Note: New CNE Procedures. See p. 84 for details.

Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

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AHC Media

Who should come first for CMs: patients or employers?

Walking a tight rope between advocacy and finances

Suppose you're a hospital case manager under pressure to move patients to another level of care and free up beds for patients boarding in the emergency department. What do you do if you think a patient really needs to stay in acute care?

Or maybe, you're a case manager for a health plan that has a program to provide bonuses to staff for keeping down the cost of care. If a patient has a certain benefit and needs the services, what do you do?

Both of these scenarios describe dilemmas for case managers who want to do the best for their patients but are being pulled in another direction by divided loyalties or financial considerations.

On the one hand, the case managers' roles and responsibilities have been defined by the employer, and they know that their job security might depend on bed turnover or moving patients to a lower level of care. On the other hand, they know their patients' needs, points out **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a case management consulting firm based in Huntington, NY.

"In today's healthcare environment, many case managers feel the ethical pull because of finances," Mullahy says. "In the past, nurses and social workers never had to be involved with money matters and never were directed to push patients out of the hospital. We did not have the technology to enable patients to survive, and few lived long enough to use

EXECUTIVE SUMMARY

Case managers often grapple with the dilemma of which master to serve, but professional organizations are clear on the subject: A case manager's first duty is to the patient or client.

- It's never ethical to deny a patient a service he or she is reasonably owed.
- Often a case manager's obligation to patients is constrained by his or her benefits.
- Real dilemmas arise when there are new treatments, modalities, interventions, and research on a particular disease, and third-party payers deem them experimental.

a million dollars worth of benefits."

Because healthcare is being run like a business, case managers find themselves reporting to business managers who might not understand or be sympathetic to ethical dilemmas. "Just as we want the CEO, the hospital director, or the medical director to understand our role, we have to comprehend their need to balance the budget. They face the same ethical dilemmas and are as unequipped as we are to address them," Mullahy says.

John Banja, PhD, professor, Department of Rehabilitation Medicine, and medical ethicist at the Center for Ethics at Emory University in Atlanta, says, "Balancing the best interest of patients and employers is a problem that is always present in the healthcare field. However, our primary obligation is to the people we serve, and that's our patients. That's what ethical healthcare is all about."

It's never ethical to provide someone with less than what he or she is reasonably owed and reasonably needs, Banja says. "If a patient needs a service and is reasonably owed it, a case manager's ethical responsibility is to see that he gets it," he adds.

All healthcare professionals, regardless of their discipline, should make being a patient advocate their greatest priority, says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm. The standards of practice for case managers developed by the Case Management Society of America (CMSA) and the Code of Professional Conduct for Case Managers developed by the Commission for Case Management Certification (CCMC) emphasize that case managers' first responsibility is to their patients or clients, Kizziar points out. "Regardless of the area of practice, the purpose of case management is to remain on the side of the patient and the outcome," she says. "If we do right by the patient by being a good steward of their funds and ensuring that they get what they need, we'll be successful in our jobs, and the patients will have the best outcomes."

Case managers have always been faced with the issue of serving too many masters, says **Annette Watson**, RN-BC, CCM, MBA, president and founder of Watson International Consulting, with headquarters in Mount Laurel, NJ, and chair of the Commission for Case Management Certification (CCMC), an organization representing more than 30,000 certified case managers. This issue is especially prevalent in organizations and areas of practice in which the case management role might include utilization management and other roles that are not consistent with the CMSA standards of practice or the CCMC code of conduct, Watson says.

"If someone is being true to the definition of case management and true to the role as defined by professional organizations, they will always put the patient first. The first duty of a certified case manager is to the patient, and no role is more important than the advocacy role," she adds.

So how do you put your patient first and still keep your employer happy? First of all, case man-

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agers and patients should keep in mind that there is no guarantee of unlimited free healthcare for anyone. Kizziar says, "Being a provider doesn't mean giving patients the Cadillac of everything that is available and being a payer doesn't mean cutting costs on everything. As case managers, we should work to get patients the best possible services for this particular episode of care, and being a good steward of their funds means doing it in the most cost effective way. *(For more information on being a good steward of patient resources, see related article on right.)*

Provider case management is not about managing the length of stay, it's about controlling the cost of care, Kizziar points out. "You can meet any length of stay requirements every single time but can still go broke if you don't monitor the cost of care. Case managers should make sure patients get what they need when they need it without any extra tests or procedures," she says. For example, a patient who is hospitalized with pneumonia doesn't need a colonoscopy as an inpatient procedure, Kizziar adds.

Banja says, "Case managers should use their wisdom and experience to look at all the variables and make good choices for their patients." The case manager's obligation to the patient is often constrained by the contractual relationship spelled out in an insurance policy or workers compensation benefit if the patient is injured on the job, he says. Taking the contractual approach to advocacy has a lot going for it, particularly if you keep in mind that a patient's benefits are likely to be what he or she chose, Banja says. "Most patients have a lot of choices when it comes to insurance coverage, and when they have a claim, they get what they pay for," he adds. "But there are instances when a person is legally entitled to, say, 10 treatments and needs them, but because of money incentives, the case manager will strongly try to persuade the powers that be to cut it off at five visits. That will go down as an attempt to defraud an individual for personal gain."

Real dilemmas arise when there are new treatments, modalities, interventions, and research on a particular disease. Every patient wants the latest and greatest treatments, but sometimes third-party payers won't pay for a new treatment, deeming it "experimental" or not an improvement over what is already out there, Banja says.

"This is an issue that case managers deal with daily," he says. "There are new treatments coming down the pike every day for a variety of conditions. We have to determine how to do what is best for the patient and use his or her resources judiciously."

RESOURCES

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• For the Case Management Society of America's **Standards of Practice**, visit: http://www.cmsa.org/SOP.

• For the Commission for Case Management Certification **Code of Conduct**, visit http://www.ccmcertification.org, and click on Knowledge Center. ■

Advocating means being a good steward

Keep limits to coverage in mind

Being an advocate for your patients is more than just trying to get them every treatment available. It's being a good steward of their healthcare funds so they'll have benefits for treatments in the future, says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"Nobody has an unlimited bucket of resources," Kizziar says. "Case managers in all practice areas should be aware that patients are going to have needs after this particular episode of care and conserve their resources whenever possible."

The first step in the process is to be informed about your patients' benefits and resources and develop a plan to make them work for the best possible transition of care, she adds. Look at your patients' lifetime benefits while developing a treatment plan, Kizziar says. "For instance, if a chronically ill patient needs home care, look at the annual limit on home care visits. It might be wonderful if he could get five visits a week but if the limit is only 20 for the whole year, suggest the minimum he can get by with so he'll have funding to last the rest of the year," she suggests.

Remember that even when a patient has no lifetime maximum, that doesn't mean he or she has a blank check for healthcare costs. Even unlimited

lifetime benefits usually have some kind of annual maximum, Kizziar points out. "Case managers should be concerned about doing the right thing for the patient at one particular time. Patients don't necessarily need a comprehensive total work up if they come in for one particular ailment. Part of the role of case managers is to partner with the physician to ensure that patients get what they need to transition as smoothly and appropriately as possible," she says.

Case managers should ensure that their patients know all the options for care and become actively engaged in the healthcare process and decision making. Case managers should also provide the information they need to make informed decisions, Kizziar says.

Beware of making personal judgments about what patients can or can't afford if their insurance doesn't cover a particular service, says **John Banja**, PhD, professor, Department of Rehabilitation Medicine, and a medical ethicist at the Center for Ethics at Emory University in Atlanta. "Often healthcare professionals make up their mind as to how much patients can afford, and they don't mention a modality if they think the client can't afford it. This is always a mistake. You never know what the client or patient has in the way or resources. Case managers should always inform the patient about whatever reasonable options there are and not make judgments about what he or she can afford," Banja says.

For example, if a patient could benefit from home care but doesn't have coverage for it, talk to the family. They might be able to find a way to pay for it. Kizziar says, "In healthcare we tend to think we know what is best for our clients, and we have made them dependent on us. But with the changing healthcare environment, it's critical to help them become more engaged in their own care plans. This means giving them more information about what is covered and what is not, and giving them the option, and letting them make their own decisions," Kizziar continues. Doing otherwise takes the decision process away from the patients, she adds.

In some cases, when spending a little more now can save a lot more later, providers and payers might be able to work out a way for patients to get what they need, Banja says. For example, a patient might have a limit of 10 physical therapy benefits, but when he is reaching the limit, the case manager sees that he is doing so well that if he has five more visits, he could be entirely fit to return to work and avoid reinjuring himself. In this case, not only would the patient benefit, the third-party payer also might benefit by saving money down the road, he says.

"The case manager could make a plea for the insurer to cover extra visits. If that doesn't work, she could ask if the physical therapist would give a self-pay patient a discount and ask the patient if he's willing to pay a reduced rate out of pocket," Banja suggests. ■

EXECUTIVE SUMMARY

Case managers should be informed about their patients' resources and be a good steward of their patients' healthcare benefits so that funds will be available if they need care in the future.

- Keep patients' lifetime limits and annual caps on healthcare funds in mind when you design a treatment plan.
- Don't omit a necessary treatment or service because you think the patient can't afford it. Give patients all the options, and let them decide.
- If a patient needs a treatment and it's not covered, contact the insurer and provider and try to work out a way for the patient to receive it.

Look to peers when ethics questions arise

Ensure your employers understand your role

When you're troubled by an ethical dilemma, don't go it alone. Reach out to your peers and your professional organizations for help, the experts say.

Case managers should consult with colleagues they trust when ethical issues arise, says **John Banja**, PhD, professor, Department of Rehabilitation Medicine, and a medical ethicist at the Center for Ethics at Emory University in Atlanta.

For example, you might be in a situation in which you're being pressured to move a patient with a long length of stay in the intensive care unit to a lower level of care, either at the hospital or in another setting. "This is a slam dunk ethical situation. If the case manager thinks the patient needs this intensity of service, he or she should speak up and resist the pressure," he says.

On the other hand, if you ask five other case managers to evaluate the same patient, two might say the patient would do well at a lower level of

care. "This illustrates the fallibility of prognostic judgment. This is one of those gray zones that healthcare professionals face all the time," Banja says.

Patrice Sminkey, chief staff executive for the Commission for Case Management Certification (CCMC) adds, "If there is a conflict, the case manager should go back to the other stakeholders within the team and help them understand the impact of the decision, whether it's moving a patient from one setting to another or eliminating part of the treatment."

In today's fast-paced healthcare environment, the people who are pushing for a patient to be members of the treatment team might not be aware of the patient's psycho-social issues or other challenges that could prevent him from being discharged or moved to a lower level of care, Sminkey points out. Reach out to your colleagues and fellow case managers for advice and direction, she says. "One of the challenges case managers face is to help team members understand how a decision will impact a patient," Sminkey says.

Case manager must take patient safety and patient health into account when they look at transitioning patients to another level of care, and this consideration might mean keeping them in one level of care a little longer than average to prevent problems down the road, says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm. "One of the good things that came out of healthcare reform is the issue of readmissions," Kizziar says. "The focus has shifted from getting patients out in a certain number of days to making sure we are providing a good outcome for patients. Case managers at the payer level as well as the provider level need to look for the same things in terms of readmissions and outcomes."

Make sure your employer is familiar with case management standards of practice and the CCMC professional code of conduct, Sminkey suggests. *(For information on how to access the Case Management Standards of Practice and the Code of Conduct, see Resources on page 75)*. "Our code of conduct goes into great detail about how to be a patient advocate and avoid conflicts of interest," she says.

Look to the professional organizations for help with ethical issues, Sminkey says. The CCMC has created an advisory service for certificants and offers opinions or case studies to answer questions about potential ethics violations.

In addition to its efforts to educate people in the healthcare field about the roles and responsibilities of case managers, the CCMC is expanding its efforts to the policy and regulatory levels of government to make sure that everyone understands that the case manager's primary responsibility is to the patient, Sminkey says. "As new models of care, such as the patient-centered medical home and Accountable Care Organizations (ACOs) are developed, it is increasingly important to be clear about the roles and responsibilities of professional case managers," she says.

Care coordination is frequently mentioned in The Affordable Care and Patient Protection Act, "but the legislation doesn't include a definition of care coordination or spell out who will do it," says Sminkey, who adds that care coordination is one function of case managers, but they also have to assess and evaluate before they can coordinate. A case management assessment is different from a physician's assessment. "It's not about diagnosis of a disease, but it looks at the person from all perspectives and all issues so the care coordination plan will work," she says.

"We want to make sure that the new models don't result in that kind of lack of clarity we found in the past where people are combining utilization review and care coordinating, or coding and utilization review, and calling it case management. As the voice of certified case managers, we want to make sure people understand the roles and responsibilities of case managers," says Sminkey. ■

EXECUTIVE SUMMARY

When case managers face an ethical dilemma, they don't have to face it alone.

- Reach out to your colleagues when ethical issues arise, and obtain their opinion about the matter.
- Educate the treatment team or people who are denying the care about the patient's situation and needs.

Project cuts costs, admissions and more

Health plans and physicians join forces

An innovative care coordination pilot project jointly developed by AmeriHealth Mercy Family of Companies' Keystone Mercy Health Plan based in Philadelphia, PA, and providers

affiliated with the Mercy Health System, also based in Philadelphia, PA, resulted in decreased costs, reduced hospital admissions, and a decrease in inpatient days for members in the health plan's Medicaid managed care plan.

In the pilot, the health plan placed a care manager in the provider setting to help overcome barriers to care for participants. The care manager addressed social concerns such as transportation and child care and provided coaching on self-care issues such as medication adherence and preventative care measures.

The program started in November 2008 with the care coordinator working at the practice one day a week with the physician champion and nurse manager. The pilot program was so successful that the care manager works with the entire team at the physician practice five days a week, and the health plan is looking at ways to implement similar programs at other provider settings. *(For details on the start-up of the program, see "Collaboration between providers, payers helps reduce gaps,* Case Management Advisor*, July 2010, p. 73.)*

"The project started as the result of a working relationship between the health plan and the health system," says **Karen Michaels** RN, MSN, MBA, vice president of clinical services for AmeriHealth Mercy. "We were serving the same people and wanted to find a way to leverage our strength and improve our services."

Spreading the model is a goal, but they know it won't work the same way at all provider settings, particularly if they don't provide care for a large percentage of Keystone Mercy members, Michaels says. "We're looking at other ways the health plan can support care coordination at the physician practices," she says.

Among patients engaged in care coordination, hospital days per 1,000 members dropped from 2,689 to 1,408, while hospital days for those not in the program remained stable. Members participating in the pilot spent an average of 2.7 days in the hospital per admission, compared to 4.3 days before the program began.

EXECUTIVE SUMMARY

By placing a care manager in the provider setting, Keystone Mercy Health Plan decreased costs, reduced hospital admissions, and decreased inpatient days for Medicaid managed care members.

- The case manager reviews records in the physician office as well as health plan records to identify gaps in care before patient visits.
- Case managers conduct a comprehensive assessment when patients are in the office.
- Patients respond when they receive better face-to-face encounters than telephonic interventions.

Face-to-face encounters

Having a care manager on site is a key component of the program's success, says **Grace Lefever**, PT, MS, MPH, project leader for coordinated care management at Mercy Health System.

"We found that the face-to-face encounters with the patients were more effective than when the care manager worked with them on the telephone," Lefever says. "Patients are more willing to engage in a relationship when they meet the care coordinator in person."

The program focuses on coordinating care for high-needs Medicare members who have health conditions that put them at risk for increased hospitalization, but it looks at the entire population of members as well. *(For more information about care for members with complex needs, see story, p. 79.)* If members are overdue for a visit or missing a recommended test or procedure, the care manager reaches out to them, Michaels says. "The health plan has an outreach team who works in the community and attempts to contact members if they can't be reached on the telephone."

The health plan assigned Lynne Major, MSW, CCM, a social worker who is a certified case manager, to work at a physician practice where 80% of the patients are AmeriHealth Mercy members. Major works closely with the physicians and the medical residents in training at the practice to ensure that the needs of the members are met. She leverages the information gathered by the health plan, as well as records at the physician practice, to identify gaps in care and ensure that members have the recommended screenings and preventive care they need to keep their chronic conditions under control.

Major has a laptop that connects remotely to the information system at the health plan, which allows her to access information not immediately available to the physician practice, such as what medications have been filled. She also has access to physician office information such as X-rays, laboratory results, and physician notes about member visits, which gives her a broad view of the patient's condition and helps her identify areas where she can help improve the outcomes.

Michaels says, "The health plan has a much broader view of patient care than the physician

office does and can give the provider a comprehensive picture of the patient. We have access to all the claims for services or prescriptions the patient has received outside of the physician's system. The physician doesn't have a health information exchange with other providers and has to depend on the information the patient shares and any information in his system." ■

Care coordinator for complex needs

Collaboration with treatment team is key

AmeriHealth Mercy's care coordinator, Lynne Major MSW, CCM, touches base with every member who comes into the physician office where she works, encourages them to call her if they have questions and spending extra time with those who have complex needs.

Major meets with all the members covered by the Philadelphia-based health plan at least once and conducts a comprehensive assessment that includes a medical and psycho-social assessment, as well as the patient's individual motivation and confidence to manage their own care. She gives members without complex needs her card, and she encourages them to call if they have questions or concerns.

Karen Michaels RN, MSN, MBA, vice president of clinical services for AmeriHealth Mercy says, "She touches base with any of our members who come into the office, even if they have no special needs. When patients need extra support, she spends time with them while they are in the office."

She follows those with complex needs through the continuum, contacts them between visits, and helps them access health plan resources, such as diabetic educators. When members schedule an appointment, the care manager compiles as much information as possible on the patients the day before they are scheduled for a visit, and she organizes it for the office staff. Major has daily huddles with the treatment team to discuss who is coming for an appointment that day and who has special needs.

She identifies any gaps in care based on national guidelines for chronic condition, and she uses the health plan database to access pharmacy utilization information. In some cases, Major has determined that the patient is taking a medication prescribed by a different physician and that it might interact with something else the patient is taking.

While patients are in the office, Major visits them and conducts a brief assessment to identify the barriers to care the members are dealing with at that particular time. She updates the physician and works on overcoming the barriers, connecting the members to resources at the health plan, referring them to the community food bank, or helping them with housing assistance applications. Major educates patients about their condition and coaches them on ways to adhere to their treatment plan. She helps them access community resources or get appointments for tests and procedures or visits with specialists.

Grace Lefever, PT, MS, MPH, project leader for coordinated care management at Mercy Health System, based in Philadelphia, says "The care manager helps patients overcome barriers to care that are difficult to address in the physician's office. She is able to improve all the connections to resources in the community and help the member deal with whatever issues are interfering with their care," Lefever says.

When patients are hospitalized, the care manager in the physician office works with the hospital case manager, the health plan case manager, the health plan's pharmacist, and behavior health staff, if appropriate. The health plan also has a transition manager at the hospital who works with the patients and the hospital case manager on the discharge plan.

All of the health plans care managers go through training on motivational interviewing and engagement techniques as well as available community resources. ■

ACO rules could create variety of new burdens

Expert says problems can be corrected

The Department of Health and Human Services'(HHS) recently published proposed rule (42 CFR 425) for Accountable Care Organizations (ACOs) could result in some positive changes for the health care industry, but there are a few problems that should be corrected, an expert says.

The proposed rules for the ACOs greatly

expand quality domains and measures to be reported to the Centers for Medicare & Medicaid Services (CMS), and this reporting likely will be onerous for hospitals, says **Lisa Graberg**, MPH, senior associate director for policy at the American Hospital Association in Washington, DC. One issue is that the proposed rule will have ACOs meet 65 quality standards in these five areas:

- patients' care experience;
- extent of care continuum;
- patient safety;
- emphasis on preventive health;
- success in treating Medicare beneficiaries who are sick and frail.

"CMS did a physician group practice demonstration project that is a precursor to ACOs, and these sites are required to report on only 32 measures," Graberg says. "To more than double the measures is concerning to us because our members are already reporting 60 measures for hospitals, and they'll have to report on 65 more without a whole lot of overlap."

Of course, hospitals don't have to establish ACOs, but starting an ACO will require extensive funding and infrastructure, so hospital systems are the best positioned to take on this task, she says. The proposed rule includes a downside risk without providing front-end funding. CMS estimates the ACO start-up costs would be nearly $2 million, Graberg notes.

The ACO program is based on the fee-for-service payments and system, but provides incentives to cut costs through shared cost savings. ACOs that do well will receive an incentive payment reflecting part of that savings. They also can be penalized financially for exceeding their spending targets.

"When exposed to downside risk in the private sector, you typically receive some upside capital in a capitated budget, and then you stay within that budget," Graberg says. "But they're not getting any upside capital at all in this program, and the ACOs make the full investment themselves." *(For more information about proposed ACO rule, see story, right.)*

CMS could change this imbalance in the final rule. "We'd rather see CMS come out with a partial capitation option that holds them accountable for risk and also gives them some capital," Graberg says.

Also, CMS could have done more to emphasize care coordination by providing upfront capital, she adds. "Even if you do qualify for a savings bonus, it's likely you won't see any money for maybe 20 full months after you start the program," Graberg says. That's a long time to receive money that could be used to improve care coordination, she adds. "I do think for the most part our hospitals are already doing things like tackling readmissions, reducing infections, and so forth, but they're paying for all of those themselves," Graberg says.

The ACOs shift incentives slightly in the direction of capitated care, but hospitals still will operate in a fee-for-service environment in which they are paid when patients are admitted and reducing readmissions actually reduces revenue, Graberg says. "So when you don't receive additional upfront capital for the savings you are generating for the program, it becomes a tricky financial dance to continue," she explains. "The more successful you become, the less revenue you receive."

Hospitals increasingly are bridging the care transition process, and the creation of ACOs drives home the importance of this trend continuing, Graberg says. *(For more information about next level of care, see story, p. 81.)* "Whether or not a hospital elects to do an ACO, our members are fully on board and understand that we are responsible and give accountable care to all patients who come into the hospital," she adds.

SOURCES

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- To access proposed rule, visit http://www.regulations.gov and search for 42 CFR 425. ■

Proposed ACO rules stress care coordination

Financial burden would grow

Proposed rules for the creation of Accountable Care Organizations (ACOs) will require participating organizations to provide primary care to 5,000 or more patients and to meet 65 quality standards. Because the new ACOs also will require substantial start-up costs, some experts say it will

be a challenge and an opportunity for hospitals.

"ACOs is a concept that would allow our hospitals to participate and get recognized for many things they're already doing well, including coordinating care for purposes of reducing readmissions and eliminating certain hospital-acquired conditions," says **Lisa Graberg**, MPH, senior associate director for policy at the American Hospital Association in Washington, DC.

The Centers for Medicare & Medicaid Services (CMS) recently released its proposed rules for creating accountable care organizations with a focus on extent of care coordination and treatment of Medicare beneficiaries who are sick and frail. "These are things a lot of our members are already doing, and there's a financial incentive for doing these sorts of things," Graberg says. "Under ACOs, when you drive down costs, you generate additional savings overall for the Medicare program, and then you're eligible to share in that savings with CMS."

Hospitals are better positioned than most providers to form ACOs because many already have several components of continuous care coordination in their systems, she notes. "Also, hospitals and health systems tend to have greater access to capital, and to become an ACO will require a significant investment that CMS estimates at $1.8 million for start-up and first year of ongoing costs," Graberg says. "We've done some internal analysis and hired a contractor, and we think it's actually much more than $1.8 million."

Large physician groups also seem interested in the ACO model, says **Beverly Cunningham**, MS, RN, vice president of clinical performance improvement at Medical City Dallas Hospital. "CMS did an open-door call in April, and the people who called in and asked the most questions were mostly large physician groups," Cunningham says. "I think hospitals will take this slowly."

Many hospitals now are focused on understanding their own readmissions, particularly in the big three of pneumonia, acute myocardial infarction, and heart failure. They also are putting processes in place that will help reduce them, Cunningham adds. "While hospitals wait to see what happens with the rollout of health care reform, they'll have these processes in place," she says.

ACOs likely will improve the overall coordination of care, reduce duplication, and enhance prevention efforts, says **Donna Zazworsky**, RN, MS, CCM, FAAN, vice president for community health and continuum care at Carondelet Health Network in Tucson, AZ. "This includes working with primary care providers," Zazworsky says. "We have those pieces in place for diabetes coordination of care, and we're already showing cost savings in being able to coordinate care better in the primary care."

The point of forming an ACO is to provide care in different ways that might improve health care access and efficiency. An example might be Carondelet Health Network's 24-hour, seven-days-a-week telecardiology program that serves rural hospitals, she notes. ■

Home health visits being redefined

Hospitals are working more proactively in forging relationships with the next-level-of-care providers, the experts say. "We're working with home health agencies and skilled nursing facilities to design agreements that help clearly define the transition process," **Donna Zazworsky**, RN, MS, CCM, FAAN, vice president for community health and continuum care at Carondelet Health Network in Tucson, AZ, says. "With home health agencies, we expect our patients to be seen within 24-48 hours post-discharge."

This immediate home health visit sometimes is necessary for step-down care, and it also ensures the discharge plan is being followed. Hospitals no longer can assume patients will follow through on discharge plans once they return home, she adds. "Our experience now tells us they don't," Zazworsky says. "It's not because they don't want to, but they might not have the support system to get their medications for several days, which ends up with them returning to the hospital."

Beverly Cunningham, MS, RN, vice president of clinical performance improvement at Medical City Dallas Hospital in Dallas, TX, says when home health care and other providers are not part of the major payer groups that serve the hospital's patients, the hospital will encourage payers to contract with the providers. "We encourage payers by saying, 'This is a company that is good; we have seen as we track them that they don't have a lot of readmissions and are really focused on managing the patient outside of the hospital,'" she says. "Then we tell the providers, 'So why don't you work together and get a contract so you can take our patients?'"

These kind of efforts might accomplish some of the same benefits and reductions in readmissions that ACOs are designed to do. Some hospitals might choose to continue their own efforts before committing to an ACO, she says. "We're not jumping into an ACO endeavor, but we're aggressively looking at readmissions and that next-level-of-care provider," Cunningham explains. "We feel if they go to that provider, they won't bounce back to the hospital."

Medical City Dallas Hospital also uses mid-level practitioners to manage high-risk patient populations. These include a heart failure nurse practitioner who identifies high-risk patients who are at risk for readmission, she says. "We have wellness clinics for them," Cunningham says. "We identify the people who will be the most difficult to manage, and we assure their transition is appropriate and at the right level of care."

This effort has been going on for a few years, but the healthcare reform bill has encouraged the hospital to improve and to become better organized, she adds.

"Healthcare reform has forced us to be better than we are," Cunningham says. ■

Purpose drives choice of content for e-readers

Feedback from patrons assists effort

What content should go on electronic readers, such as iPads and Nooks, purchased for use in community health libraries and facility-based resource centers?

Staff at the Community Health Library within the Samuel and Sandra Hekemian Medical Library at Hackensack (NJ) University Medical Center wants to offer information found at their library in a new way. The plan for the pilot project, which is still in the research process, is to put a selection of materials on certain topics on each electronic device so there is variety from which to choose. For example, there might be books on asthma and cancer on one electronic reader, and books on cardiac disease and diabetes on another. Also, there might be two or three of the same titles on every device. One iPad and one Nook will have identical content so staff can determine which device

Codes add value to patient education

Smartphone users are beginning to use a device called a "barcode scanner" that allows them to open Quick Response (QR) codes. These codes are found on a multitude of items including magazine ads, signs, business cards, and museum graphics, says **Fran London**, MS, RN, a health education specialist at The Emily Center, a family health library at Phoenix (AZ) Children's Hospital.

Anyone with a barcode scanner on their phone can read the code by putting it in the telephone camera's view, she explains. The scanner takes the smartphone user to the link associated with the QR code, which can be anything from a web site URL to a Google map location. *(For more details on QR codes, see the source, at right.)*

According to London, there are web sites that can be used to create a QR code for free. Just search for "QR Code generator," she instructs. Once a QR code is established, it can be included on a teaching handout, for example. When the code is scanned, it might connect to a video that demonstrates the self-care skill for an area such as a dressing change, London explains.

While the QR code is not a way to communicate essential information to patients and their families, it is a free tool that facilitates interaction, she emphasizes.

SOURCE

For more information, contact:

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Or scan this QR code to link to the article mentioned above. ■

patrons prefer. Each device will have 30 to 40 titles.

According to **Barbara Reich**, MLS, AHIP, director of the medical library, her first thought was to have one Nook and one iPad dedicated to a specific disease, such as cancer. Then she realized that if the device was checked out, the topic would not be available to other patrons. "I began to realize things should be more evenly divided, with a few subjects on each device," says Reich.

As the project progresses, it will be easier to determine what content to put on the electronic readers, says **Deborah Magnan**, PT, MLIS, AHIP, associate librarian. If patients are asking for books that are not on the iPads and Nooks, the librarians will know which titles to add. Also they will learn the value of the content by asking patrons to fill out a brief questionnaire after they use the iPad or Nook. Questions might include: "Was what you read helpful to you?" "Did you ask your doctor a different kind of question based on what you read?" "Did you look at your disease differently because of something you read?" and "Did the information change the way you make decisions?"

The questionnaire will help librarians know if the content impacted the patient's care and decision-making process, explains Magnan.

Feedback from patients and family members using the electronic readers will provide future guidance for content choice. "In going forward it is important to have the patient give us feedback. This is a very new project, and we don't know how it will be received," says Magnan. ■

Caregivers lack skills for home care

Paid caregivers make it possible for seniors to remain living in their homes. The problem, according to a new Northwestern Medicine study, is that more than one-third of caregivers had difficulty reading and understanding health-related information and directions. Sixty percent made errors when sorting medications into pillboxes.

In a first-of-its-kind study, nearly 100 paid, non-family caregivers were recruited in the Chicago area and their health literacy levels and the health-related responsibilities were assessed, said **Lee Lindquist**, MD, assistant professor of geriatrics at Northwestern University Feinberg School of Medicine and physician at Northwestern Memorial Hospital, both in Chicago.

"We found that nearly 86% of the caregivers perform health-related tasks," said Lindquist, lead author of the study. "Most of the caregivers are women, about 50 years old. Many are foreign born or have a limited education. The jobs typically pay just under $9.00 per hour, but nearly one-third of the caregivers earn less than minimum wage."

Lindquist found that despite pay, country of birth or education level, 60% of all the caregivers made errors when doling medication into a pillbox. This statistic is alarming, because patients who don't take certain medications as prescribed could end up in the hospital, Lindquist said. "Many of these caregivers are good people who don't want to disappoint and don't want to lose their jobs," Lindquist said. "So they take on

COMING IN FUTURE MONTHS

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health-related responsibilities, such as giving out medications and accompanying clients to the doctor for appointments. Most physicians and family members do not realize that while the caregiver is nodding and saying 'yes,' she might not really understand what is being said."

The title of the study is "Inadequate Health Literacy Among Paid Caregivers of Seniors." The study will be published in the *Journal of General Internal Medicine*. It has been published online at http://www.springerlink.com/content/t3h82492566524p8. ■

CNE QUESTIONS

1. According to the Case Management Society of America's Standards of Practice and the Commission for Case Management Certification Code of Professional Conduct, a case manager's first loyalty should be to what entity?
   A. Your patient
   B. Your employer
   C. Your patient's health plan
   D. Your conscience

2. True or false: According to John Banja, PhD, a medical ethicist at Emory University, a case manager's obligation to the patient often is constrained by the contractual relationship spelled out in an insurance policy or workers compensation benefit.
   A. True
   B. False

3. According to B.K. Kizziar, RN-BC, CCM, CLP, owner of B.K. & Associates case management consulting firm, what should case managers take into account when developing a treatment plan?
   A. The patient's healthcare benefits.
   B. The lifetime of healthcare benefits.
   C. The annual limit of healthcare benefits.
   D. All of the above

4. Care coordination is just one function of professional case managers, Patrice Sminkey, chief staff executive for the Commission for Case Management Certification points out. What are two other functions?
   A. Assessment and evaluation
   B. Evaluation and treatment
   C. Assessment and benefits management
   D. Evaluation and utilization review

CNE OBJECTIVES

After reading this issue, continuing education 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.

CNE INSTRUCTIONS

Nurses participate in this continuing education program and earn credit for this activity by following these instructions.
1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■