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AHC Media

Want good results? Coordinate medical, behavioral case management

Mental, physical issues often occur together

Recognizing that medical problems and behavioral health issues are often intertwined, payers and providers are coordinating behavioral health and medical health case management.

"It's imperative to take an integrated approach to meeting the medical and behavioral health needs of patients. This approach treats the whole patient," says **Dena Miller**, RN, MSN, vice president of clinical innovation and implementation at Fallon Community Health Plan in Worchester, MA. "Commercial payers, as well as state and federal government payers, see the value in an integrated model of care coordination that deals with mental health and substance abuse issues as well as medical issues."

People with significant medical illnesses often develop depression, anxiety, or substance abuse problems that can interfere with their treatment, Miller says. At the same time, people with serious mental illnesses tend to also have severe medical needs. They are more likely to smoke and get less exercise than people without mental illness, which often leads to cardiovascular issues. People who are taking the second generation of antipsychotics have fewer side effects but tend to gain weight and have an increased risk of diabetes.

EXECUTIVE SUMMARY

Payers and providers are finding that integrating medical case management and behavioral case management helps optimize treatment for both conditions.

- Patients with significant medical illnesses often experience depression or anxiety, which can interfere with their adherence to their treatment plan.
- People with mental illness are more likely to engage in unhealthy behaviors and ignore their physical health.
- Collaboration between medical case managers and mental health case managers is more effective than handling both sets of problems separately.

"More attention to good behavioral health will increase the quality of life for people with medical illness. It's wonderful that providers no longer identify people in silos but instead look across the spectrum," she says.

Fallon Community Health Plan's medical and behavioral case managers sit in close proximity and often co-manage cases for members in its Medicaid HMO and dually eligible members over 65. (For details on the programs, see related article on page 88).

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Bob Holtz, MA, MBA, LMHC, vice president of behavioral health services for Capital District Physicians Health Plan, with headquarters in Albany, NY, adds that behavioral health issues often affect medical issues, Holtz says. "When our predictive modeling software mines claims data and identifies patients who are at risk for hospitalization, those with high risk factors for medical issues often have a comorbidity with a mental illness," he says.

For instance, there is a high rate of comorbidity between diabetes and depression, and each condition affects the self-management and self-care of the other, he adds.

Diabetics typically have a complicated care plan. They have to measure their blood sugar levels and take medication on a daily basis, and have their eyes checked and their feet examined regularly. "They often have medical complications as well," he says.

When patients are depressed, they often don't feel like doing anything and managing their health doesn't seem important to them, so they don't follow their treatment plan, he says. "They may be inconsistent in care and may feel suicidal. They may think 'diabetes is going to kill me anyway so why should I do these things?' and their motivation level is very low."

If behavioral health problems such as bipolar disorders, depression, anxiety, or substance abuse aren't treated, patients may miss self-care, resulting in an exacerbation of their symptoms and putting them at a risk for complications that could lead to emergency department visits, and hospitalization, he says.

"If we can manage the physical and mental health symptoms together and get patients on medication or psychotherapy, their mood improves, they can manage their self-care, they experience fewer complications, and become a healthier individual all around," he says.

Depression is often the underlying cause in why patients with chronic diseases can't improve or self-manage their conditions, adds **Angela Gandolfo**, MBA, advisor for performance improvement in clinical operations at UC Davis Health System in Sacramento, CA. Gandolfo helped develop a depression management program in which nurse case managers and primary care physicians at UC Davis Family Medicine collaborate to help patients manage their depression along with their medical illnesses. *(For details on this program, see related article on page 90.)*

"Depression is often one of the root causes of why people can't move forward with taking care of themselves. Patients who have chronic illness often have underlying depression as well," she says. Chronic diseases often enhance depression if people already have it or cause depression among newly diagnosed patients who didn't previously have depression, she adds. "When patients have depression, ongoing management of their chronic conditions is impacted. That's why we need to address depression along with their chronic diseases."

Capital District Physicians Health Plan (CDPHP) had carved out services to a managed behavioral healthcare company for 13 years when the health plan decided to move behavioral health services in house. At the time, patients with behavioral health problems were referred to the vendor but there was no coordination with the staff providing medical management at CDPHP. "There was no effective continuity of treatment and care between behavioral health and the medical world," Holtz says. "The clinical staff felt that behavioral health issues are part of the whole medical picture and that operating in silos isn't an effective way to reach out to members. We designed the behavioral case management model so that it is connected and integrated with the existing medical case management."

Under a new program, rolled out in 2010, the medical case managers and behavioral health case managers collaborate on management of patients with medical and behavioral health diagnoses. "Clearly patients receive better medical care and have better outcomes if we manage both the behavioral issues and the medical issues together," Holtz says. *(For details on the program, see related article below.)* ■

Integrating medical, mental CM saves money

Models calls for collaboration among clinicians

In the past, if a member of Capital District Physicians' Health Plan (CDPHP) in Albany, NY, was hospitalized for a suicide attempt and ended up in the intensive care unit, or was hospitalized with a medical problem and diagnosed with a behavioral health issue as well, the medical case manager would give him or her a referral to a toll-free number for an out-of-state vendor that provided behavioral health management for the health plan.

In 2009, the physician-guided organization reviewed the process and determined that the clinical staff were not happy with that arrangement. "They felt that behavioral health issues were part of the whole medical picture," says **Bob Holtz**, MA, MBA, LMHC, vice president of behavioral health services for CDPHP. The board of directors of the physician-guided organization decided in 2009 to integrate medical and behavioral health care and not separate the two, Holtz says.

Now the CDPHP social worker assigned to the hospital collaborates on the discharge plan with the health plan's medical case manager, and the two collaborate on subsequent care if the patient needs follow up for a medical issue. If the patient needs only behavioral health management, only the social worker follows up. It took about a year to build a model that integrated behavioral health into the medical health structure and to recruit hospitals and clinics to participate in the behavioral health side of care, Holtz says.

"It's too soon for us to have firm statistics about the specific impact of the integrated case management program, but we know our overall program has been successful," Holtz says. In the first year of the program, the health plan saved $8.4 million off of what the vendor would have charged. In addition, the health plan experienced a drop in readmission rates for behavioral diagnoses from 12% in 2009 to 9% last year. "We can't say it's all because of the case management program, but we do know that case management is a contributing factor in reducing readmissions and the overall dollar amount we spend," he says.

The health plan's behavioral health staff includes a full-time psychiatrist, 15 social work case managers, a nurse, four bachelor's-prepared clinical assistants, and an operations manager. The social work case managers are clinical social workers with experience in a clinic or private practice performing psychotherapy. They work side-by-side with the medical case managers and can easily collaborate on a care plan.

"This model integrates care completely. When we have a case where patients have both a chronic disorder and a mental health disorder, we call that complex cases and work

together. The social work case managers and the medical case manager have a meeting to collaborate on care and sometimes reach out to the member together," Holtz says.

When patients are hospitalized, CDPHP care coordinators go into the hospital, review the charts, and talk to doctors to identify comorbidities such as bipolar disorders, depression, anxiety, or substance abuse. They visit the patients in the hospital and work with the health plan case manager on a discharge plan.

Everyone who is being followed by the medical staff is screened for depression. In addition, in talking with patients, medical case managers may uncover behavioral health issues.

Other candidates for behavioral case management are identified through health risk assessments or referrals from a physician.

When members are identified for the behavioral health case management program, a case manager calls them and introduces the program. "The majority of patients are a little resistant," Holtz says. "The case managers are skilled in motivational interviewing geared toward engagement and focus on the importance of support as part of the recovery process whether the patient has a comorbid medical condition, a primary diagnosis of a behavioral health problem, or a substance abuse problem."

If people are still resistant, the case managers ask if the health plan can send out literature and call the member back. "The key is developing the relationship. We tell them that we'd like to engage them in case management because other members have found it helpful," he says.

The behavioral health case managers work with patients to establish goals and plans for meeting their goals. For instance, the goal for a patient with depression might be taking medication on a regular basis or attending a counseling session. The case managers encourage members to get involved in physical activities and try to establish some kind of support system for the patient, such as a relative who can support the patient through recovery.

"The plans are all unique to the individual," Holtz says.

The case managers work with individuals to remove barriers to adherence with both the medical and the behavioral health treatment plans. For instance, if patients can't afford the co-payment to see a therapist or have housing issues, the case manager refers them to community services. If the patient is struggling with drug abuse and lives in a neighborhood with a lot of drug use, the case manager would suggest that the patient find another place to live while he or she recovers, or if the problem is severe, would work to get the patient into a residential program.

"There are often barriers to getting the care they need, and we try to help them think through ways to overcome them," Holtz says. For instance, Medicare members have free transportation services to medical appointments but many don't know it. The case managers can help Medicare members identify volunteers, such as those at senior centers, who will drive patients to their doctors' appointments.

Sometimes the medical and behavioral health case managers collaborate in helping the patient overcome barriers to adherence to the plan.

In one instance, a patient with diabetes had an adult child who had a drinking problem. The woman was so preoccupied and worried about her son, who would drink heavily and call her in the middle of the night, that she forgot to take her pills. "She was having reactional depression to life's circumstances and was neglecting herself," Holtz says.

The medical case manager asked the behavioral case manager to join the next conversation with the member. The medical case manager introduced the behavioral case manager as her colleague who was working jointly on the case. The behavioral case manager discussed counseling options, including Al-Anon, the support group for family members of alcoholics. During the ongoing conversations, the behavioral health case manager arranged for the woman to have a therapy visit with an alcohol treatment program to consult about her son's problem.

"By following up on the patient together, the two case managers were able to engage the member, and the result was that the woman learned to cope with her day-to-day problems and improved her self-care for diabetes," he says. ■

Integrated CM cuts ED visits, hospitalization

Medicaid members assessed for behavioral issues

Since Fallon Community Health Plan in Worcester, MA, began integrating medi-

cal case management and mental health case management, members in the health plan's Medicaid HMO with medical issues have experienced fewer inpatient days and emergency department visits and those in behavioral health have less need for unplanned medical care, says **Dena Miller**, RN, MSN, vice president of clinical innovation and implementation for the health plan.

All Medicaid members who have been in the hospital receive a welcome-home call and an assessment to determine if they are in further need of case management for their medical condition or have a behavioral issue. Patients are referred to case management for either medical or behavioral health issues. If the case manager determines the patient has both issues, the medical and behavioral case managers may co-manage the case, or one case manager may serve as the lead and the other as back-up.

At Fallon Community Health's Medicaid HMO, mental health case managers and medical case managers are located in close proximity so the two groups of clinicians can have a free exchange of information. They have weekly rounds during which they discuss brand-new cases as well as challenging cases to brainstorm on managing the issues the individual patients face and overcoming barriers to care.

When the medical case managers get a referral, they ask the members a series of questions designed to identify signs of depression, anxiety, or substance abuse. For instance, they ask about their eating habits and what medications they are taking.

EXECUTIVE SUMMARY

Members with medical issues in Fallon Community Health Plan's Medicaid HMO have had fewer inpatient days and visits to the emergency department since the plan integrated medical and mental health case management.

- Hospitalized members receive a welcome home call and assessment to determine their medical and/or behavioral health needs.
- If members have both mental health and medical issues, the medical and behavioral health case managers collaborate or manage the patient together.
- A separate program for dually eligible members over 65 includes face-to-face interventions by medical and behavioral health case managers.

"If their medication use sounds inappropriate, the case managers try to find out if the patients are getting prescriptions from multiple providers. If this is the case and the patient is having chronic pain, we may refer them to a pain management program," she says.

If the assessment indicates behavioral health issues, the medical case manager consults with the behavioral health case manager on availability of treatment and whether the member would benefit from behavioral health case management. If so, the medical case manager asks the member if he or she is willing to speak with someone from behavioral health.

"Sometimes, they manage the case together. Other times, the two types of case managers consult on cases. Because they are co-located, they can always walk over and talk to each other about their patients," she says.

A separate program NaviCare, for members who are over 65 and eligible for both Medicare and Medicaid also combines medical and behavioral case management and includes face-to-face interventions.

When members enroll, a medical case manager visits the members in their homes or another location if the patient is more comfortable meeting outside the home, and conducts a thorough assessment to determine what services they need. "Every member in NaviCare is assessed upon admission to determine the additional assistance they need," Miller says.

"Face-to-face visits give us a more thorough way of assessing than conducting the assessment by telephone. When you see someone face-to-face, you can pick up on the non-verbal clues as well as verbal clues. The more vulnerable the population, the more important it is to see them face to face," she says. "By going into members' homes, case managers can see how they function, if they have physical challenges or if there are home safety hazards, like scatter rugs, or if they have to climb stairs to get to the bathroom."

Since medication management is a big part of the care management program, case managers can see the member's prescription bottles and get a complete picture of what medications he or she is taking. Most dually eligible members have complicated medication regimens and often need help understanding them, or they may be taking the medication they took before they were hospitalized as well as those they were prescribed in the hospital, she adds.

After the initial assessment, the case managers visit the members in person periodically depending on the members' needs and follow up by telephone between visits. When members have both behavioral health and medical issues, the behavioral health and medical case managers may visit together.

Case managers in the NaviCare program typically have a case load of about 100 members at a time. They are assisted by non-clinical navigators who handle the non-clinical work such as making appointments, arranging for transportation, and facilitating communication between specialists and the members' primary care physicians. ■

CMs, MDs collaborate on depression care

Patients also improve their physical health

A collaborative approach in which primary care physicians and nurse case managers work with patients with depression has resulted in a 50% improvement of scores on a depression questionnaire among patients who were part of a pilot project at UC Davis Family Medicine in Sacramento.

The initiative was piloted in the academic primary care office, staffed mostly by residents at UC Davis Medical School, then rolled out to UC Davis Family Medicine's 11 primary care offices, according to **Angela Gandolfo**, MBA, advisor for performance improvement in clinical operations at UC Davis, who worked with Jaesu Han, MD, assistant clinical professor and program director for the combined medicine/psychiatry resident training program at UC Davis Medical School. About 16% of patients treated by UC Davis Family Medicine have a diagnosis of major depressive disorder in addition to a physical diagnosis.

"Mental health benefits are declining in California, especially from MediCal," Gandolfo says. "More and more primary care providers have to deal with psychosocial issues and depression. We recognize that patients' underlying mental health issues have a lot to do with their physical health. Our pilot study showed that a collaborative effort between physicians and case managers can help patient manage their behavioral health problems and improve their physical health by becoming more compliant with their treatment plan."

Every patient seen by UC Davis Family Practice is offered the Patient Health Questionnaire (PHQ-9) depression screen. The tool is available in multiple languages, and patients are offered interpreters if necessary. When patient scores meet the minimum criteria for major depression, they are offered the opportunity to enroll in the collaborative care program.

"Many patients, particularly those with chronic diseases such as diabetes, hypertension, and heart failure, were grateful that we brought up the subject of depression. They were struggling and didn't know how to ask for help," Gandolfo says.

Interventions are based on the patient's score on the depression screen. For most patients, the primary care provider conducts the initial intervention and prescribes medication to help with depression, then refers the patient for case management. The physician practices have a psychologist or social worker on site who also can provide interventions when appropriate. In some instances, patients may see their primary care provider and a psychiatrist at the same time.

The nurse case managers are nurses with backgrounds in case management and behavioral medicine and work in the UC Davis managed care and utilization department in a site near the hospital. The case management interventions are customized for each individual patient. The case managers call patients at intervals that depend on patient needs. Patients can call their case manager at any time if they have questions or concerns. The case managers document their encounters in the electronic medical record and send the notes to the primary care provider and Han, who oversees the program.

"The key to this program is collaboration between the case manager and the physician," Gandolfo says. "When patients have problems with adhering to their treatment plan or experience side effects, the case managers often pick it up in between visits to the physician. The physician can change the medication or take other action to prevent the patient's condition from exacerbating."

Often, patients with depression start to feel good and stop taking their medication or they stop taking it because of the side effects. The

most typical side effect is that patients feel sick until their body adjusts to the medication, Gandolfo says. The case managers educate them to understand the side effects and how to manage them until they stabilize. If the patients continue to have progressive symptoms, the case managers coordinate with the primary care physician and the psychiatrist about whether the medication should be changed.

In every conversation, the case managers educate the patients about depression and teach them how to manage their symptoms at home. They work with the patients on exercise and good nutrition and help them adhere to their treatment plan. If the patient isn't taking medication, the case managers work through why they aren't taking them and educate them about the necessity to continue the medication.

The case managers help patients with everything from basic social needs to medical management and refer them to resources that can meet their needs. They may refer them to their health plan for help in managing a chronic disease, arrange for durable medical equipment or orthotics, or help them access community programs to help with their transportation needs.

Right now, the program is strictly telephonic. "The long-term plan is to have the nurse case managers do onsite visits with the primary care provider with certain patients so the patients can meet them face to face and they can be part of the care team," Gandolfo says. ■

Study: ED care should fit unique needs

Embed community health workers in the ED

To keep a lid on costs, health care policy experts recognize that hospitals need to find more effective ways to manage transitions. The care coordination piece can be particularly problematic in the fast-paced ED setting, and yet it can make a big difference in determining whether a patient receives appropriate follow-up after an acute event and whether he or she is back in the ED within days or weeks with another acute exacerbation of the same issue.

While the rationale for effective care coordination is clear, it turns out that identifying effective inventions for the ED setting is problematic, according to researchers who attempted to compare the effectiveness of ED-based care coordination interventions in a systematic review.[1] "We know that certain interventions are more effective than others, but really the question for an ED manager is what is going to be the effectiveness of this particular intervention in my setting," says **Jesse Pines**, MD, MBA, a co-author of the study and director of the Center for Health Care Quality and associate professor of Emergency Medicine Health Policy at George Washington University in Washington, DC. "I think different interventions are going to behave differently in different settings."

Pines adds that whether an intervention is effective depends not just on the quality of the particular intervention, but also on whether the local people in the ED implement the intervention in an effective way and whether the providers outside the ED are receiving the information and really connecting with the ED. "One of the themes of care coordination is that you basically need individuals or entities working with each other," says Pines. "Organizations and providers outside the ED need to be interested in working with the ED to improve care for their patients."

With these caveats in mind, the researchers did find that certain ED-based interventions were more effective than others at increasing follow-up rates or reducing repeat ED utilization, says Pines. For example, automatically making follow-up clinic appointments for patients has had some success, although the progress is variably effective across different settings, says Pines. Also, providing care coordinators for older adults has been shown to be effective in some studies, but most studies do not tell the whole story, he stresses.

"Our goal is that by improving care coordination, health is going to be improved and patients are going to be better linked in with a primary care provider who can follow them longitudinally, but, ultimately, the downstream costs are going to be lower because people are going to be healthier and they are going to use fewer health care resources," says Pines. "And the missing link in [the literature on this area] is really demonstrating that care coordination interventions are associated with big differences in downstream costs."

Form links with providers, organizations

One persistent barrier to effective care coordination is the fact that ED physicians are gen-

erally not incentivized to make the extra effort required to connect with other providers. "In order to make emergency physicians want to do this, there are a couple of things that need to happen," says Pines. "First, there needs to be an explicit incentive to [provide care coordination], and two, there needs to be systems in place to coordinate with. And those systems need to be built outside of the ED."

Indeed, Pine points out that it is the payers who will benefit most financially from achieving better quality care at lower cost. "One of the ways to reduce costs is to reduce downstream utilization through better care coordination, but essentially if it is the hospital that invests in the effort and the payers who are reaping the benefit, that is a problem," says Pines. "Everyone has to benefit. It needs to be win/win."

The newer payment models, such as accountable care organizations and bundled payments, are attempting to better align incentives and benefits, but the role of the ED in these new systems has yet to be determined, says Pines. "My vision would be that the ED becomes a critical part of the medical home, and that there is a free flow of information between the ED and the medical home so that everyone is on the same page with regard to care plans and it is easy to get rapid follow-up for people," he explains. "But essentially what that will require is not only a care coordinator who is present in the ED, but also a care coordinator who is online and available for outpatient clinics."

Pines adds that this type of coverage needs to be available 24/7 because, while it is easy to call a clinic during business hours, the majority of ED patients don't present for care during business hours. "I think trying to coordinate care with people during non-business hours is going to be one of the most effective things that clinics can do to help promote care coordination for their patients," he says.

While it will take time for newer payment models to positively affect care, Pines advises ED managers to begin reaching out to organizations and providers outside of the ED. "Care coordination is about a dyad between two providers or a provider and a patient working together to come up with the best care plan, and one of the major things that is lacking right now is those linkages," says Pines. "I think the first step is to start creating those linkages and to develop systems that can improve care coordination in the future because once these new payment incentives roll out, part of the responsibility is going to be on the ED to insure that patients get follow-up and that their care is coordinated, both on the front end and on the back end."

Get to the root of health problems

The U.S. Department of Health and Human Services (HHS) certainly believes that better care coordination between the ED and other providers is one of the primary keys to controlling costs. Health care organizations with specific plans to address this area figured prominently in the first round of Health Care Innovation awards that were announced in early May 2012.

For example, University Emergency Medical Services (UEMS), a team of emergency physicians that is affiliated with the State University of New York (SUNY), Buffalo, is set to receive $2.57 million in federal grant dollars to launch a program that will deploy community health workers (CHW) to help certain high-need patients who present for care in the ED get established with a medical home for routine medical care, as well as link up with any social services that can help these patients get their health and their lives on a better track.

"The current state of affairs is that EDs are silos in the sense that people show up there and they receive some care, and then they are sent back into the world where they will hopefully find their way into the other parts of the health care system," explains **Anthony Billittier IV**, MD, FACEP, dean, School of Health Professions, D'Youville College, Buffalo, NY, an attending physician at Erie County Medical Center in Buffalo, and an assistant professor of emergency medicine at SUNY Buffalo. However, navigating the health system is very difficult, adds Billittier, noting that he has even had trouble navigating the health system with his own family. "What the community health worker system will do is once we send patients on their way, we won't actually leave them, at least not immediately."

Instead, Billittier explains that the CHWs will follow these patients out into their communities where they live and work and help them with any follow-ups they need from a medical, social, or environmental standpoint. "The CHWs will do what they can to make the

patients' lives better, so the end-game here is that they will have better health and they won't need to come back to the ED again, or at least not for things that are not true emergencies," he says.

Billittier adds that a key thrust of the CHW model is to address health in a more comprehensive way. "The [traditional] health system sort of ignores the social determinants of health," he says. "Very often we think that if we give people a pill or give them an operation or take some other medical intervention, we are fixing their health care problems, but the reality is that the root of their problems is really seated in their socioeconomic [circumstances] and their environment, so until we begin to deal with those issues, we are only going to continue to give them pills and operations and those sorts of things."

For example, to get at the root cause of their health problems, some patients may require life coaching, and they may need help in getting plugged into non-medical social services such as food stamps or workforce development programs, explains Billittier. "We think if we can help them with some of their non-health-related issues, their health problems will then be that much easier to solve, so that really is the foundation of the program," he says. "We have to get them into a medical home. That has to be part of this, but that is only half the battle."

Derail inappropriate ED utilization

The CHW model is not new, but it has gotten results in other health care settings, observes Billittier. "Community health workers have a track record of being effective at life coaching and helping their peers," he says. "That is the whole point of community health workers. They are really peers of people, and that is why they are effective."

The health system has contracted with D'Youville College in Buffalo to help recruit the 10 CHWs that will be deployed in the two EDs that are participating in the program, Erie County Medical Center and Buffalo General Medical Center. "The college is going to train our CHWs, using standardized models," explains Billittier. D'Youville will then work collaboratively with UEMS to provide ongoing education to the CHWs and to address any issues that come up that require added training.

"We don't know yet exactly how we will need to retool, but D'Youville will develop training programs on various issues that are needed, and they will also help us with some quality oversight," explains Billittier. "That goes hand-in-hand with the ongoing educational component."

Billittier emphasizes that for the UEMS model to work, the CHWs need to be embedded in the ED. "What is going to happen is a community health worker or a community health worker supervisor is going to need to spend time in the ED case finding," he explains. "However, the CHWs are going to spend most of their time out in the community because that is where their real work is going to be done. To be effective, they have to interface with people where they live, learn, work, and recreate every day, but the linkage has to be made right in the ED."

Billittier envisions that especially in the early stages of the model's implementation, the CHWs will be building their caseloads while working in the ED side-by-side with the emergency physicians to identify patients who have a high likelihood of coming back to the ED. "We have defined these patients as people who have already used the ED two or more times [in the previous 12 months]," explains Billittier. "These will be people who already have a history of using the ED, and I think there is pretty good [evidence to suggest] that they are going to continue to use it."

There will undoubtedly be times when the CHWs will be faced with medical issues that they are not trained or equipped to handle on their own. Consequently, another component of the model is that there will always be three emergency physicians on call to make medical judgments or to intervene, as needed, explains Billittier. For example, an emergency physician could determine whether a patient who was discharged from the ED with pneumonia on the previous day needs to come back to the ED for added treatment, or he might get on the phone with the patient's primary care provider (PCP) to explain the patient's clinical circumstances and to arrange a speedy follow-up appointment.

The basic idea is that through the work of the emergency physicians and the CHWs, the repetitive, inappropriate use of the ED will be derailed and the patients will be linked into a more appropriate care setting for their routine medical needs. Also, since the program is an initiative of the Centers for Medicare & Medicaid

Services (CMS), the CHWs will focus their attention, at least initially, on Medicare and Medicaid patients.

"Our long-term target is [for CHWs to work with] anyone who needs the service, regardless of the payer, or lack thereof, because that is how we approach patients in the ED," says Billittier. "As clinicians, we don't even know what type of insurance patients have, and we don't care. We provide the same level of care, so, ultimately, that is the way the system needs to go forward."

Administration of the CHW program will require a director and two social workers to supervise the CHWs, but program developers are aiming to save more than $6 million over a period of three years.

REFERENCE

1. Katz E, Carrier E, Umscheid C, Pines J. Comparative effectiveness of care coordination interventions in the emergency department: A systematic review. *Ann Emerg Med*. 2012 Apr 26. [Epub ahead of print]

Sources

1. Anthony Billittier IV, MD, FACEP, Dean, School of Health Professions, D'Youville College, Buffalo, NY, Attending Physician, Erie County Medical Center, Buffalo, NY, and Assistant Professor of Emergency Medicine, State University of New York, Buffalo, NY. E-mail: Billitti@dyc.edu.

2. Justin Chang, MD, Chief of Hospital Operations, Kaiser Permanente, Denver, CO. Phone: 303-344-7518.

3. Adam Hill, MD, Regional Department Chief, Department of Emergency Medicine, Permanente Medical Group, Denver, CO, and Medical Director, Emergency Department, Exempla St. Joseph Hospital, Denver, CO. Phone: 303-344-7518.

4. David Kaleugher, MD, Assistant Regional Department Chair for Emergency Medicine, Kaiser Permanente, Denver, CO, and Senior ED Champion, Exempla St. Joseph Hospital, Denver, CO. Phone: 303-344-7518.

5. Jesse Pines, MD, MBA, Director, Center for Health Care Quality, and Associate Professor, Emergency Medicine and Health Policy, George Washington University, Washington, DC. E-mail: Jesse.Pines@gwumc.edu.

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NQF endorses chronic conditions measures

Effort to look at patients across the continuum

As the National Committee for Quality Assurance hopes that all-cause readmission rate reporting by health plans will assist in creating more consideration of patient care across the continuum, the National Quality Forum (NQF) hopes a new measurement framework for multiple chronic conditions will likewise help improve care in and out of the hospital.

"This is a guide that can help inform decision-making," says **Karen Adams**, PhD, MT, vice president of national priorities for the organization. "This provides a way for us to look at care not by patient, and not by setting, but through something else."

A patient might be in a hospital, in rehab, having home health care, or just at his or her primary care physician, she continues. This is a way to approach care across phases and look at performance measurements that meet the needs of patients. Looking at issues such as care coordination, functional status, hand-offs and shared accountability could change the game. "This puts the patient as the unit, not the place where the care is given."

Among the concepts key to the new framework, the framework document notes, are:

- optimizing, maintaining, or preventing further decline in function;
- seamless transitions between providers and sites of care;
- determination of what outcomes are important to the patient;
- avoiding inappropriate, non-beneficial care, including at end of life;
- access to usual source of care;
- transparency of cost;
- shared accountability among patients, family, and providers;
- shared decision making.

"I think of the value of the framework as how it would be used and what work it would inform," says **Tom Valuck**, MD, JD, senior vice president for strategic partnership at NQF. It could affect policy makers and researchers, and how payers reward and punish providers for the care they give to these patients. It might even help consumers make better decisions, he adds.

Valuck says the framework will also be instrumental in helping determine measurement gaps for this population.

This all started from the previous framework on patient-focused episodes of care, Adams explains.

"This was when we first started to think across settings," she says. "We looked through various conditions — cancer, diabetes, substance abuse, AMI. But what's important from that learning is that for a large portion of the population, you aren't just someone with one of those, but with multiple conditions. This evolution of looking at multiple diseases is different."

If you instead used the measures for each of a patient's individual conditions, you could end up with some unintended consequences, she notes — harm to the patient, extra work for various providers, and greater cost for payers.

Adams would like to see professionals throughout the healthcare community gain a real understanding that the care doesn't end at the door to their office or facility. "I know they want to provide high-quality care in that setting," she says. "But there have to be hand-offs, and providers know that they can't achieve good outcomes in isolation. We want them to think about how to orient their quality improvement, how they respond to external entities along the continuum of care. When you think of transitions, what measures do you want to pilot or use? Think of that. Be ahead of the game."

Organizing around outcomes

Valuck worries that there is a cacophony of disorganized quality measurement on the front line of healthcare. This kind of framework — applied specifically here, but bootstrapped elsewhere in the future — can help rationalize and organize all the work that patient safety and quality improvement staff do. "If we can make measurement line up in ways that make sense to QI and providers alike — wouldn't that be great?" he asks.

The key is to organize the process around patient outcomes. "If Javier has depression, COPD and diabetes, we could do a lot of process measures around each of these diseases," Adams says. "If we provide guidelines for each of these, are we paying attention to what matters most to this patient? One might want to walk across the room to pick up his grandchild. That means regimented A1C measurement might make him too wobbly to do that. But we can titrate that so that we meet health needs and patient goals."

That's what this is all about, Valuck concludes. "It's about triaging, and prioritizing at the highest level opportunities. It's about helping the provider focus on what's most important."

The entire measurement framework report is available at www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71227.

For more information on this topic, contact Tom Valuck, MD, JD, Senior Vice President of Strategic Partnerships, and Karen Adams, PhD, MT, Vice President of National Priorities, National Quality Forum. Washington, DC. Telephone: (202) 783-1300. ■

COMING IN FUTURE MONTHS

- Health plans, providers collaborate for better patient care
- Following patients throughout the continuum
- How your peers are preventing hospital readmissions
- New opportunities for professional development

CNE QUESTIONS

1. According to Angela Gandolfo, MBA, advisor for performance improvement in clinical operations at UC Davis Health System in Sacramento, depression is often the underlying cause when patients can't manage their chronic diseases.

   A. True

   B. False.

2. How are patients identified for Capital District Physicians Health Plan's behavioral management program?

   A. Depression screenings.

   B. Referrals from health risk assessments.

   C. Referrals from physicians.

   D. All of the above.

3. What is the average case load for case managers in Fallon Community Health Plan's NaviCare program for dual eligible members over age 65?

   A. 20

   B. 40

   C. 100

   D. 150

4. In the UC Davis Family Practice depression management program, what clinicians collaborate with primary care physicians to manage the care of patients with depression when appropriate?

   A. RN case managers.

   B. Psychiatrists.

   C. Social workers and psychologists.

   D. All of the above.

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. ■