vocational, motivational/behavioral, and financial. Case managers enter their summary and impression and recommendations.

CMA: Why does it work better for case managers to use the tools or follow the tips, rather than rely on their usual methods?

Mullahy: Unfortunately, the "usual" way is to rely on software programs and not consider the human factors, which are the patient's voice and the value of patient exchanges. There is so much to be gained in the assessment process when [patients provide feedback] on what they understand their medical condition to be and how it is being treated. Based on their perceptions, a case manager often gains new insights into what the patient is experiencing and whether further communications and/or education are necessary for the patient and/or the patient's family and whether adjustments to the treatment plan may be warranted.

It is often in the nuances conveyed in these patient exchanges that new and valuable insights can be gained, which put in motion essential measures that enhance the case management process.

CMA: Is there anything else you would like to say on this topic?

Mullahy: Technology has certainly advanced medical care and many administrative processes associated with the delivery of care. Commonly used assessment software programs have a place, but they should not be regarded as a substitute for direct case manager-to-patient/family communications, as related to the assessment process. These communications are a pillar to best-in-class case management across all stages of the process, including the assessment stage. ■

Unit-based Case Management Model Works Best for Organization

Case managers do what they do best

Once upon a time, a hospital's case manager performed all case management responsibilities and utilization review work. Social workers performed a lot of the discharge planning. All worked fairly well, but something was missing: Case managers were limited in their ability to care for patients.

The hospital changed its model to a unit-based approach in which case management was divided into the utilization review segment and the case management piece, says **Tamara Crawford**, RN, MSN, manager of clinical research management at Riverside Healthcare in Kankakee, IL.

"Now, case managers do professional care, working with physicians; social workers do psychosocial counseling and have meetings with patients, families, and physicians; and utilization review is a separate department within resource management that does all utilization reviews," Crawford explains.

Prior to the switch to a unit-based model, the health system tried a physician-based model, and some staff had concerns with this, says **Mary Schore**, RN, MSN, CPHQ, CPPS, director of quality improvement at Riverside Healthcare.

"We were hearing from nursing and case managers that they preferred the unit-based method because they could build relationships with nursing staff on the units, and the case managers could build it with nursing staff on the units," she says.

Utilization review specialists cover 24 hours a day, seven days a week in the health system.

The case management department makes referrals to skilled nursing facilities, home health, etc., and there are several post-acute care coordinators. They also work with patients, staff, and families to help with the progression of care for the patient. These in-person meetings include an assessment of patients and collaboration with physicians to determine the right level of care for the patient, Crawford says.

> "IT'S DIFFICULT FOR A CASE MANAGER TO DO IT ALL, AND THAT'S PROBABLY WHY THEY'RE SEPARATING THESE ROLES."

"Then they do discharge planning, making sure the patient is discharged to the appropriate level of care and taking into consideration the patient's choice," she adds.

Social work specialists provide psychosocial counseling. They also work with patients and families, staying involved in family meetings, Crawford says.

"If they need home healthcare, case managers, social service, and nursing units on the floor can call this department, and the post-acute care coordinators will fax out information and make the referrals, depending on patient choice," Crawford says.

Utilization review specialists review patients and observe them to make sure they're receiving the right level of care. They complete all of the insurance reviews in hospitals and work on appeals and denials, she says.

"Access utilization review is in the emergency department," Crawford says. "They use specific criteria as a guideline and actually review patients when they come in to determine their status, to observe, and to suggest and work with emergency department physicians."

Care coordinators are responsible for taking phone calls to make sure referrals get out appropriately and to touch base with the facilities, she says.

"Sometimes, care coordinators will talk with the nursing staff, letting them know what's going on, and they make referrals while the patient still is in the facility," she adds. "Care coordinators make sure there is a bed in a skilled nursing facility, and they call case management staff to let them know about the care transition."

What used to be two departments now has these five subgroups: case management, social work, utilization review, access utilization review, and post-acute care coordinators, she says.

"All of access utilization review staff members are registered nurses and utilization review employees are also, but post-acute care coordinators are not nurses," Crawford says.

Some post-acute care coordinators have advanced college degrees, but this is not a requirement, she says. Training is individualized.

"We separated case management and utilization review," Crawford says.

Nurses perform medication review, several people were assigned the role

of utilization review specialists, and there are more than a half-dozen each of case managers and social work specialists. There also are access utilization review staff and several full-time care coordinators.

"We had to have administrative approval to expand this area to improve the services we were providing," Schore says.

The model change and division of duties were necessary to improve quality care, Crawford and Schore say.

"It's difficult for a case manager to do it all, and that's probably why they're separating these roles," Schore explains. "It takes a lot of time to be on the phone with the insurance company and waiting for callbacks." ■

Communication Failures Let Multidrug-resistant Bug Spread Between Settings

Oregon law now requires that transferring facilities flag patient status

An outbreak of extremely drug-resistant *Acinetobacter baumannii* at multiple facilities in Oregon underscores an open secret as bad bugs move across the healthcare continuum: There are disincentives to telling the receiving facility that the patient has a history of a drug-resistant bacteria or other problematic pathogens.

This has been going on in one form or another since hospitals and nursing homes were blaming each other for methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococci (VRE) patients going back and forth between facilities in the 1980s and 1990s. The rise of multidrug-resistant organisms (MDRO), particularly gram negatives such as *A. baumannii* and carbapenem-resistant Enterobacteriaceae, has heightened the stakes considerably. Some of these pathogens are virtually pan-resistant and carry transmissible plasmids that can confer drug resistance in other bacteria.

"We know that patients move throughout the healthcare system across the continuum," says **Jon Furuno**, PhD, a co-author of the recently published investigation[1] and associate professor at Oregon State University in Corvalis. "We all kind of recognize that that's happening. There are a lot of data out there now [showing] that we are just not great at providing information to optimize care as [patients] move between these different care settings."

The multifacility outbreak in Oregon resulted in a state law requiring a transferring healthcare institution to notify the receiving organization that the patient being transferred has a history of infection or colonization with a pathogen of concern.

"It requires that healthcare facilities provide written communication about MDROs and *Clostridium difficile* status to the receiving facility," Furuno says. "It also includes transport [to notify] the folks transferring the patients as well."

Other states may take similar action. At the federal level, CMS issued a proposed rule last year to address the patient transfer issue. It had not been finalized as this issue went to press.[2] "Given the number of facilities through which a patient might travel, [CMS] proposes to increase the involvement of hospital infection prevention and control programs [to] facilitate communication across settings," the agency stated in the proposed rule. While the multifacility outbreak was a primary driver of the Oregon law, the investigators were reluctant to assign blame or suggest there was any intention by healthcare facilities to mislead the receiving organization.

"You hear about it anecdotally. People do worry about how they are going to get someone to take this patient if they have this organism," Furuno says. "There is that concern out there, but I'm not sure if that happened in this scenario. But sure, the way the healthcare system works, patients tend to move between various levels of acuity. The way the reimbursement system works, there are incentives to discharge patients and [that leads to] concern about things that may affect your ability to do that."

Lead author **Genevieve L. Buser**, MD, an infectious disease physician at Providence (OR) Medical Group, says the investigation revealed no effort by any facility to intentionally withhold information about a transferring patient.

"Having spoken to the skilled nursing homes, long-term care,

and hospitals, everyone wants to know this information — that's for sure," she says. "However, prior to having more formal requirements for communication of that [with the new Oregon state law] I believe — by oversight, mostly — it was buried within the progress notes. Usually these were patients with prolonged stays, and maybe they had that infection somewhere in the middle [of care]. That may have been a multidrug-resistant organism which they were able to clear, but it's still a part of their microbiome and needs to be part of their current history. These organisms can hang around in the gut and in wounds, and really remain a part of that person's current history for some time. Everybody needs to know about it and share; let's not hide it under the rug. We need to be open about it so we can have that knowledge and prepare for this."

The investigators identified 21 cases of *A. baumannii*, most of which were highly related by molecular epidemiology and suggestive of a single clone moving between care sites. Overall, 17 patients (81%) were admitted to either long-term acute care hospital (LTACH) A (8), or skilled nursing facility (SNF) A (8), or both (1).

"Interfacility communication of patient or resident [drug-resistant] status was not performed during transfer between facilities," the authors noted. "An entire chain of transmission at SNF-A might have been prevented if its staff had been notified by LTACH-A of the MDRO status of one patient."

Reviewing the epidemiologic evidence and genetic sequencing data, the authors concluded that three persistently colonized patients transmitted *A. baumannii* to at least a dozen other patients and residents. Risk factors for prolonged colonization included chronic wounds, morbid obesity, tracheostomies, and indwelling urinary catheters.

The outbreak, which occurred over a period of two years, required considerable detective work to trace back the transfers and the transmission within facilities. It was originally discovered by an infection preventionist performing a routine review of drug-resistant organisms.

"The IP was reviewing isolates and sensitivities, particularly those in which this resistance was noted," Buser says. "They actually happened to be isolates that were processed through the hospital lab, but weren't from inpatients. Two of these resistant isolates had been sent in by the same skilled nursing facility. Not only were they an unusual gram negative resistant to carbapenems, but the specimens had been sent in by the same facility. So, with that information, she contacted county public health."

> "EVERYBODY NEEDS TO KNOW ABOUT IT AND SHARE; LET'S NOT HIDE IT UNDER THE RUG. WE NEED TO BE OPEN ABOUT IT SO WE CAN HAVE THAT KNOWLEDGE AND PREPARE FOR THIS."

The state health department also was performing surveillance for MDROs as part of its role as an Emerging Infections Program sponsored by the CDC.

"We discovered that [long-term care] residents had common healthcare contacts in that skilled nursing facility, and that turned this into a larger investigation," Buser says. "Ultimately, by tracing it back [it involved] many healthcare facilities. Chronologically, it appears that this carbapenem-resistant *Acinetobacter* initially appeared at the LTACH in January of 2012, related to a patient before we started doing the investigation. That's as far as we can trace it back."

That linked not only other facilities, but a neighboring state, as that patient had been previously treated in Washington.

"Then one of the patients, as care improved, was transferred [from the LTACH] down to the skilled nursing facility and she likely took the bug with her," Buser says. "A couple of months later, we ended up with the two cases that came to the infection preventionist's attention."

Infection control lapses at the facilities involved included lax bronchoscope reprocessing and poor handwashing compliance. In addition to placing the identified patients under contact precautions, the patients received chlorhexidine baths and their surrounding environments were rigorously cleaned and disinfected.

"*Acinetobacter* is a very hardy bacteria," she says. "It can remain on fomites and hands. It probably became endemic in each facility and then popped up every once in a while as clinical cultures, and those are what we saw as the cases."

Carbapenem resistance typically means providers are reduced to last-line drugs such as colistin, which was used in at least one of the cases of invasive infection. There was

one patient death retrospectively identified, but *A. baumannii* was not definitively implicated as the cause of death.

In addition to improving communication, the authors are trying to raise awareness and emphasize the need for education to prevent such incidents in the future.

"These skilled nursing facilities and other non-hospital facilities need to be comfortable managing this and caring for these patients," Buser says. "That's another piece that Oregon is trying to work on. What we can see with [the new law] is that it is becoming part of the hospital discharge notation. With electronic medical records there is better flagging [of transmissible pathogens] in the chart." ■

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Copy-and-Paste Continues to Threaten Documentation Safety

Copy-and-paste is so easy and time-saving that it can be tempting to overuse it in the medical record, and some electronic medical records encourage clinicians to use blocks of text over and over. However, liberal use of copy-and-paste can diminish the quality and reliability of an electronic medical record.

Some medical records even routinely repeat blocks of text from previous versions of the note, without the user manually doing so.

Copied information in a medical record can mislead clinicians in several ways, says **Diana Warner**, MS, RHIA, CHPS, FAHIMA, director of health information practice excellence with the American Health Information Management Association (AHIMA) in Chicago. For instance, information that was accurate when first entered may no longer be accurate, but is copied forward into the current version of the note.

Copying too much information also promotes "note bloat," in which the record becomes so large that it is difficult to find what you're looking for, Warner says. "You also can have redundant information that makes it difficult to see what is new in the record. If you see the same thing over and over, it can make it hard to see what is new and notice any noteworthy additions, to know what's going on with the patient right now," she says. "There also is the danger of copying and carrying forward incorrect information, or maybe you didn't copy the full text that you needed. Maybe the patient has a family history of breast cancer, but you only copied history of breast cancer, and now that is going to totally change how you look at and treat that patient."

The legal veracity of the note can be compromised, and overcopying can result in both undercoding and overcoding, Warner says.

The risks posed by overuse of copy-and-paste were illustrated in a recent study led by **Michael D. Wang**, MD, a physician in the Department of Medicine at the University of California, San Francisco (UCSF). *(An abstract of the report is available online at: http://bit.ly/2wqepeJ.)* While previous studies on copied text could not distinguish manually modified text from automatically updated, imported values in electronic note templates, Wang's study used a new tool that distinguishes manual, imported, and copied text in hospital progress notes.

Wang and his colleagues studied records from an inpatient electronic record at the UCSF Medical Center. They analyzed 23,630 inpatient progress notes written by 460 clinicians, including direct care hospitalists, residents, and medical students on a general medicine service over an eight-month period.

They found that 18% of the text was manually entered, 46% copied, and 36% imported. Residents manually entered less (11.8% of the text) and copied more (51.4%) than did medical students (16.2% of the text manually entered and 49% copied) or direct care hospitalists (14.1% of the text manually entered and 47.9% copied).

With less than one-fifth of note content manually entered, Wang says the results cast doubt on the validity of many electronic records.

"A better system is like the tool we used that lets you see what was imported from the previous version or a template, and what was manually entered that day. Those manual entries are usually what you're looking for," he says. "That separation of the pure clinical note from the other functions of the electronic record, like billing or clinical history, are key to ensuring the validity of the text that clinicians are depending on."

Wang and his colleagues suggest in the paper that more electronic records could be designed so that copied and imported information is readily visible to clinicians as they are writing a note, but not stored as a permanent part of the note.

In the meantime, Wang suggests educating clinicians about the risks and, particularly, the dangers of depending too much on a copied clinical history.

"They will rely on that clinical history, but is that medical record really the best place for that clinical history to live? Maybe it should live somewhere else so the clinical history is not compromised and isn't overwhelming the part of the record the provider wants to access," Wang says. "But that's something we have to work on with our vendors."

Wang's research also revealed a belief among some clinicians that more text leads to higher billing, which he says should be addressed with education on why that is not so.

When medical records are compromised by overuse of copying, so is patient safety, Warner says.

"Simply making the record too long and full of too much text is a danger. When you have providers wading through so much text, especially blocks of repeated text, they may not have the time to go through all of that and pick out what one bit of information is key for the patient's care at that moment," she says. "Particularly in an emergency situation, the provider may look at all that text and decide there's no time for that. They will act on what they normally do in this situation without that information available."

Hospitals should address the risk through policies and workflow analysis, Warner says. Identify when clinicians are using copy-and-paste and why, then educate them about the potential dangers. Implement policies that specify when it is allowed, she suggests. *(AHIMA offers guidelines on copy-and-paste use at: http://bit.ly/2eqwwsC.)*

"There may be alternatives that could be offered, such as using scribes to capture information during a patient encounter, and systems that use voice recognition," she says. "There are times when it is OK to copy information and bring it forward, such as a past surgical history or similar information that has not changed since the last visit." ■

Research Shows Link Between Quality and Readmission Rates

New research using CMS data is confirming the relationship between quality care and lower readmission rates.

Researchers studied readmissions of more than 2.7 million Medicare patients over age 65, treated at more than 4,700 hospitals between 2014 and 2015. They found that hospitals in the highest performance quartile for quality had significantly lower 30-day readmission rates than those in the lowest quartile.

Those with the lowest quality scores had a readmission rate of about 25%, while the highest performers had a readmission rate of about 23%, according to data published in the *New England Journal of Medicine*. *(The report's abstract is available online at: http://bit.ly/2xJqtIM.)*

"An absolute difference of two percentage points may seem to be small relative to the overall readmission risk, but it indicates that for every 50 patients who are admitted to a hospital in the lowest-performing quartile rather than in the highest-performing quartile, there is one additional readmission," the report says.

There was no statistically significant difference in other quartile comparisons and the median readmission rate was about 15%, the researchers found. ■

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CE QUESTIONS

1. **The American Academy of Family Physicians developed a chart that describes examples of potentially significant risk factors in patients, including which of the following?**

   a. Clinical diagnoses, behavioral health, special needs
   b. Potential physical limitations
   c. Social determinants
   d. All of the above

2. **The overall major depressive episode prevalence for adults in the United States is 6.7%, according to the National Institute of Mental Health. What is the overall percentage of adults screened for depression, as reported in a July 2017 study published in the journal *Psychiatric Services*?**

   a. 3.3%
   b. 4.2%
   c. 12.1%
   d. 28%

3. **In a care management model at Riverside Healthcare in Kankakee, IL, in which different roles are divided, which professional communicates with nursing staff and makes referrals while patients still are in the hospital?**

   a. Case management
   b. Utilization review specialists
   c. Care coordinators
   d. Social work specialists

4. **What is the philosophy underlying risk stratification?**

   a. Not all patients with multiple comorbidities need the most complex care management sources, so improved data collection and risk stratification can identify precisely the patients who would benefit most.
   b. Risk levels vary, and health systems can place most of their resources into strategies that will turn these high-risk patients into low-risk patients.
   c. Patients who have the highest healthcare costs are given the most case management attention in hopes of reducing an organization's financial risk.
   d. None of the above