Case Management ADVISOR™
Covering Case Management Across The Entire Care Continuum

February 2013: Vol. 24, No. 2
Pages 13-24

IN THIS ISSUE

Financial disclosure:
Editor **Mary Booth Thomas**, Executive Editor **Russ Underwood**, Senior Vice President/Group Publisher **Don Johnston** and Nurse Planner **Margaret Leonard** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

AHC Media

Preventing readmissions benefits patients, saves money

Good communication, follow-up calls are key

In a concerted effort to improve patient care, payers and providers are collaborating to improve transitions of care and reduce readmissions.

A study in the *New England Journal of Medicine*[1] showed that one-fifth (19.6%) of Medicare beneficiaries were rehospitalized within 30 days of discharge, at a cost of $17.4 billion. The study concluded that the average stay of rehospitalized patients was 0.6 days longer than patients in the same diagnosis-related group whose most recent hospitalization had been at least six months prior.

"It's clear that keeping patients from being readmitted benefits the patient and saves the healthcare system money as well. When you add 0.6 days onto the typical diagnosis, it adds up to a lot of money. In addition, hospitalization can expose patients to infections and put them at the risk for falls," says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, consulting firm specializing in hospital case management.

Reasons for avoidable readmissions include poor or inadequate discharge plan, discharging the patient too soon, no plan for follow up care, medication compliance issues, and the patient's failure to see a primary care physician for follow-up within a week after discharge, according to **Toni Cesta**, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, NY,

EXECUTIVE SUMMARY

When patients are readmitted to the hospital, they typically have longer lengths of stay than patients with the same diagnosis, are exposed to infections, and face the risk of falls.
- Make sure patients have a follow-up visit with their physician.
- Call to make sure they understand their treatment plan, have filled their prescriptions, and are taking medications appropriately.
- Collaborate with post-acute providers to ensure a smooth transition.

and health care consultant and partner in Case Management Concepts, LLC.

"When people are readmitted within 30 days, it means that somewhere the system has failed. Either the patient didn't get appropriate ambulatory or inpatient care, they didn't receive care at the appropriate level of care at the most appropriate time, or there were problems with the transition of care," says **Tracy Langlais**, RN, vice president of medical affairs operations for Capital District Physicians Health Plan (CDPHP), based in Albany, NY.

Since studies have shown that one cause of readmissions is lack of follow-up care, case managers should make sure that patients have an appointment to see their doctor for follow up within seven days of discharge and should make sure they understand the importance of keeping the appointment, Cesta says.

Make a follow-up phone call shortly after discharge to make sure the patient is taking his or her medication, has a doctor's appointment, and is not having problems, she says.

Following up after discharge helps the case managers identify issues that could mean problems down the road for patients, says **Mary Hickie**, RN, case management services director for Blue Cross Blue Shield of Arizona Advantage. The health plan makes follow-up calls and home visits after discharge to patients who qualify for case management.

"Patients are given so much information at discharge that they often don't remember everything. The case managers have access to the electronic medical records at Banner Health facilities and can review the discharge instructions to make sure the patient understands them. They get information about the medication prescribed and can conduct medication reconciliation over the telephone," she says.

In one instance, when a case manager made a follow-up call the day after discharge, the patient didn't remember getting two prescriptions, one of which was for an antibiotic. The case manager asked the patient to check the bag he received at discharge and he found the prescriptions. When she called back the next day, the patient reported getting his prescriptions filled and taking them as instructed.

If the patient hadn't found the prescriptions, the next step was for the case manager to visit the home the next day and go over all the paperwork with the patient.

Communicating with the patient and family before and after discharge is an important part of reducing readmissions, but don't overwhelm them, Kizziar says.

"When patients leave the hospital, they sometimes get follow-up calls in a matter of days from the hospital, their health plan, their doctor, and in some cases, someone doing a patient satisfaction survey. It is overwhelming and confusing and may annoy patients and family members to the point that the calls are ineffective and it certainly doesn't speak well for the healthcare industry," she says.

She advises case managers making follow-up calls to ask open-ended questions rather than those that can easily be answered "yes." Ask them to tell you what medications they are taking and when they are

Case Management Advisor™ (ISSN# 1053-5500), is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Website: www.ahcmedia.com. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Case Management Advisor™, P.O. Box 105109, Atlanta, GA 30348.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, $449. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $67 each. (GST registration number R128870672.)

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity has been approved for 15 nursing contact hours using a 60-minute contact hour. Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours. This activity has been approved by the Commission for Case Manager Certification for 18 clock hours. This activity is valid 24 months from the date of publication.

EDITORIAL QUESTIONS

Questions or comments? Call Mary Booth Thomas at (770) 939-8738.

Editor: **Mary Booth Thomas**, (770) 939-8738, (marybootht@aol.com).
Associate Managing Editor: **Jill Drachenberg** (404) 262-5508.
Executive Editor: **Russ Underwood** (404) 262-5521, (russ.underwood@ahcmedia.com).
Production Editor: **Kristen Ramsey.**
Senior Vice President/Group Publisher: **Donald R. Johnston**

taking them. Instead of asking heart failure patients if they are weighing themselves daily, say "tell me your morning routine."

Payers and providers need to work together to coordinate phone calls and improve transitions, Kizziar says.

Capital District Physicians Health Plan partners with physicians to ensure that patients receive follow-up appointments and provides in-home case management for frail elderly members at highest risk. In addition, case managers call at-risk patients at regular intervals for 30 days after discharge and provide daily discharge reports to physicians.

"Everybody in health care is trying to reduce readmissions, but those who are the most successful are those that are collaborating with other organizations. When the payer, the hospital, and the primary care provider come together, they are able to make a program happen," she says.

REFERENCE

1. *NEngl J Med* April 2, 2009:360:1481-28 ■

Home visits help reduce Medicare readmissions

Nurses educate patients, link them with resources

A program that provides at least one home visit for members who qualify for case management has helped Blue Cross Blue Shield of Arizona Advantage drop its all-cause readmission rate for all ages to 13%.

The program is a joint venture of Banner Health and Blue Cross Blue Shield of Arizona Advantage and serves members in the Maricopa County area. "The goal of the program is not just to reduce readmissions but to assist our members in obtaining the services they need and to provide case management in the community," says **Mary Hickie**, RN, case management services director for Blue Cross Blue Shield of Arizona Advantage.

The program receives referrals from physicians, home health nurses, and case managers in the acute care hospitals and skilled nursing facilities. Family members and caregivers refer patients, and some members self-refer.

"We are the last stop for people in the community. We step in when home health is no longer visiting and they aren't ready for hospice but they still need care coordination. Our goal is to provide at least one home visit for every individual we identify for case management," Hickie says.

Members who qualify for the case management program have experienced strokes or myocardial infarctions or have chronic conditions, such as chronic obstructive pulmonary disease, heart failure, or cardiovascular conditions.

"We work hard to identify those conditions that may be at more risk for readmissions," she says. "We zero in on patients with diagnoses that make them likely to be readmitted." For instance, patients with chronic obstructive pulmonary disorder have an average of six comorbidities and often need a lot of assistance to stay out of the hospital, she says.

"We make an effort to identify as many of them as possible and to provide standardized education and outreach," she says. The case managers assist patients in getting financial assistance if they qualify.

The health plan also includes patients in the program who have been treated for falls in the emergency department or admitted to the hospital because of fractures caused by falling. They conduct a home assessment, evaluate the patients' functional status in the home, and check for safety issues.

Members have the opportunity to opt out of the program, but if the case manager feels strongly that the member would benefit from assistance, he or she asks the patient's primary care physician to recommend the program.

When eligible patients are discharged from the hospital, the case manager makes a call within three days to address questions and concerns, ensures that the member has a follow-up physician visit, makes sure the new prescriptions have been filled, and conducts medication reconciliation.

Case managers carry a caseload of 70 to 75

EXECUTIVE SUMMARY

Blue Cross Blue Shield of Arizona Advantage dropped its all-cause readmission rate to 13% after beginning a program that provides home visits to patients who qualify for case management.

- Case managers contact the patients within three days of discharge to schedule a home visit.
- In the home, they go over medications, educate them on their condition, assess their home situation, perform a falls risk assessment, and help them sign up for financial assistance if appropriate.
- They follow patients by telephone, or in person, for an average of three to nine months.

members in varying stages of case management. The frequency and types of interventions depend on the member's needs. In some instances, the case manager assesses the member in the home and follows up by telephone. Other times, the case manager may feel that the member needs additional home visits. In some cases, the case manager may conduct an assessment over the telephone and determine that a home visit is not necessary if the member understands the medication regime and treatment plan, and knows to follow up with his or her physician.

Case managers spend an average of one to one-and-a-half hours in the home talking with patients and family members and assessing what is going on in their lives. The case managers may follow up by telephone or make another home visit, depending on what they determine the patient needs.

"Visiting the home helps us get a better idea of what is going on. Many times patients tell us over the phone that they are doing great, but when we get into the home setting, we may find that there's no food in the refrigerator or that all of their medications are in a bowl in the middle of the table," she adds.

Case managers follow the members in the program for an average of three to nine months, but some have been in the program for six years or longer. One case manager followed a member at home, visiting once a month, until the woman was moved to a long-term care facility. The case manager now works with the spouse and is guiding him as he gets his wife into hospice.

The case managers also visit members in skilled nursing facilities and assisted living centers to coordinate care with the staff. They visit members in the hospital and coordinate care with the hospital social worker or case manager.

The program also provides educational programs to help members manage their conditions and helps them access community resources such as support groups, financial assistance organizations, long-term care planning, and education on advance directives and hospice options, when appropriate.

"We are looking at the entire paradigm of health and wellness. Our goal is not specifically to reduce readmissions but to make sure members get the right care at the right time and in the right place. We want our members to establish ongoing, consistent care with their physicians to improve the quality of care and avoid hospitalizations and emergency department visits," she says.

The case managers meet monthly at the Banner Alzheimer's Institute for guidance on how they can help families whose loved ones have behavioral issues. "It's been helpful for us to have people with expertise to share," she says. "Our program focuses on the full continuum of care, and we share information and coordinate care at all levels of care."

The nurses meet twice monthly with representatives from the Banner Home Care Agency to share information, brainstorm on ideas for managing the care of members and discuss ways to improve the transition process.

"Sharing information reduces the situations when we ask patients the same questions over and over and improves the care coordination process. The home health nurses, case managers, and therapists all call each other when they have questions. This very good relationship benefits our members," she says. ■

CMs make multiple contacts to reduce readmissions

Health plan partners with hospitals, MDs

After a program to reduce readmissions showed positive results but not a clear downward trend in readmissions, Capital District Physicians Health Plan (CDPHP) is trying another tactic.

Instead of having home health nurses make one visit and a follow-up call to at-risk patients after discharge, the health plan is restructuring its efforts and providing intensive case management to at-risk patients for 30 days after discharge. The new program began Jan. 1, 2013.

"We think that contacting people multiple times during the month will be more effective than a one-time visit. We want to reduce readmissions first and foremost to improve quality of care," says **Tracy Langlais**, RN, vice president of medical affairs

EXECUTIVE SUMMARY

Capital District Physicians Health Plan's new readmission reduction program includes multiple phone calls by case managers during the month after discharge and a collaboration with physician offices and hospitals.

- Physician offices make outreach phone calls to schedule follow-up appointments after discharge.
- Embedded case managers at participating hospitals work with hospital case managers on discharge plans.
- Frail elderly patients receive in-home case management.

operations from CDPHP, based in Albany, NY.

In addition, the health plan is working closely with physicians to schedule follow-up appointments for members within seven days of discharge, as well as partnering with participating hospitals to reduce readmissions through quality incentive programs. Other initiatives include in-home visits to provide face-to-face case management on an ongoing basis for the frail elderly, performing in-hospital risk assessments to identify members with a high potential for readmission, and using community resources to supplement member benefits.

"The biggest disappointment with the program as previously designed was the large number of people who declined the home visits. So many people felt that they didn't need anyone to come into the home. In addition, the number of patients who saw their physician within seven days was not as high as we would have liked and the number of members linked to case management was also low," Langlais says.

The new program's telephonic outreach is less invasive ,and once a relationship is established, in-home services are still an option, she adds.

The original program focused on congestive heart failure, chronic obstructive pulmonary disease, and coronary artery disease. "We have expanded the program to provide the same quality of care for all our patients. We believe that there are a lot of opportunities to reduce readmissions," she says.

The health plan embedded RNs — called inpatient care coordinators — in local hospitals with a high volume of members to assist the hospital-based case managers in discharge planning for all CDPHP members. They meet with hospitalized patients and use a tool to assess the members' risk for readmission. Members whose score indicates a risk for readmission are referred to case management.

The case managers at the health plan call the members on Days 2, 7, 14, 21, and 28 after discharge to go over the discharge plan and answer any questions or concerns. They make sure the patients have gotten their prescriptions filled and understand their medication regimen, educate them on their treatment plan and the importance of following it, educate them on signs and symptoms that indicate they should call their doctor, and make sure they have a follow-up visit.

"We instituted a full court press to educate our primary care medical home practices on the importance of ensuring that patients get in see their doctor within seven days. We believe that when the physician's office makes an outreach call to set up an appointment, it's much more effective in getting the member into the practice in a timely manner, rather than leaving it to the member to set the appointment," she says. The health plan posts a daily discharge report for each practice that the staff can use to contact the members and get them an appointment.

The health plan partners with a case management firm to provide ongoing case management in the home for high-risk frail Medicare members.

"We are moving to a focus on preventing all-cause readmissions by looking at the whole person and his or her situation and history of readmissions. Younger members with multiple comorbidities or no support system, or social needs like transportation assistance, get the full program," she says.

Health plan representatives meet with hospital case management staff once a month and quarterly with the medical directors, case managers, and financial departments at the hospitals.

"We have a very good working relationship with the hospitals in our area. They are very excited about partnering with us to reduce readmissions. We are monitoring the effectiveness of the program on a monthly basis and will make additional changes if we don't see a downward trend in readmissions," she says. ■

Calls remind members of gaps in their care

Program integrates with CM, DM

To help members of its Medicare Advantage Plan stay healthy, healthcare professionals at WellPoint make individual outbound calls to members with clinical gaps in care to remind them of what preventive measures they need.

In a pilot study, the members who received the calls reduced their care gaps from 15 to 5.9 percentage points for each of nine measures. The program won a URAC gold award for consumer health improvement.

"We wanted to change the way we approach the members. Unlike population based initiatives, this program is member-centric, driven by member needs and care gaps," says **Catherine MacLean,** MD, staff vice president of clinical quality and intervention for the Indianapolis-based health benefits company, which operates commercial, Medicare,

EXECUTIVE SUMMARY

WellPoint's pilot study of phone calls to Medicare Advantage members with clinical gaps in care reduced the care gaps and earned the health benefits company a URAC gold award for consumer health improvement.

- Patient education coordinators call members with one or more gaps in care, reminding them of the need for the procedures and offering to help them schedule appointments.
- Members who need additional help are transferred to a case manager or a pharmacist for assistance.
- The program is integrated with another WellPoint program that calls members just before discharge and after they get home to ensure a smooth transition.

---

and Medicaid plans in many states. Traditionally, health plans have provided case management for the sickest members and conducted population-based campaigns to remind members to get their flu shots and have regular screenings, she points out.

"We are not just sending out random calls. We are determining everything needed by the member and tying that into the calls. This isn't an Interactive Voice Response (IVR) call. The members get a call from a live person," she says.

WellPoint analyzes medical claims data every month to identify clinical gaps in care according to evidence-based clinical practice guidelines. Members with one or more gaps receive outbound calls from patient education coordinators who educate them about the gaps, encourage them to seek whatever tests or procedures are missing and offer assistance in scheduling appointments.

"Seniors have health problems that are different from those of other age groups. They have risks for falls, urinary incontinence, and other issues that are unique to older patients. This program aims to address those problems and help our members optimize their health," McLean says.

The patient educators are college-educated but do not necessarily have clinical degrees. The company provides extensive training to help them do their job.

The patient education coordinators talk with the members about all of their healthcare issues, not just the preventive measures they are missing. If members have a question about medication, the patient education coordinators can transfer them to a pharmacist. If they have clinical issues, they are transferred to a case manager or a disease manager. They help them with doctor appointments and transfer them to a social worker for help if they have additional needs, such as transportation, financial needs, or community resources. Depending on the provider group, the patient education coordinators will arrange a three-way call with the doctor's office to set up an appointment or contact the provider group staff to call the member to set up an appointment.

"This is a more holistic and meaningful approach. We put this all together so we aren't operating in silos. The patient education coordinators can connect members to whatever Wellpoint program can meet their needs," McLean says.

The program is integrated with another WellPoint program that calls members just before discharge and after they get home to make sure that the transition is going smoothly, that they have a follow up appointment with their physician, and that they understand their medication.

"Problems that arise when patients transition from one level of care to another are big issues for every age group, so we make the calls to all our members, regardless of age. However, ensuring a smooth transition is particularly important for the senior population," she says.

The program is year-round. Every month, the health plan analyzes data to identify members with care gaps. Members are called back repeatedly when data show the care gaps haven't been closed. Some members may receive as many as six calls a year.

Members who are new to WellPoint's affiliated Medicare Advantage plans complete a health risk assessment that is used to identify potential gaps in care. The health benefits company uses medical and pharmacy claims and other data to identify members for outreach.

The goal is to contact each member at least twice a year. Patients newly diagnosed with diabetes, heart failure, or coronary artery disease and those who have persistent clinical care gaps get three calls a year. The health plan records the calls and conducts monthly auditing and quality review to make sure the patient education coordinators are meeting appropriate standards.

"We developed this program for seniors because they are more likely to struggle with poor care coordination, health literacy, access to providers, transportation issues and other barriers to care that reduce adherence. The program allows members to be proactively involved in their own care by notifying them of preventative screenings that can detect and prevent chronic illness and educating them on the potential benefits of getting the recommended tests and procedures," MacLean says. ■

Study: Frequent ED users misunderstood

Experts find fault with growing focus on ED cost

In an effort to drive down health care expenditures, a key target of state legislatures and healthcare policy makers in recent years has been frequent users of the ED. The thought is that many of these patients are using the ED for routine or non-urgent care when they really should be opting for less-expensive care settings. However, new research into exactly who these frequent users are suggests that a high percentage of these patients are, in fact, using the ED for urgent or emergent concerns, and that efforts to find cost-savings could be better focused elsewhere.

As this issue is of high concern to the American College of Emergency Physicians (ACEP), several investigations looking at this issue were presented in October at the group's scientific meeting in Denver. **Robert O'Connor**, MD, MPH, chair of Emergency Medicine at the University of Virginia School of Medicine, Charlottesville, VA, and a co-author of one of the studies presented at the ACEP meeting, notes that while the investigations utilized varying definitions of how many visits to the ED qualified a patient as a frequent user, they did arrive at many similar insights about this patient group.

"Despite the widespread belief that these patients can easily be directed elsewhere in the health care system for less expensive care, and that these patients are somehow abusing the system, the reality is much more complicated," says O'Connor. "These patients actually need, for the most part, to be treated when they come in. And regardless of the definition used, most of the studies found frequent users to be a very small percentage of the total number of emergency patients, although these patients did make up a disproportionate share of ED visits."

In his own study looking at the characteristics of repeat ED users at a university medical center, O'Connor found that frequent users made up about 20% of the volume in the ED and accounted for nearly 40% of the visits.[1] However, in most of the other studies, O'Connor notes that frequent users made up a smaller proportion of the ED volume.

For example, in a study out of Harvard, frequent users made up 2.1% of all emergency patients and accounted for 11.5% of all visits.[2] Similarly, a study conducted at the University of Wisconsin (UW) found that frequent users represented about 8% of all emergency patients and accounted for about 26% of all visits.[3] And a study out of the University of California at San Diego (UCSD) found that frequent users represented 3.1% of all emergency patients and accounted for 16.5% of all emergency visits.[4]

New re-admission penalty unfair?

Another insight O'Connor notes from these studies is that while many healthcare experts believe that frequent users tend to be uninsured, it turns out that is not true. "Most frequent users are likely to be insured by Medicare or Medicaid," he says. "What we found in our study was that the distribution by type of insurer roughly represents the community as a whole."

Similarly, O'Connor notes the UCSD study found that the percentage of frequent users who were self-pay patients was similar to the percentage of uninsured patients overall, which was about 14.2%.

The UCSD study found that the most common diagnoses among frequent users were the same as for the occasional users: respiratory complaints and abdominal symptoms. Being a frequent user was also linked with a pain diagnosis or a heart failure diagnosis, says O'Connor.

O'Connor notes that the UW study found that 77% of the frequent users with seven or more visits during a 12-month period were only frequent users for one year, and most of these patients had the same rates of non-urgent visits as the non-frequent users.

"In our study, low and moderate repeat users were just as likely as non-repeat users to be admitted to the hospital from the ED," says O'Connor. "This suggests that the ED visits for these patients are justified as necessary for an acute illness, and high repeat users, once admitted to the hospital, were more likely to require re-admission."

Such findings raise questions about the recently implemented Medicare rule that penalizes hospitals for higher-than-average 30-day re-admission rates, notes O'Connor. "If you have a sick population that you are caring for, such as at a university hospital, I think it is unfair to the patients and to the hospital to penalize them for re-admission rates."

Misconceptions persist

ACEP's incoming president, **Andrew Sama**, MD, FACEP, senior vice president, Emergency Services, North Shore — Long Island Jewish Health System, Manhasset, NY, notes that the studies make clear that there are a number of misconceptions about who these frequent users are and how they use the health care system.

"The perception is that these are only people who are uninsured or they have mental health problems or they are abusing pain medication. In fact, there is a significant number of patients who fall into those categories, but this is also a group of people who, over a period of time, have a significant medical or surgical illness, have complications, and require recurrent and intermittent evaluation and treatment," says Sama. "Some of these folks are medically very sick and do present with new, acute problems in percentages that are very similar to the general population."

Sama adds that it is important to recognize that frequent users are actually a heterogeneous group of patients rather than a single patient type that can be easily matched with a single solution. "What we are trying to do as emergency physicians, state by state, and location by location, is put together intelligent processes and policies and procedures to begin to manage the very types of patients who are frequent users of emergency care so we can actually make improvements that can preclude some of this activity from occurring," he says. "It is not a simple problem; it is a social, medical, mental health, and community resource problem."

Further, Sama notes that the type of patients being seen in the ED today are more complex and require higher-level medical decision-making than in the past. "Five years ago, there were very few retail clinics and maybe half as many urgent care centers. Currently, there are 170-180 million patients who are being seen in retail clinics and urgent care centers, and these are the lower-acuity patients who used to be seen in the ED," he says. "We are seeing a shift."

While the studies did not specifically look at the cost associated with frequent ED users, O'Connor points out that most of these patients lack other care options. "Someone who is five days post surgery, who is having nausea and vomiting and can't keep anything down at 3 o'clock in the morning, has nowhere else to go, so they come to the ED," he observes. "They then may go home and develop a second complication from the surgery, which is totally unforeseen, and so they come back."

In this instance, O'Connor notes that utilizing the ED is actually less expensive than to trying to replicate the kind of care offered in the ED somewhere else. "Where else is someone going to go at 3 o'clock in the morning, unless you set up a parallel emergency care system?"

While the financial implications of frequent ED utilization are a concern, Sama points out that EDs are open every day around the clock, and they have 136 million encounters every year. "Emergency care in the United States only costs 2% of the entire national health care budget," he explains. "Only spending 2% on all of those acute care encounters is actually a pretty good return on investment."

Triage decisions tell a different story

Many of the findings about frequent ED users unveiled at ACEP's scientific meeting echo the results of similar studies released earlier this year. For example, a study unveiled in July by the Washington, DC-based Center for Studying Health System Change (CSHC) found that contrary to common belief, the majority of ED visits made by non-elderly Medicaid patients are for symptoms that suggest they have urgent or emergent problems.[5]

Such findings contrast with earlier research, but **Emily Carrier**, MD, MCSI, an emergency physician and senior health researcher at CSHC, explains that this is because most researchers have based their findings on claims data, which reflect final diagnoses. "When looking at final diagnoses, you end up with one picture of why people use the ED, but when a patient on Medicaid [or some other type of coverage] enters they ED, they obviously don't know what their final diagnosis is going to be," says Carrier. "We looked at triage acuity, and that gives you a very different picture."

For example, Carrier observes that most patients who come to the ED complaining of chest pain are not having a heart attack, but they do what public information campaigns tell them to do, which is to come to the ED and get checked out. "For many of these people, the problem is going to turn out to be something as benign as reflux disease or heartburn," she says. "Most of these people are not going to have a heart attack and die, but they don't know that in the beginning."

Similarly, parents commonly come to the ED with young children who have high fevers and appear to be very sick. Many of these cases turn out to be viruses for which there is supportive care and reassurance available in the ED.

"In retrospect, you could say that they didn't really need to come in, but at the time the parent was bringing in the child, they were very concerned, and a small proportion of those kids are going to be really sick and have a potentially life-threatening illness," she says. "What our study shows is that most of the patients who came in had concerns that appeared to be significant — not just to them, but to the triage staff who evaluated them as well."

While the researchers found no evidence that patients on Medicaid have any special propensity to abuse the ED, Medicaid patients did tend to use the

ED about twice as often as patients with private insurance. "If you went to an ED waiting room and started interviewing people, you would find a lot more who had Medicaid relative to the overall proportion of the population who have Medicaid than you would for people with private insurance," says Carrier. "But if you asked them what brings them here, you would find that folks with Medicaid were about as likely as folks with private insurance to describe a really concerning symptom or a minor symptom."

The CSHSC study notes that diagnoses of acute respiratory and other common infections in children and injuries accounted for more than half of the ED visits by children on Medicaid younger than the age of 12 years and more than 60% of ED visits by children younger than 12 years covered by private payers. The authors concluded that the greatest potential to reduce ED use lies in developing appropriate alternative care settings for these conditions, but they caution that such alternative sites would have to be able to provide prompt care.

REFERENCES

1. Miller S, O'Connor R, Ghaemmaghami C. Characteristics of repeat emergency department users at a university medical center: Frequent emergency department utilization is associated with higher rates of 30-day inpatient readmission. *Ann Emerg Med* 2012 Oct;(60):S102-S103. University of Virginia Health System 2012.
2. Liu S, Nagurney J, Chang U, et al. Frequent users of the emergency department: Do they make visits that can be addressed in a primary care setting? Massachusetts General Hospital, Beth Israel Deaconess Hospital, Harvard Medical School 2012.
3. Polsinelli A, Hamedani A, Svenson J. Frequent fliers and hot spotters: Characterization of distinct subgroups of frequent users of the ED. *Ann Emerg Med* 2012 Oct;(60):S104. University of Wisconsin-Madison, School of Medicine and Public Health 2012.
4. Brennan J, Chan T, Vilke G, et al. Identification of frequent users of ED resources using a community-wide approach. University of California, San Diego Emergency Medicine 2012.
5. Sommers A, Boukus E, Carrier E. Dispelling myths about emergency department use: Majority of Medicaid visits are for urgent or more serious symptoms. Center for Studying Health System Change, July 2012, Research Brief No. 23.

SOURCES

Emily Carrier, MD, MCSI, Emergency Physician and Senior Health Researcher, Center for Studying Health System Change, Washington, DC. E-mail: ecarrier@hschange.org.
Robert O'Connor, MD, MPH, Chair, Department of Emergency Medicine, University of Virginia School of Medicine, Charlottesville, VA. E-mail: reo4x@virginia.edu.
Andrew Sama, MD, FACEP, Senior Vice President, Emergency Services, North Shore — Long Island Jewish Health System, Manhasset, NY: E-mail: asama@nshs.edu. ■

Readmissions are on more shoulders now

Reports looks at how all players impact data

You know that you are going to get dinged for any unplanned readmissions related to a patient's original hospitalization. You have probably felt the heat about that for some time and have worked on how to make sure no one bounces back unless it's part of the plan. Well, now you can feel less alone. The National Committee for Quality Assurance (NCQA) released its Insights For Improvement: Reducing Readmissions: Health Plan Performance report in November and it includes a good deal of emphasis on how hospitals aren't alone in this (to see the entire report, go to http://www.ncqa.org/Portals/0/Publications/2012%20BI_NCQA%20ReAdMi%20_Pub.pdf).

The report, which includes a detailed look at the Plan All Cause Readmissions measure from development through initial data, includes commentary about the multiple factors in the in- and outpatient settings that can impact readmission, and how a strategy that keeps both elements in mind is required. "From a system perspective, a safe transition from a hospital to the community or a nursing home requires care that centers on the patient and transcends organizational boundaries," the report states.

The NCQA has the Plan All Cause Readmissions measure to "complement hospital-based measures," the report notes, and put some emphasis on how well plans as a whole manage the care members receive in the wider community. Together, the authors hope that hospital readmissions data and the plan all-cause readmissions data will provide more fodder for improvement in the delivery of care and the outcomes for patients.

The issue has to be addressed: NCQA says that up to a fifth of Medicare patients are readmitted within 30 days, and a lot of those could be prevented.

"One of the main things we wanted to do was call attention to the importance of readmissions as an issue and to highlight the fact that hospital readmissions are not strictly a hospital problem," explains **Robert Saunders**, PhD, assistant vice president of research and analysis at NCQA and one of the main authors of the report. "Many factors go on in the lives of patients, particularly once they leave the hos-

pital. While other measures have been focused on the hospital, we know that there are other actors and factors. We believe as a matter of philosophy that a health plan has a role in shaping the coordination activities." He hopes the report will help hospitals develop strategies and the impetus to connect to those other parts of the continuum and work on issues of care coordination. "We wanted to highlight the fact that measurement in the area of readmission has to also take into account the health plan focus."

This is not necessarily something new, says **Mary Barton**, MD, vice president of performance measurement. "But we are putting this all in one place and cementing the idea of those connections. You should look at where your interests are lined up with others in the community and think about how if you worked more together, how much more effective you would be."

Saunders says looking at the history of the plan measure might be interesting to some, too. "When we developed the measure, much of the work was focused on hospital-based measures on congestive heart failure, pneumonia, and myocardial infarction — and with good reasons," he says. "But the process of the care, the issue of handoff problems, the issue of patients coming back, well that all spans diseases. We wanted to focus on the totality of the problem, even if people are looking for actionability on specific causes of it. There are some issues of commonality, even if there are also some intervention opportunities that are related to specific causes."

The first data on the Plan All-Cause Readmissions shows that some areas are doing better than others. Seattle region had the best performance, for both commercial and Medicare plans. In the commercial sector, there was about 15% less readmission than expected. Kansas City region had the worst performance in both commercial and Medicare, with about half a percent more readmissions than expected in commercial plans.

But overall for both Medicare and commercial plans, there were slightly fewer readmissions than expected.

To continue on this path, hospitals should be looking for problem areas in care transitions, improve transition planning with the receiving care setting, and letting the patient's usual doctor know of the transition. They can improve communications with patients about the pending transition of care, and their health status and plan of care. For high-risk patients, the report suggests hospitals work on creating systems that proactively coordinate services and educate patients and caregivers about how to prevent bouncing back to the hospital.

"This is an issue of equity and disparity," Barton says of the effort made on the measure and data collection. "When you don't measure all-cause readmission, you don't have information on people who have COPD and CHF. You have one or the other. This is meant to be an instigator for system thinking, for a broad look that will help patients make successful and safe transitions."

RESOURCE

For more information on this topic, contact:

• **Robert Saunders**, PhD, Assistant Vice President, Research and Analysis, NCQA, Washington, DC. Telephone: (202) 955-1746.
Mary Barton, MD, Vice President Performance Measurement, NCQA, Washington, DC. Telephone: (202) 955-3500. ■

Study: Cases at end of hand-off get less time

Experts advise steps to prioritize complex cases

A new study, led by researchers at the University of Michigan (UM) in Ann Arbor, suggests that clinicians might not be spending enough time discussing some of the most complex patients when they are handing off these cases during shift changes. And there is a simple reason why, according to Michael **Cohen**, PhD, professor of complex systems, information, and public policy at UM.

"We found that even when the physicians are very experienced, they spend about 50% more time on the patients discussed early in a hand-off than they do on those discussed near the end of the session," explains Cohen. "This was true despite the fact that they were working from a list ordered by room number, and so they were taking the patients essentially in random order."

Cohen's study consisted of an analysis of 23 hand-off sessions, involving 262 patients in the intensive care unit (ICU) at Kingston General Hospital in Ontario, Canada. The physicians turned over between six and 23 patients in each of nearly two dozen hand-off sessions. While the physicians spent, on average, 2.5 minutes per patient, this varied significantly. The researchers report that for physicians who were handing off medium-sized groups of 11 patients, the average time spent per case steadily declined as the physicians moved down the list of patients to be handed off.[1]

Consider 'the portfolio effect'

While this study involved patients in the ICU, Cohen says that the findings should apply to hand-offs in the ED as well as other hospital units. Regardless of the unit or setting, people tend to rush at the end, an observation that should be familiar to people who regularly attend other types of meetings, he says.

However, hospital hand-offs can have a major impact on patient care, particularly in the early parts of a shift. More than a billion of these hand-offs happen in the United States every year, according to the researchers. And they say the number has increased substantially in recent years, as administrators have become more focused on enforcing work-hour regulations.

While patient safety breakdowns during hand-offs have received considerable attention among researchers and quality experts, Cohen points out that most of the training in this area focuses on how to hand off a single patient as opposed to groups of patients. He suggests a better approach would take into consideration the fact that most hand-offs happen in batches. And the results, which he calls "the portfolio effect," can adversely impact patient safety.

Cohen says he has observed hand-offs in which key details were left out of the conversation about a patient. Indeed, the Institute of Medicine reports that preventable medical errors cause as many as 98,000 deaths each year, and studies show that hand-off miscommunications are a major contributing factor. Considering the hundreds of millions of hospital hand-offs that occur every year, Cohen argues that even a slight improvement in hand-off communications could prevent a huge number of injuries and deaths.

Try simple remedies

Cohen points out that informal observations suggest that the problem is "very widespread," but he says it is easy to assess whether it is happening, and there are a number of relatively simple remedies. "The key point is for the off-going physician to begin the [hand-off] session identifying the cases that need the most time," says Cohen, noting that these cases can then be taken at the beginning of the session. "The whole patient list can be ordered by the time required, or time can be preserved later on for the cases that need it."

While the changes required are not difficult, Cohen stresses that participants, whether they are physicians or nurses, need to become mindful of how much time they have to allocate across all the cases so that they can then put in the time where it is most needed.

REFERENCE

1. Cohen M, Ilan R, Garrett L, et al. The earlier the longer: Disproportionate time allocated to patients discussed early in attending physician handoff sessions. *Archives of Internal Medicine* 2012 [Epub ahead of print]

Source

Michael Cohen, PhD, Professor of Complex Systems, Information, and Public Policy, University of Michigan, Ann Arbor, MI. E-mail: mdc@umich.edu. ■

COMING IN FUTURE MONTHS

- Helping the frail elderly stay safe at home
- Career opportunities for case managers
- Case management in primary care settings
- Collaboration through the continuum of care

CNE QUESTIONS

1. According to Toni Cesta, RN, PhD, FAAN, senior vice president, operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, reasons patients are readmitted within 30 days of discharge include which of the following?
   A. Poor or inadequate discharge plan and discharging the patient too soon.
   B. Having to plan for follow-up care and medication compliance issues.
   C. The patient's failure to see a physician for follow-up within a week after discharge.
   D. All of the above

2. What is the caseload of Blue Cross Blue Shield of Arizona Advantage case managers, who make at least one home visit to their patients?
   A. 20 to 30.
   B. 30 to 40.
   C. 50 to 60.
   D. 70 to 75.

3. How often do case managers call at-risk patients after discharge to go over the discharge plan and answer questions and concerns?
   A. Days 2, 7, 14, 21, and 28 after discharge.
   B. The day after discharge and once a week after that.
   C. Within three days after discharge and then as necessary.
   D. Days 3, 14, 21 and 28 after discharge.

4. Members in WellPoint's Medicare Advantage plans who have clinical gaps in care may receive as many as six phone calls a year if they haven't received the recommended tests and procedures.
   A. True
   B. False

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. ■