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

May 2013: Vol. 24, No. 5
Pages 49-60

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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.

Primary care — the new frontier for case managers?

Opportunities abound in physician offices

As payers and providers recognize the value of care coordination for people with chronic conditions and complex care needs, opportunities are opening up for case managers in primary care practices.

Consider these facts:

• Aetna has embedded or dedicated its own case managers to 75 provider facilities across the country where they work with physicians and staff to coordinate care for patients with chronic conditions and advanced illness.

• Primary care providers who participate in Cigna's Accountable Collaborative Care program are required to employ care coordinators to act as a link between the patients, the providers, and the health plan.

• Advocate Health, a Chicago-based health system that includes 12 acute care hospitals and more than 250 sites of care, embeds case managers in primary care practices when the size of the patient population warrants it.

Case managers have new opportunities as the medical home model evolves and providers and payers recognize the value of care coordination, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM,

EXECUTIVE SUMMARY

Case managers have an increasing number of opportunities in primary care as providers and insurers look for ways to improve the health of patients and reduce the need for interventions.

• Case managers can take the time to get the whole picture of the patient's situation and follow up to reinforce the physician's treatment plan.

• Primary care case managers follow patients long-term and have a chance to see the effect of their interventions.

• Case managers build relationships with their patients and often can elicit information that physicians never have time to find out.

president and founder of Mullahy and Associates, a case management consulting firm based in Huntington, NY.

Physicians don't have the time to spend with complex patients who need assistance in managing their conditions or illnesses. Case managers do have the time to work with patients and drill down to identify barriers to adherence that providers may miss, Mullahy says. "There is a definitely a need in group medical practices for someone who has the knowledge, the skills, and the time to help patients access community resources, learn about their medication regimen and treatment plan, and ensure that they have recommended tests and procedures," she adds.

The medical group practice, the insurer, and the patients benefit when case managers are embedded in a primary care practice to help patients manage their chronic conditions and stay out of the hospital, Mullahy says.

Colleen Holland, RN, CCM, loves her job as an Aetna case manager embedded in the Cleveland Clinic and works as a team with two Cleveland Clinic case managers to coordinate care for at-risk patients covered by Aetna's Medicare Advantage plan who have been recently discharged from the hospital or who need help managing their chronic conditions.

Embedded case managers have the opportunity to build relationships with their patients and stay with them until they have good outcomes, Holland says. "A lot of times, nurses in a hospital setting follow patients for only a short time and never know what happened. Being a case manager gives me the chance to know that I am helping my patients over the long term. It's very rewarding," she says.

She contacts her patients by telephone and works with the Cleveland Clinic team to connect patients with other assistance beyond telephone coaching, such as community services and psychosocial support. The case managers work together to enroll the patient in Cleveland Clinic or Aetna programs that can help them manage their conditions and avoid readmissions.

"It's more than just making phone calls. It's helping them work through the system. The healthcare system is overwhelming to many people, especially the elderly. Some find it hard to call the doctor's office and they are grateful when I offer to send the doctor a message to call them," she says.

Many times, elderly patients are taking multiple medications and may not follow their discharge instructions when they get home. "They appreciate having someone to walk them through the discharge plan and tell them which medications to take. They know that I am just a phone call away if they need help, and when I call them, they sound happy to hear from me," she says.

Embedded case managers can work closely with primary care physicians to determine patients' needs beyond the reason for the office visit and to support the physician's plan when between office visits, says **Sharon Rudnick**, vice president for outpatient care management for Advocate Health

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.

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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**

in Chicago. "They make sure the plan of care is going well rather than waiting for something to go wrong that will bring the patient back in or will result in an emergency department visit or hospital admission," she says.

Most medical practices do not have an infrastructure in place to manage people who are not in the office, says **Randall Krakauer**, MD, national medical director for Aetna Medicare. Aetna has embedded or dedicated case managers in 75 provider care sites nationwide. Case managers can fill that gap by checking up to make sure the patient has gotten his prescription filled and understand the treatment plan, Krakauer says.

"When physicians see patients in a hospital and write a set of orders, they have a high level of confidence that their orders will be carried out. If they see them in the office, they have a low level of confidence that patients are going to follow their treatment plan," he says.

That's where an insurer's expertise and experience in case management is invaluable, he adds. "We have case managers who are trained and experienced and who can produce good results. We take our capabilities and combine that with the medical practice to create something better than either of us can do ourselves, and that's provide better care for our members and the physicians' patients," he says.

Embedded case managers know the work flow of the practice and build a good working relationship with the physicians and the rest of the staff, says **Lauri Rustin**, chief executive officer of Fairfax (VA) Family Practice , a physician practice group with 12 practice sites that participates in Cigna's collaborative accountable care model. The practice has one care coordinator and plans to hire another one.

Physicians trust the care coordinator and welcome the information she can provide, Rustin says. "They have access to information in the electronic medical record to help them coordinate care, and because they have a good relationship with the staff and the providers, they can communicate with them quickly. They can gather information from the insurance company and the patient that helps the physician decide what course of treatment will be best for the patient. Then, they work with the patient to reinforce the patient's plan of care," she says.

One advantage of having care coordinators embedded in the physician practice is that when they call patients, it shows up on caller ID that the call is from the doctor's office. "The perception is entirely different when a doctor's office calls than when an insurer calls. Patients are more likely to answer a call from their doctor," says **Harriet Wallsh**, director of collaborative solutions and effectiveness for Cigna.

Holland recommends being an embedded case manager if you are someone who wants to be on the cutting edge of healthcare and like working independently.

"Embedded case managers have to be able to prioritize their work and make quick decisions, such as whether to suggest that a patient go to the emergency room or instruct them to call their doctor. It's not a job for someone who needs a lot of guidance or who prefers a slow pace," she says. ■

Embedded CMs cut admissions, LOS

Good relationships are key to success

Since Advocate Health Care began embedding case managers in primary care offices, hospital admissions and emergency department visits have decreased and length of stay has dropped, says **Sharon Rudnick**, vice president of outpatient care management for the Chicago-based health system. Advocate Health Care includes 12 acute care hospitals and more than 250 sites of care with about 4,000 physicians, a quarter of them employed by the health system.

It's all about building relationships, Rudnick says. Care managers, who work on site directly with physicians, know what is expected and how to support a treatment plan between visits. "Our dedicated care managers work very hard

EXECUTIVE SUMMARY

Advocate Health Care's embedded case management program has helped reduce hospital admissions as well as length of stay.

- CMs at the larger sites meet patients in person and follow up by telephone. Telephonic case managers work with patients at several small sites.
- They look beyond the physical needs and assess for psycho-social issues that could interfere with the plan of care.
- Case managers may be RNs or social workers and have a caseload of 80 to 120 patients.

to develop close working relationships with the physicians," she says.

The arrangement also helps the care managers cement their relationships with the patients whose case they are coordinating, she adds. "When patients know that care managers are part of the physician office team, it helps build trust more quickly than if someone they know nothing about approaches them," she adds.

The larger practices have care managers on site who meet with patients when they come in for visits and follow up by telephone. In smaller practices, they work with patients by telephone. Each care manager is assigned by physicians and works as a team with his or her providers. "This way if a patient calls into the physician office and wants to talk to the case manager but doesn't remember the name, the front desk staff knows instantly who should get the call," Rudnick says.

Patients in the program are identified by predictive modeling or referrals from the emergency department, the acute care hospital, a post-acute facility or their physician.

"Physicians may know that a patient already had an acute event or is having other problems and they can anticipate that they will need care coordination," she says.

Care managers reach out either in person or over the telephone and work with patients to create individual care plans that engage patients in their own healthcare. They work to identify patient needs that can range from gaps in care to psychosocial issues. "The care managers look beyond the patient's physical needs and link them with resources that can help. For instance, a patient with diabetes also may be struggling to care for an elderly parent and needs assistance," she says.

Care managers use a case management tool that helps them assess the patient and prompts them as to which questions to ask.

Depending on the physicians' preferences, care managers meet with the patients during the office visit or come in at the end as the physician is leaving.

Recognizing that patients don't always remember everything the physician told them, the care manager reminds them by saying something like: "remember when Dr. Jones told you …" and the instructions come back into their minds, she says.

The care managers have a caseload of 80 to 120 patients with both Medicare and commercial insurance.

Advocate Health Care's care managers are either RNs or social workers and are trained on motivational interviewing and engaging patients.

"The nurses and social workers each have their own strengths. If it's a complex clinical case, the social worker may need assistance from the RN. If the nurses need help in working through the barriers to care, they can call on the social workers," she says.

The majority of patients receive care in 12 hospitals in the Advocate network. The primary care case managers share information with their counterparts in the hospital and work with them on a smooth transition. Then at discharge, the primary care case manager picks up the case again. "It makes our patients feel cared for across the continuum and helps facilitate good transitions in care," she says. ■

Embedded CMs work with health plan CMs

Collaboration results in better care for patients

Aetna started partnering with physician practices to improve outcomes by coordinating care in 2007 before the term "accountable care" came into use, says **Randall Krakauer**, MD, national medical director for Aetna Medicare.

The insurer has embedded or dedicated case managers in 75 practices throughout the country where they work with physicians and staff to coordinate care for Medicare Advantage members with chronic illnesses and advanced illnesses. "They are employed by Aetna, but they become

EXECUTIVE SUMMARY

Aetna's embedded or dedicated case managers who work with primary care physicians have achieved a 12% reduction in acute care days above and beyond the reductions generated by the insurer's in-house case managers.

- Case managers work closely with physicians in the way that the individual practices choose, and although they are employed by the health plan, they serve as case managers for the physicians.
- Patients in the program are targeted by the health plan's risk assessments as well as referrals by physicians.
- Some case managers work with their patients face to face. Many work with them telephonically.

indispensible to the physicians and their staff. Our case managers become the physicians' case managers," Krakauer says.

Aetna spent a great deal of time and effort over the years into building a robust and effective internal case management program, Krakauer says.

"Case management serves us extremely well. We had impressive results on improving chronic illness and advanced illness, but we wanted to get closer to the scene of action and partner with provider groups to provide case management and do a better job," he says.

The initiative is working, he says. In 2010, across all participating Medicare Advantage members, the embedded case management program produced a 12% reduction in acute care days, in addition to reductions already achieved by Aetna's internal case management program, he says.

Aetna's embedded case managers work in medical groups, including primary care and multi-specialty practices, integrated health systems, and with some independent physicians whose offices are in close proximity to each other.

Each practice chooses an appropriate population to target in the program and develops outcomes metrics that include recommended tests and procedures and chooses how the case managers will operate. The case managers typically work with members by telephone, but some are beginning to see patients face to face at the physician office and visit them at home. "We adapt what we do to the environment of the practice," he says.

Aetna identifies patients for case management using its health risk assessment and predictive modeling, but many of the members in the program are identified by their physicians. "Providers can identify issues that members may not report on the health risk assessment and they can identify people who need care coordination earlier than when the claims come in. Often the people in the office have a better perception of which patients need interventions than we do by looking at the data," Krakauer says.

The case managers collaborate with physicians and their staff to determine the needs of targeted patients and to identify barriers to adherence. "Because of the good relationship, physicians can contact the case manager when they are concerned about a patient and ask for follow-up phone calls to make sure the patient has filled his prescription and is following the treatment plan," he says.

The health plan hires case managers who can build relationships and work largely on their own. They work in the physician practices but report to their supervisors at Aetna.

Aetna's case managers are predominately nurses, but some are social workers and psychologists with clinical experience.

Some Aetna embedded case managers are already employed by the company; others are hired in the local market. "We screen them carefully, train them in geriatric care and change management, and mentor them. It's important to have good people who can create a good personal relationship with the medical staff and the patients," he says.

The case managers meet with the primary care practice team to discuss the needs of patients targeted for the program and identify barriers to adherence.

"We hire people with a real passion for working with people. The key to successful case management is not technology or a script. It is the ability to develop a good personal relationship," he says. ■

Care coordination generates savings

Model calls for CMs in primary care offices

A study of three primary care practices that participate in Cigna's Collaborative Accountable Care model, which includes care coordination for at-risk patients, showed significant cost savings and improved quality of care when compared with other practices in the same geographic area.

Cigna developed collaborative accountable

EXECUTIVE SUMMARY

A study of Cigna's Collaborative Accountable Care Model, which requires participating physician practices to employ RN care coordinators, showed significant savings and improved quality of care.

- The health plan provides reports on gaps in care, unfilled prescriptions, hospitalizations, and other data that help the care coordinators choose the patients with which to intervene.
- The embedded case managers access their patients' electronic medical records as well as health plan data to develop a plan of care.
- They work with Cigna case managers to determine what benefits the patient has to help them adhere to the treatment plan.

care in 2008 as a way to create a patient-centered approach and an outcomes-based payment system, says **Harriet Wallsh**, director of collaborative solutions and effectiveness. One of the requirements for the program is for the practice to employ an RN care coordinator to work with patients and providers. "The care coordinators are the link between the patients, the doctors, and the insurer," Wallsh says.

In a typical practice, about 3% to 5% have chronic conditions or complex care needs that make them eligible for the care coordination program, Wallsh says.

Cigna aims for a ratio of one care coordinator for every 10,000 Cigna customers and provides an extensive educational program that orients the care coordinators on how to use the patient-specific data that Cigna provides. Where the nurses are located is up to the individual practices, Wallsh says. Some physician groups with multiple offices may have care coordinators in a central location. Some meet the patient person to person, but many work with them on the telephone. *(For details on how one physician practice's care coordination program works, see the next story).*

The health plan provides detailed reports to the nurse care coordinator on a daily, monthly, and quarterly basis that helps him or her target patients for interventions. The reports include patients with gaps in care, patients who are not filling prescriptions in a timely fashion, and those who are in the hospital, as well as those the health plan determines by predictive modeling are at risk for an inpatient admission, an emergency department visit, or exacerbation of a chronic condition.

"We share information that helps the nurses identify patients who need a higher level of touch and they contact the patients," Wallsh says.

The care coordinators have access to claims information from Cigna as well as information in the patients' medical records. "This gives the clinical staff the big picture about the patient that enables them to put together a comprehensive plan," she says.

For instance, if the nurse care coordinators see that a patient has missed appointments or has gaps in care for recommended diabetes care, they call their counterparts in Cigna to see what benefits the patient's employer has that could help him manage his diabetes. "Then the care coordinator calls the patient with full knowledge of Cigna programs or local programs for diabetics," she says.

"The care coordinators prevent fragmentation of care by identifying patients in need and intervening," Wallsh says.

When care coordinators get a report that patients are in the hospital, they call them while they're still in the hospital or immediately after discharge and help them set up follow-up appointments with their primary care physician. The care coordinators at the medical practices work closely with the Cigna case management staff and each embedded care coordinator is assigned to a specific Cigna staff member. "This gives both nurses the opportunity to build a relationship and provide better continuity in care," Wallsh says. ■

CMs build relationships with physician practice

Nurses work with insurer to fill gaps in care

When patients at Fairfax (VA) Family Practice who are covered by Cigna are hospitalized, the primary care practice's care coordinator calls them not necessarily to intervene in every case, but to let patients know that their physician office cares to make sure they're recuperating and assess their needs.

"Sometimes, the patient doesn't have any needs, but the fact that someone from the physician office is checking on them helps build the relationship that is key in a medical home," says **Lauri Rustin**, chief executive officer of Fairfax Family Practice, which participates in Cigna's Collaborative Accountable Care model. The primary care provider has 12 practice sites staffed by about 108 providers. The practice has one care coordinator, with plans to hire a second nurse in 2013.

Cigna sends the practice a daily report of patients in any facility, including hospitals and long-term acute care hospitals. "Our care coordinator monitors these daily reports until the patient no longer is on the report. As soon as patients are discharged, she contacts them to get them into the office within seven days," says **Susie Smith**, PhD-c, RN, NE-BC director of quality for the physician practice.

The practice also participates in a residency training program for family practice physicians through Virginia Commonwealth University. "The residency program helps us coordinate care with our patients who are hospitalized because we have people in the hospitals who can give us the information we need for follow-up care," she says.

When patients are discharged, the care

coordinator contacts them and assesses their needs, then works with a Cigna case manager to determine if the patients have benefits that could help them, such as smoking cessation, weight loss programs, or chronic disease management. The care coordinator checks the electronic medical record for patient medication and compares it with the medication prescribed in the hospital. She works with the patient's primary care physician to get orders for physical therapy, durable medical equipment, or other post-discharge needs.

"The care coordinator is the health coach within the team the physician oversees. They see that the physicians have better information and that the patients have better access to the resources they need," Smith says.

Depending on the needs of the patients, the care coordinator may make multiple telephone calls over a period of time, checking back to see how the patients are doing and helping them navigate the healthcare system.

For instance, one patient was being denied coverage for back surgery after it was completed because of a misunderstanding between the provider and the insurer. "Because our care coordinator had a relationship with Cigna, she could go directly to the right person and get the problem cleared up," Rustin says.

The care coordinator works with patients who have had a hospital stay as well as those who are frequent users of the emergency department or have incurred high healthcare costs.

"When patients who are high cost are on the list from Cigna, the care coordinator reviews the medical record, then calls the patient to find out what is going on," she says. ■

Faster care for sickle cell patients in the ED

Giving patients control boosts satisfaction

Great strides have been made in the treatment of sickle cell disease, the inherited blood disorder that occurs most commonly in African-Americans. Patients with the disease used to die before reaching adulthood, but today many patients live well into their 40s and beyond. However, experts point out that sickle cell patients often have a difficult time getting the treatment they need when they present to the ED for care.

"Sickle cell disease is a chronic, life-long illness with acute episodes of pain that are really severe," explains **James Eckman**, MD, director of the Georgia Comprehensive Sickle Cell Center at Grady Memorial Hospital in Atlanta. "When patients go into pain, they usually treat it at home, but when that doesn't work, they tend to go to the ED, and EDs are really busy. The waits to get in and actually to be seen are often quite long."

Another issue may then compound the suffering that sickle cell patients face while awaiting care. "These patients are primarily presenting with extreme pain but no other physical findings or lab changes to indicate whether or not they are in a crisis, so they are commonly not believed," adds Eckman. "This is really one of the main issues that causes difficulty with the disease — not only for the patients because they are suffering from pain, but also for health care systems because they really have a great deal of difficulty dealing with these patients in the ED."

Grady has eliminated this problem by creating an emergency clinic specifically for the management of sickle cell disease pain. It is open 24/7 so sickle cell patients who are experiencing a pain crisis can simply bypass the ED and go straight to the emergency clinic. "We offer eight hours of intensive treatment with pain relief and IV hydration," says Eckman. "About 80% of the time that is adequate so that the patients can then go home on oral therapy. If it is not, and their pain is too great, then we admit them to the hospital."

While most EDs do not see enough sickle cell patients to warrant a separate emergency clinic just for these patients, some hospitals have taken steps to optimize care for these patients so that they don't suffer the indignity of not being believed, and they don't have to wait two or three hours for the analgesic therapy and IV hydration they need to relieve their acute pain.

Implement a protocol

For example, **Matthew Lyon**, MD, RDMS, the director of the observation unit in the ED at Georgia Health Sciences Medical Center in Augusta, has developed a protocol so that all sickle cell patients who present to the ED with pain will be sent directly to the observation unit for treatment as soon as any potential complications related to sickle cell disease are ruled out. The approach is designed to eliminate treatment delays and improve management of the relatively large population of sickle cell patients in the Augusta area.

Lyon, who has been fine-tuning the protocol for

years, developed the approach because he observed evidence that many sickle patients were being treated as if they were drug seekers when they presented with true pain crises. "Sickle cell patients kind of get lumped into that group of patients because they don't exhibit pain the way you or I would," he explains, noting that many of these patients have lived with pain their entire lives.

A sickle cell pain crisis typically lasts for 10 to 14 days, but what used to happen is that patients presenting to the ED in severe pain would be under-treated. "If you under-treat their pain in the ED, and then the pain goes on more than a few days, then they end up coming back," says Lyon. "Then they look like they are seeking drugs when really they are just trying to find relief for their pain."

To fix the problem, Lyon decided to use the observation unit as a tool to eliminate the opportunity for such judgments to impact care, and to standardize the way sickle cell patients are treated. As a result, the wait time for sickle cell patients who present to the ED with a pain complaint is now less than 15 minutes. "They are bypassing the normal processes because we know what is wrong with them, we already have a diagnosis, and we have already screened out most of the bad things, and so they are ready to be put on the treatment plan," notes Lyon. "The quicker we can start them recovering from their pain, the quicker they can go home, which is really the goal — to decrease admissions and to improve their care."

Give patients some control

Under the sickle cell protocol, the nurses in the observation unit will immediately start the patients on fluids, oral medications, and a patient-controlled pump for their narcotics. "That was an adjustment we made right at the beginning, and the reason for [the patient-controlled pump] is so that the patients can control how much pain medication they are receiving," says Lyon. "They are not over-dosed or under-dosed, and they are not having to listen to someone tell them that they don't really think they are in pain. There is no one making that determination except the patient."

With the pump, the patients get a continuous infusion per hour, although the machine limits how much they can receive. "Generally what you will see is that when someone comes in with acute pain, they will be pushing the button fairly rapidly, perhaps five to seven times per hour," says Lyon. "As their pain comes down, they may only push it two times per hour, and then as their pain starts being well-controlled, they might not be pushing the pump at all."

When the patients stop pushing the pump, they are generally ready to go home, but it is up to them to make the decision that they can handle their pain on their own with oral medications. "What we have found is that our typical length-of-stay (LOS) for sickle cell patients is 16 hours," says Lyon. "Most of the patients stay a little bit longer than they would in the regular ED. However, our admission rate with these patients is very low."

Lyon aims for an admission rate that is below 15%, and he is generally able to keep it at about 12%. This compares very favorably to the 40% or 50% admission rate that results when sickle cell patients receive typical care in the ED, he says. "And there is a downstream impact, too. When our sickle cell patients are admitted from the observation unit, their admission LOS is about three days," says Lyon, noting that the approach slices about two inpatient days off of what typically happens when sickle patients are admitted directly from a traditional ED.

While it can be difficult to provide these patients with the optimal dose of narcotics when they present to the ED with a sickle cell pain crisis for the first time, Lyon uses a database to track the care that each patient receives so that it can be used as a reference for future visits. "That allows us to give each of our patients an individualized dose so that every time they come in they will get the exact same dosage of meds," says Lyon. "I adjust the dosages over time, but this takes a lot of the anxiety away from the patients because they know exactly what they are going to get every time they come in. They know what their situation is going to be and what is going to happen."

Consider patient and provider satisfaction

Eliminating anxiety from the equation can only help these patients recover from their pain crisis more quickly, and they are also more satisfied with their care, says Lyon. "The providers are happier, too. Emergency physicians don't have to feel like they are negotiating with patients," he says. "This is taking a subset of patients and moving them into a controlled setting where the physicians don't have to have any anxiety about under-treating or over-treating them. It is just part of the standardized pathway."

What's more, with the protocol in place, the nurses in the observation unit have become experts in sickle cell care just as they are experts in treating

low-risk chest pain, another major pathway in the observation unit, says Lyon.

Roughly 50 sickle cell patients a month are treated in the observation unit at Georgia Health Sciences Medical Center. This is, in part, because Georgia Health Sciences University operates a comprehensive sickle cell center and clinic nearby, and this draws patients from surrounding communities. However, Lyon believes his specialized protocol could work well in other EDs that may not see large numbers of sickle cell patients or even have observation units. In fact, he is currently using grant funding to help EDs in other communities put his protocol in place.

"I am going to places that don't have sickle cell centers to set this up because I believe this is the best way to treat people," says Lyon. "It is best for the patients, but it is also best for the health care systems. It can save them a lot of money from [the avoidance of] repeat admissions."

Sources

• **James Eckman**, MD, Director, Georgia Comprehensive Sickle Cell Center, Grady Memorial Hospital, Atlanta, GA. Phone: 404-616-3572.
• **Matthew Lyon**, MD, RDMS, Director, Observation Unit, Emergency Department, Georgia Health Sciences Medical Center, Augusta, GA. E-mail: mlyon@georgiahealth.edu. ■

CMS pilots discharge planning, quality surveys

Tools created to go with infection control survey

The Centers for Medicare & Medicaid Services (CMS) has started pilot testing of two more survey tools to go with the infection control pilot it began testing last year. The new tools are for hospital activities related to quality assessment and performance improvement (QAPI) and discharge planning and are already being used by state survey agencies, according to a CMS spokesperson who asked to remain anonymous.

The spokesperson says that they will be used separately during the pilot phase and that CMS is seeking feedback from surveyors and hospitals about the worksheets under consideration. Which hospitals are chosen for the pilot tests is, itself, being tested, says the spokesperson. CMS will look at readmissions data and use the knowledge of hospitals accrued by the state surveyors in past surveys. So a hospital that has higher risk-adjusted, all-cause readmission rates, or a hospital that a surveyor has found issues with previously is more likely to encounter the pilot test. Hospitals that don't meet the criteria of the tools won't be cited during the pilot phase.

Testing is due to be completed in a few months, and then revisions to the tools will be incorporated. The spokesperson says there is no word on when a final tool will be ready for surveyors. The infection control tool, in use for more than a year, has already had some tweaks due to comments from users, but there is no word on when it will be put into use officially, either. It has been praised by infection control professionals.

The new tools still need some work, though. "There is no instruction manual that goes with the tools," says **Patrice Spath**, RHIT, a quality consultant at Brown-Spath & Associates in Forest Grove, OR. "So a lot of the questions asked are very subjective. There is nothing here that defines the terms." For example, in the discharge planning tool, question 4.2 asks: Can hospital staff demonstrate that the hospital's criteria and screening process for a discharge planning evaluation were correctly applied? "But is that verbal demonstration? Written in the record? They don't tell you, and your assumption of what qualifies as 'demonstrate' may be different from the surveyor's."

Another discharge planning question Spath thinks needs clarification is 4.6, related to evaluating the post-discharge needs of the patient in the environment from which the patient was admitted to the hospital. "Not all patients go from the hospital back to the place they came from," she says. "You might have a patient admitted from home, but going to a skilled nursing facility. Why would you need a home assessment then?"

In general, Spath says that many of the questions are similar to what you would expect from Joint Commission surveys, so incorporating these pilot tools into your current tracers could help you determine if you are meeting both Joint Commission and CMS requirements. But beware that things will change in the pilot tools. "Use this as a guidepost," she says. "It could be useful to understanding the CMS requirements and knowing what may be a focus in a survey. These are the things that will probably have a high priority when a surveyor comes."

In the QAPI survey, Spath says many of the questions have a "flavor" similar to Meaningful

Use Stage 1 requirements, and she wonders if the Government Accountability Office will incorporate those questions into the audits they do for Meaningful Use. For example, question 3.1: Can the hospital provide evidence that each quality indicator selected is related to improved health outcomes? (e.g., based on QIO, guidelines from a nationally recognized organization, hospital-specific evidence, peer-reviewed research, etc.). "I could say yes to that, but will anyone be showing up to check on that?"

She also thinks that some of the questions are difficult to interpret, and that some organizations could be cited, even accused of fraud, simply because the questions are difficult to understand. "I may think I'm doing something, I may think that I meet the requirements related to following specific data specifications, but am simply unclear on what the question really means." This is, of course, why a pilot survey is done, and Spath thinks that comments on confusing areas will be helpful to CMS.

At the very least, look at the surveys, she says. Follow the news as the pilot progresses and changes are made to the tools. They can be a useful way to know how you are doing and to ascertain the areas that are of interest to CMS and the state surveyors.

All three of the CMS surveys are available at: http://ow.ly/hJt1C.

For more information on this topic, contact Patrice Spath, RHIT, Principle, Brown-Spath & Associates, Forest Grove, OR. Email: Patrice@brownspath.com. ■

TJC certifies primary care medical homes

Aim is to smooth transitions

Hospitals that have physician offices connected to and affiliated with them now have another option for getting certified for a Primary Care Medical Home. Along with programs run by the National Committee for Quality Assurance (NCQA), The Joint Commission started offering such certification in late February.

Based on the Agency for Healthcare Research and Quality model, the certification focuses on patient-centered care, care coordination, superb access to care, and a systems-based approach to quality and safety, says **Mark Pelletier**, RN, MS, interim chief operating officer and director of accreditation and certification services at TJC. "We built our standards on those definitions, and they require that an organization supply timely, evidence-based treatment. This will result in higher patient satisfaction, improved outcomes, and also reduced costs."

There are some additional standards included in the TJC program that others do not have, and Pelletier emphasizes that they require a site visit, not a desk review of policies and procedures. For hospitals getting such certification, it will add at least an extra day to the general survey process. "I think our scope of accountability is broader than what's out there, and we add requirements for oral health and end-of-life care." The TJC model also includes standards related to health care literacy for patients, as well as proof of competency of the primary care clinician and care team. "It has to be an interdisciplinary team working in the primary care medical home," he explains.

While the physician offices will handle the bulk of the preparation for the primary care medical home survey, there will be some impact on hospital-based quality managers. "You won't be leading the charge, but you will probably be called on to assist with preparation."

Keeping patients in the community

Despite the fact it might cause you some extra work, Pelletier thinks this is something that all appropriate hospitals should consider. "This is what is expected from the government after healthcare reform. We have to improve outcomes and make healthcare more efficient. This will help with that. And the good thing is that when you do that, you will have fewer readmissions, which will be an increasing financial burden for hospitals that don't address them."

Take typical congestive heart failure patients, who are the most likely type of patient to come back to the hospital because they can't get in to see a primary care physician in a timely manner. Having that medical home connected to the hospital will help to smooth that transition and make it easier for patients leaving the hospital to see their doctors quickly.

Keeping patients out of the hospital and in the community is the idea behind medical homes, and while it might seem strange to think of a hospital trying to keep customers away, that's the right thing to do and increasingly, the thing that will

help hospitals financially.

"I think this is the best thing for patients, and that should make it exciting. Look at the return on investment. If you invest in that primary care medical home model, you can accomplish savings to the organization as a whole."

The standards for certification as a primary care medical home are available at http://www.jointcommission.org/accreditation/primary_care_medical_home_certification_option_for_hospitals.aspx.

RESOURCE

For more information, contact: Mark Pelletier, RN, MS, Chief Operating Officer, Joint Commission, Oakbrook Terrace, IL. Email: mpelletier@jointcommission.org. ■

South Carolina hospitals collaborate on safety

Working with TJC to improve systems

The Joint Commission's Center for Transforming Healthcare has started working with 20 hospitals in South Carolina to improve their safety by examining systems, processes, and structures in an effort to minimize variability in practices.

Focusing on elements perfected by high-reliability industries, the hospitals will meet regularly to create projects, do survey assessments about their organizations, and come up with ways to improve what they do so that harm is reduced, quality is improved, and costs decrease. They will use a Web-based application to figure out which practices to focus on and assess how they are doing in those vital areas.

"Eventually, we hope this will include all the members of the South Carolina Hospital Association," says **Colleen Smith**, RN, MBA, CPHQ, director of high reliability initiatives at the Joint Commission Center for Transforming Healthcare. "The other hospitals will be pulled in as the work moves forward," she says.

What is different about this collaboration is that it isn't a single project. "There is no end point," says Smith. While the commission will stop working with the group in three years, the aim is for life as South Carolina hospitals know it to change forever with this collaboration. Once they start, they don't stop.

"The work of high reliability is forever," she says. The initiative came from South Carolina to The Joint Commission, in part because of personal relationships between leaders at TJC and the hospital association. It's possible that in the future, success in South Carolina might breed other such efforts in other states.

Over the summer, and regularly after that, the collaboration will update watchers with news of its efforts and the results they achieve. Tools they use may also be made available to the wider public.

For more information on this topic, contact Colleen Smith, RN, MBA, CPHQ, Director, High Reliability Initiatives, Joint Commission Center for Transforming Healthcare, Oakbrook Terrace, IL. Email: csmith@jointcommission.org. ■

COMING IN FUTURE MONTHS

- Tips for working with diabetic patients
- Managing the care of senior citizens
- Insurers, providers collaborate on readmissions
- Why healthcare literacy is important

CNE QUESTIONS

1. Colleen Holland, RN, CCM, an Aetna case manager embedded in the Cleveland Clinic, finds her job satisfying for what reason(s)?
   A. She builds relationships with patients over time.
   B. She can see the results of her interventions as patients' conditions improve.
   C. She can help patients, especially the elderly, navigate the complex healthcare system.
   D. All of the above.

2. What is the caseload of case managers embedded in primary care practices that are part of Advocate Health Care?
   A. 20 to 30.
   B. 50 to 75.
   C. 80 to 120
   D. 100 to 150.

3. In practices participating in Cigna's Collaborative Accountable Care model, what percentage of patients typically have chronic conditions or complex care needs that make them eligible for care coordination?
   A. 2% to 3%.
   B. 3% to 5%.
   C. 5% to 8%.
   D. 8% to 10%.

4. When a Cigna member who is a patient at Fairfax Family Practice is hospitalized, the care coordinator calls them to get them into the office in what time period after discharge?
   A. Five days
   B. Seven days
   C. Ten days
   D. Two weeks

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. ■