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Coordinate care for physical, mental health issues

Each condition can affect the other

Healthcare organizations are recognizing that medical problems and mental health conditions often are intertwined and that each condition exacerbates the other. Organizations are taking steps to improve communication between mental health and physical health providers.

A tremendous body of research shows the connection between physical and mental health. For instance, in the *Preventing Chronic Disease* journal published by the Centers for Disease Control and Prevention (CDC), **Daniel P. Chapman**, PhD, and colleagues wrote that a review of published materials showed that mental illnesses were associated with increased prevalence of chronic diseases and that the association "appears attributable to depressive disorders precipitating chronic disease and to chronic disease exacerbating symptoms of depression."[1]

Their review of articles showed that nearly 50% of asthma patients may have significant depressive symptoms and that 87.5% of people who have frequent asthma attacks manifest psychopathology compared

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Researchers and healthcare organizations alike recognize the connection between physical conditions and behavioral health conditions and are working to coordinate care between the providers.

- Many people with chronic diseases also suffer from depression and other behavioral health issues.
- People with mental health problems die earlier than the general population because they smoke, are overweight, and have chronic illnesses.
- Behavioral and physical healthcare providers often operate in silos and lack coordination, which can result in a negative impact on individuals.

with 25% of persons with less frequent attacks. They wrote that research shows that people who are depressed are more likely to develop coronary artery disease and that people with significant depression are twice as likely to have a stroke as people with fewer symptoms and more than four times as likely to have a myocardial infarction as people with no history of depression.

The National Center for Disease Prevention and Health Promotion at the CDC calls for including mental health promotion as part of its efforts to prevent chronic disease in the report, "The Public Health Action Plan to Integrate Mental Health and Promotion and Mental Illness Prevention with Chronic Disease Prevention 2011-2015."

"The interconnections between chronic disease, injury, and mental illness are striking," the report says.[2]

People with behavioral health conditions die on average 25 years earlier than the general population because they tend to smoke more, be more overweight, and suffer from chronic obstructive pulmonary disease, according to **Sue Bergeson**, vice president of consumer affairs for Optum, a health services company based in Eden Prairie, MN.

"They spend so much time with psychiatrists and other behavioral health professionals that they don't see their primary care provider and deal with their physical conditions, such as diabetes and chronic obstructive pulmonary disease," she says. People with behavioral health conditions smoke 44% of all cigarettes and may be taking medications that make them gain as much as 30 pounds a year, she adds.

"Many people who have behavioral health issues don't adhere to their treatment plan because, like other people with chronic illnesses, they don't like to admit that they have a condition they have to treat for the rest of their lives. In addition to coping with their condition, they have to cope with the stigma of mental illness and don't take their medication because they feel ashamed to have the condition. Sometimes they stop taking their medication because they feel better or don't like the side effects of their medication and suffer a relapse," she says.

To help people who have been hospitalized for a psychological condition remain out of the hospital, Optum's Field Care Advocates — licensed, community-based clinicians — work with people who are at risk for rehospitalization for behavioral health issues to ensure that they receive adequate therapeutic support and that they are receiving care for their medical comorbidities. They support the individuals on following their treatment plans and promote communication between the patients' medical and behavioral health providers. Patients who need extra help are paired with a peer specialist, who assists the patients in making lifestyle changes. *(For more on Optum's program, see related article on page 89.)*

Recognizing that behavioral and physical healthcare systems often lack coordination which can result in a negative impact on individuals, UPMC Insurance Division developed Connected Care, a program that links behavioral health providers and medical providers, says **James Schuster**, MD, chief medical officer for Community

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Care Behavioral Health Organization. The program provides coordination of mental health and physical health benefits for members of UPMC for You, a Medicaid managed care plan, as well as Community Care Behavioral Health for its behavioral health services. Case managers from both organizations have access to a shared database with information on all the care patients receive, and they meet regularly to brainstorm on difficult cases. *(For details, see article on page 90.)*

"People with serious mental illness have significantly shorter life expectancies than the rest of the population. Many are impoverished, and their illness often prevents them from taking medication as directed and making the lifestyle changes that would improve their physical health. Coordination of the mental and physical health services is a key to helping them improve their health," he says.

Licensed behavioral health clinicians in the behavioral health unit of Aetna's Disability and Absence Management Services coordinate behavioral health interventions for employees with a primary or secondary diagnosis of a mental health issue that may impact the member's return-to-work.

"We look at the person holistically and deal with more than just the primary medical condition. When the medical disability management unit uncovers a psychiatric issue, the claims are referred to a behavioral health clinician for review and consultation to identify any psychosocial issues that can impede treatment and lengthen the time it takes for the employee to return to work," says **Adele Spallone**, LMHC, LMFT, clinical services head for Aetna Disability and Absence Management services.

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Mental health care gets employees back to work

Care coordination for mental and physical issues

Aetna's disability behavioral health clinicians educate primary care physicians on the employees' disability plans and requirements, along with stressing the importance of a referral. Employees who were on short-term disability because of a behavioral health condition averaged 11 fewer days out of work than an industry benchmark when their claims were managed by Aetna's disability behavioral health unit, a study by Aetna's Disability and Absence Management Services determined.

The results translate into a savings for employers of $1,177 per employee when compared to the benchmark, according to **Adele Spallone**, LMHC, LMFT, clinical services head for Aetna Disability and Absence Management services.

The behavioral health unit is staffed by licensed behavioral health clinicians who work with employees, employers, and physical and behavioral health care providers by telephone to coordinate care and see that employees receive the care they need for a safe and successful return to work.

Most of the claims referred to the unit are for employees who see multiple providers, have complex return-to-work issues, and need frequent interventions and assistance with medication management.

"When employees have a primary or secondary diagnosis of mental health issues, it may impact their health recovery or return to work. We take a holistic approach to managing return-to-work and help our members deal with both physical and emotional health issues and return to work sooner," Spallone says.

When employees file claims for disability because of behavioral health issues, the claims automatically are referred to the disability behavioral health unit for assessment and management. If they file medical claims and the

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A study by Aetna shows that employees with a behavioral health condition return to work sooner if their claims are managed by a behavioral health clinician.

- Employees with a primary or secondary diagnosis of a behavioral health issue are referred to the disability behavioral health unit.
- The disability behavioral health clinicians identify all the physicians treating the employee and contact each of them, becoming their partner in coordinating care and getting the employee back to work.
- When employees with a behavioral health issue are seeing only a primary care physician, the disability behavioral health clinicians encourage them to refer patients for specialty behavioral health treatment.

medical disability management unit uncovers a psychiatric issue, the claims are referred to a behavioral health clinician for review and consultation.

In some cases, employees call in to the disability management unit to file a claim because of a medical event and speak only about the medical condition, but they may also have behavioral health comorbidity, Spallone says. "Often there are also psychosocial issues, such as financial problems or childcare issues that go along with the medical event," she says.

For instance, if an employee calls in about a back problem, the claims processor asks the employee about other problems that may be going on that could exacerbate his or her physical condition and prevent a return to work, such as if the employee feels anxious about returning to work or is concerned about loss of income if he or she doesn't recover sufficiently to return to work. People with long-term back problems tend to suffer from depression, she points out.

"We look at the person holistically and deal with more than just the primary medical condition. We identify the non-medical drivers upfront that can impede treatment and return to work. For example, we go beyond making sure the employee has an MRI and takes his medication but look at all the other factors that could make the duration of the claim longer," she says.

When disability claims analysts don't identify non-medical issues, employees may improve medically but say they still aren't ready for work. The disability claims analyst may uncover depression or fears of returning to the job and will have to help the employee overcome the psychosocial issues, which sometimes lengthen the time out of work, she says.

Many times employees who are out of work with a psychiatric issue don't have a relationship with a behavioral health physician and see a primary care physician. "When patients are treated for behavioral issues by a primary care physician, they often don't get the follow up they need. Some doctors just write medication prescriptions to address the psychological symptoms. But when people are dealing with depression and are out of work for any reason, they need to see a behavioral health professional regularly who will assess the patient's coping skills and their ability to function and help the individual work on things that affect their lives," Spallone says.

Aetna's disability behavioral health clinicians educate primary care physicians on the employees' disability plans and requirements, along with stressing the importance of a referral for specialty behavioral health treatment, she says. Many times primary care physicians don't realize that patients have behavioral health benefits and don't consider making a referral for that reason, she adds.

Some disability claims are subjective in nature and driven by the patient, Spallone points out. "Patients will go to their physician with whom they have a long-standing relationship and say they don't feel like they can work and the physician will concur. The physicians are not trained in disability benefits and often don't know what the patient's responsibilities are at work or what their job entails. Our clinicians educate physicians on the employee's job description and the national benchmarking tool used to determine how long people with a specific diagnosis are typically out of work," she says.

If patients stay out of work longer than the norm, it's usually because of other factors. "Some employees go out of work because of a non-physical problem such as getting a bad performance evaluation or if they don't like their work shift. We'll have a conversation with the physician to find out why patients can't work and don't feel they are ready to return to work and work with them on a return-to-work plan," she says.

When a claim is referred to Aetna's disability behavioral health unit, a clinician immediately makes contact with the employee and the primary care physician as well as all of the other providers who are treating the employee.

"We believe it's important to get the right clinical resources and right clinical interventions in place up front," she says.

When they talk to employees, the clinicians conduct a functional assessment and ask a series of questions, including how long the employees have had the condition, what happened to exacerbate it, who their treating physician or physicians are, when the employees last saw their doctors and the date of their next office visits, and what the employees think are the barriers to going back to work.

The clinician also asks questions about the employee's ability to perform activities of daily living. When an employee is out of work due to chronic or major depression, the clinician looks for any potential suicidal ideation. "If the employee voices a threat to themselves or others, the clinicians have a threat protocol to follow," Spallone says.

The disability behavioral health clinicians identify all the physicians treating the employee and contact each of them. "We want to gather information from everyone to get a holistic view of what's going on," she says. The team created a behavioral health questionnaire that asks each treating physician to assess the patients in three areas: cognitive, emotional, and behavioral impairment.

"When we talk to the treating physicians, we want to go beyond the diagnosis and make sure that the employee meets the requirements of their disability contract and is not able to perform core elements of their job. We talk to the physician about the employee's job description and educate them about duration guidelines. We become their partners in determining the best approach for the patient getting back to work," she says. ■

Readmissions reduced with psychiatric care

Patients stay out of hospital longer

Optum's Field Care Advocacy program, which provides comprehensive services to people who are being discharged from a psychiatric hospital, has resulted in fewer hospital readmissions and longer periods of time between admissions.

Patients admitted to the hospital due to a behavioral health condition are often at high risk of being rehospitalized within 30 days after discharge because of a variety of factors, including the need for better coordination between medical and behavioral health providers and inadequate links to community-based resources and support, says **Margaret Brennecke**, PhD, national president for outpatient programs for Optum's behavioral health business.

"To address this problem and promote the goal of recovery, the Field Care Advocacy program targets people who have recently been discharged from inpatient and residential settings who have been identified as being at highest risk for readmission. Our data analysis shows that the program helps decrease hospital rates and extends the time that people spend in the community between hospital visits," Brennecke says.

Based in Eden Prairie, MN, Optum contracts with employers, health plans, public sector programs and health care providers to support the needs of people with behavioral health problems.

Care for people in the program is coordinated by Field Care Advocates, who are independent licensed behavioral health clinicians who work with patients in person and over the telephone. Because they live in the communities in which they work, they understand the residents of the community and the services that are available. The Field Care Advocates have received extensive training from Optum Behavioral Health on engaging patients and tools and techniques that patients can use to manage their own mental and physical health.

Whenever possible, the Care Advocates make initial contact with patients while they are still in the hospital to introduce the program. Otherwise, they contact the patient immediately after discharge.

"When people are hospitalized for a behavioral health condition, it's usually a traumatic and frightening experience. Nobody wants to feel that ill, and they don't want it to happen again. At this point, they are open to making changes in their lives so this is often the best opportunity for the Field Care Advocate to go in and engage them in a plan of care," says **Sue Bergeson**, vice president of consumer affairs for Optum's behavioral health business.

When patients have complex physical and mental health conditions, have experienced multiple hospitalizations and have had difficulty coping with their illness, they also may be assigned to a peer specialist who works as a health coach. They help the patients set goals and work with them on making lifestyle changes such as getting regular exercise or eating a healthy diet. The

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Optum's Field Care Advocacy program that provides services for people at risk for rehospitalization for a behavioral health condition helps decrease readmissions and extend the time that patients are able to live in the community.

- Field Care Advocates, who are licensed behavioral health clinicians, work with patients in person and over the phone, help them follow their treatment plan and access needed services, and coordinate care with their providers.
- They typically work with the patient and providers for 90 days.
- People with complex needs who have problems following their treatment plan are paired with peer specialists who act as health coaches and work with them for about six months.

peer specialists are people who are in recovery from behavioral health conditions and who go through extensive training on engaging patients in managing their physical and mental health.

Optum's Field Care Advocates work with people with behavioral health issues to ensure that they receive adequate therapeutic support and that the medical comorbidities are addressed. "We bring the concepts of recovery and resilience to the table and provide support so participants can learn to manage their own health," Brennecke says.

When patients are identified for the program, the Field Care Advocate conducts an assessment in four areas—therapeutic support, community and family support, medical comorbidities, and recovery and resilience. "We look at whether therapeutic services are available and if the patient has made appointments. If the services are in place, we make sure that all providers are aware of what others are doing, and that the patient is receiving effective, evidence-based care," Brennecke says.

The Field Care Advocates also assess whether the patient and/or family members need education and support and refer them to support groups, online sources, and other support systems.

When they conduct the initial assessment, the Field Care Advocates also assess the need for interventions for physical conditions. When there are medical comorbidities, the Field Care Advocate contacts the treating physicians and works to ensure appropriate communication between the patient's medical and behavioral health providers. "Many times we find that physical illnesses are being under-treated because the patients are so focused on the demands of their behavioral health condition. To address that gap the Field Care Advocates coordinate with the behavioral health practitioners and physical health providers to make sure they are communicating with each other to meet all the patient's needs," Brennecke says.

Often behavioral health providers and physical health providers work in silos and don't know what the other providers are doing, she adds. "Our ultimate goal is to get patients aligned with services that meet their needs and get all providers communicating with each other," Brennecke says.

Bergeson adds, "The fourth pillar of the program, recovery and resilience, assesses whether, from the patient's perspective, they are living a quality life and working toward goals that are important to them and whether they need support to enhance that," she says.

Typically, the Care Advocate works with the patient for 90 days but can extend the program if the patient needs it.

"The Care Advocate's goal is to engage individuals, help them put a recovery plan in place, and step away. We don't keep a member chained to our engagement because our goal is to help. We want them to take charge of managing their own conditions," Bergeson adds.

People who are paired with a peer specialist are identified when they come into the program. Typically, they have experienced multiple hospitalizations and have difficulty in coping with their illness and becoming engaged in adhering to their treatment plan.

Because the peer specialists have experienced hospitalization and treatment for behavioral health problems themselves, they have a good understanding of how these conditions can affect the physical and psychological wellbeing of the patients with whom they work. They often share stories of their own illness and recovery as they help patients identify their challenges and work through them. They typically work with patients for about six months, helping them develop recovery goals and support them in following the wellness and treatment plan the patient has developed with his or her providers.

"The peer specialists demonstrate the power of peer support in helping people improve their overall health and wellbeing. They work along with the rest of the team to ensure that the patients' needs are met and that they continue to be able to stay in the community rather than being hospitalized," Bergeson says. ■

Program joins physical, behavioral healthcare

Initiative focuses on mentally ill patients

UPMC Insurance Division's Connected Care, a program that links behavioral health providers and medical providers, has reduced the use of behavioral and physical health services by participants in the program.

"We've seen a significant reduction in hospital admissions and emergency department visits among members in Connected Care," says **James Schuster**, MD, chief medical officer for Community Care Behavioral Health Organization,

which partnered in this effort with UPMC Health Plan and the Allegheny County Office of Mental Health.

The program provides coordination of mental health and physical health benefits for members of UPMC for You, a Medicaid managed care plan as well as Community Care Behavioral Health for its behavioral health services. Community Care manages behavioral health services for recipients of Pennsylvania's Medical Assistance program in 39 counties.

Connected Care is an effort to better coordinate care for individuals with serious mental illness by linking health plans, personal care physicians, and behavioral health providers in outpatient, inpatient, and emergency department settings, Schuster says. The program aims to improve the health of people with serious mental illness and enhance the patient experience of care by coordinating both physical and mental health services as well as minimizing the cost of care for the population.

"Many individuals with mental illness have wellness and physical health issues as well," Schuster says. The majority of people with serious mental illness smoke or are significantly overweight, and many have chronic conditions such as diabetes, heart disease, and respiratory problems. Even without health problems, their behavior often places them at risk," Schuster says.

When it created Connected Care, UPMC merged data from care management systems at UPMC for You and Community Care Behavioral Health to create a database that both physical health and behavioral health care managers use to share information about patients. The database helps staff identify what providers each member is seeing, what case manager from each component is coordinating care, and any barriers to receiving care that have been identified. A multidisciplinary team from both Community Care and UPMC for You worked together to design the program.

"Connected Care allows us to share information about acute services with providers. If members have a hospital admission, we notify behavioral health providers who use the information as an opportunity to reconnect with the patient," Schuster says.

The care managers from both organizations were trained to function as wellness and health coaches as well as learning how care coordination works in both organizations.

The program has developed patient registries that list members with gaps in care for preventive services or chronic conditions, cuing the case managers to intervene. The care managers notify primary care and behavioral health providers, including community-based case managers, when patients are admitted to the hospital or visit the emergency department and when there are gaps in refilling antipsychotics and receiving recommended lab tests and other care.

As members are identified, a multidisciplinary team from both organizations discusses the case and chooses a lead case manager, based on the member's needs and existing relationships. The multidisciplinary team works together to develop individual integrated care plans for each member in the program and meets periodically to discuss specific patients with complex needs and brainstorm on ways to help them follow their treatment plan. The lead care managers contact patients by telephone and make sure they understand their medication regimen and work with them on following their treatment plans. The team contacts each individual's mental health and physical health provider, informs the provider of the treatment plan, and talks with a therapist or a nurse about concerns for each individual patient.

When patients are admitted to the hospital, the program care manager assists with developing the discharge plan and follows up to ensure that patients receive a post-discharge visit with an appropriate physician and understand their discharge plan and how to take their medication. In addition, the care coordinators share

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By coordinating care between behavioral health and medical health providers, Connected Care, part of UPMC Insurance Division, has reduced hospital admissions and emergency department visits for members of UPMC for You, a Medicaid managed care plan as well as Community Care Behavioral Health which manages services for recipients of Pennsylvania's medical assistance program.

- Case managers at both organizations share a database that shows physical health and mental health interventions for patients in the program.
- When patients receive services from a mental health or physical health provider or are hospitalized, the care managers make sure all of the patient's providers are aware of what has happened.
- A multidisciplinary team from both organizations develops a plan of care for individuals and assigns a lead case manager who coordinates care with the patients' providers.

information with primary care providers about the patients' behavioral health interventions and alert mental health providers when patients have a medical intervention.

"The care managers do a lot of work and ongoing communication to engage community-based mental health providers and care managers as well as working to support the primary care physicians in managing the physical health of the patients. In the past, communication between providers was not as predictable or regular. We created a structured process to make sure that physicians and behavioral health providers are aware of what's going on with patients in regards to both their physical and behavioral health issues," Schuster says. ■

Team reduces ED wait times, improves safety

Collaboration nurtures quality improvement

The fast pace of a busy ED can make it difficult to focus in on processes that could be improved, but leadership and commitment can move the needle in the right direction as long as emergency personnel understand why change is important. That, at least, is what **Erin Muck**, RN, the ED manager and trauma coordinator at Avera Marshall Regional Medical Center, a 25-bed hospital in Marshall, MN, has discovered. The ED treats about 7,200 patients annually, and 100 patients per month are admitted to the hospital from the ED.

When the ED at Avera Marshall began participating in a project aimed at improving throughput times toward the end of 2011, Muck utilized a collaborative process to identify steps that could be improved. Muck asked one of the ED's four physicians to participate in the effort by attending a monthly meeting in which ideas would be solicited and discussed. She also invited nurses to participate, and she brought in representatives from the lab and radiology departments as needed. Two representatives from the hospital's quality department participated in the meetings as well.

To make it convenient for the physician to participate, Muck says she always scheduled the meetings during the morning hours when the ED is typically not as busy, generally around 9 a.m. The discussions typically lasted for 30-60 minutes, she explains.

Use data to drive improvement

Over a period of several months, the so-called "quick-hits" meetings produced a number of ideas to shorten wait times for patients while also improving safety. One of the biggest improvements that resulted from the process was a reduction of 12 minutes in the ED's average decision-to-admit time, bringing this metric from 44 minutes down to 32 minutes. "It was hard to address the decision-to-admit times because a lot of people don't document them," says Muck. "It took us a good six months just to get that piece of it done."

The "quick hits" team theorized that the admission process could be expedited if the charge nurses were notified earlier on that a patient was likely to be admitted. "That way they could be thinking about who they are going to assign the patient to, what room they are going to open up, and those kinds of things," says Muck. Under this type of arrangement, charge nurses would be able to give the nurses on the inpatient floors a heads-up when they are likely to receive a patient. "It would just give them the time to wrap up whatever they are doing so that they are prepared for an admission," says Muck. Also, the charge nurses would be mentally prepared for a phone call when the decision to admit is made by the physician, she says.

One other reason why Muck felt the approach would work well is because she has a very experienced group of nurses manning the ED. "The nursing staff here average about 24 years of service, so they are very well versed in working the ED and estimating [which patients are likely to be admitted]," she explains. "They do a pretty nice job."

However, when the approach was first implemented, there was snag. "Most of the charge nurses were awesome about this," says Muck, but there was one charge nurse who was not acting on the early information. Consequently, Muck shared a report with the charge nurses showing the decision-to-admit times per charge nurse. "Then she stepped up her game," says Muck.

To sustain the improvement in decision-to-admit times, Muck acknowledges that she needs to keep her eye on it. "If I am not watching that

constantly and putting the data out there for [the staff to see], then it is out of sight, out of mind, so then they aren't doing quite as well," she says.

A similar approach worked well in getting the physicians to pay attention to their throughput times. "Every month I would have a printout of our general throughput times, and then I would have it per physician," says Muck. "Occasionally, I still run those reports. We have some locum physicians [who work in the ED now], so I want to keep track of them and how their throughput times compare with our own physicians. It is a little friendly competition."

Get buy-in

Other ideas that came out of the "quick hits" process include the establishment of a goal for completing the triage process by the time a patient has been in the ED for 10 minutes. Also, blood is now routinely drawn during triage for patients who present with an issue that will likely require blood work, such as patients presenting with abdominal pain, explains Muck. "We figured out how to do triage quicker and better, and these were ideas that we got from the nursing staff, physicians, and sometimes lab or X-ray," she says.

While some organizations might struggle to prevent this type of team-driven process from turning into a blame game, Muck says hospital administrators have nurtured a culture in which it is not OK to get defensive or angry when discussing problems. "We don't have that problem here. It is always good to get advice," she says. "The managers work well together and we are always open for suggestions. If my suggestion doesn't work, then they will suggest something different that does."

Muck acknowledges that it can be more difficult to get physicians on board with any type of change. The key, she says, is making sure they understand what the benefits will be of a change in process. She adds that a team-driven approach can facilitate this type of exchange. "In order to problem solve, it is good to have the people involved because you can have better buy-in regarding how to fix things," she says.

While the formal monthly "quick hits" meetings no longer take place, Muck explains that she regularly uses the approach for quality improvement. For example, she is now engaged in an effort to identify ways to improve trauma care. "We have a trauma surgeon involved, trauma physicians, and sometimes orthopedics as well," she says. "Who we invite to the meetings just depends on what issue we are addressing."

SOURCE

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What makes for good care coordination?

Start by asking your patients

Ask a doctor if she thinks her hospital does a good job at care coordination — or an administrator or board member — and she'd probably say yes. She might admit to room for improvement, but in all likelihood, she would think she and her peers do a good job taking care of patients in and out of the acute care setting. But the reality is different, says quality guru and Harvard professor **Lucian Leape**, MD, chairman of an eponymous institute at the National Patient Safety Foundation.

"I teach a course on quality and safety in health care, and the first day, I ask the students to find a patient — any patient — with a serious medical problem who will talk to them about it, and interview them about their experience," he says. "It's very worthwhile for the students. I read the essays and this year, three quarters of them had patients that reported serious care coordination problems. These are people with complex problems. And my take away is that this is endemic. These are patients from all over the country. It's a huge problem, and yet most places think they coordinate care well."

A starting point

Leape says one of his colleagues has decided that talking to patients about their perception of care coordination is so vital, that she has developed a survey tool just for that.[1] It's currently being piloted. He says that hospitals can get a sense of patient views from other patient experience surveys, but those other surveys are not focused on how well patients think providers care for them across the continuum. Consider developing questions that would help you determine how your organization does in the eyes of patients.

There are some existing tools that offer a starting point, such as one created in Australia in 2003 (available at http://intqhc.oxfordjournals.org/content/15/4/309/T5.expansion.html).

Part of the problem is that the consequences of doing a bad job seem to fall on the patients, not providers. "Who sees it when you do not do a good job? And for the poorest or those in the worst health? Well they're not really a vocal bunch are they?"

Another issue is that the position of "care coordinator" is not dignified by payers financially. "If you have a patient with more than two diagnoses, we need payers to pay for someone to actively coordinate their care," Leape says. "There is a ton of data that shows asthma patients, for example, have fewer emergency room visits and fewer hospitalizations when they have highly coordinated care. What we need is a certified care coordinator position whose time is billable and paid for by insurers."

Some organizations seem to do it well — Group Health in Seattle, for instance, and Cambridge Health Alliance. The latter provides safety net services for a "difficult" population of poorer, less healthy people in Massachusetts, Leape says. "But they have put a big emphasis on coordinating care for a long time."

Cambridge Health Alliance has certified five outpatient sites as patient-centered medical homes in the last 18 months, says **David Osler**, MD, MPH, senior vice president of ambulatory services for the organization in Somerville, MA. Most of the ambulatory sites for the organization are staffed with care coordinators, too. They have achieved some cost savings and some improved outcomes as a result, he says.

What he thinks would help would be a unified electronic medical record that both inpatient and outpatient providers can readily access. They have also had success by putting some patients on risk-based contracts. Perhaps the best thing a hospital can do is work with area providers to ensure every patient has ready access to outside primary care providers.

The playbook

"The hospital is like the quarterback in the football team," says **Angel McGarrity-Davis**, RN, a healthcare consultant based in Clearwater, FL. "The hospital must lead the other members on the team to perform their duties," she says. "They have to know what every person's job is in the post-acute care arena. They must be able to relay to the various players what their responsibilities and accountabilities are. And they need to have input into the playbook."

That book would be the various clinical pathways and processes they use, as well as the evidence on which they are based.

Share that playbook throughout the healthcare community, she continues. Get out of the silos that isolate the various parts of the continuum — have joint training, for instance. Gather the team members to discuss what works and what doesn't. "Working together is key," McGarrity-Davis says. "Get together with the skilled nursing facilities, long-term acute care hospitals, and home health agencies. Everyone should be on the same page for discharge planning, and the entire multidisciplinary team should be involved to follow up."

Most organizations will admit that such collaboration sounds like a great idea. Many may already do it.

But McGarrity-Davis adds another layer in that echoes a suggestion Leape makes: Get patients and their caregivers and/or families involved in the process, too. Have them work with the rest of the team to create forms that work, information that is understandable, and procedures that take the patient into account in the process.

Payers introduced penalties for unplanned readmissions for a reason, she says. "It's not because hospitals are responsible for or the cause of the readmissions all by themselves. But they are the industry leader. So if the hospital seeks solutions, creates a plan, and says it should be done, then the rest of the continuum will follow suit."

REFERENCE

1. Singer SJ, Friedberg MW, Kiang MV, Dunn T, and Kuhn DM. Development and Preliminary Validation of the Patient Perceptions of Integrated Care Survey Med Care Res Rev April 2013 70: 143-164

SOURCES

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System said to reduce falls, transfers in elderly

Also helps reduce other adverse events

A fall reduction system that encourages caregivers to respond early to warning signs has been proven to significantly reduce falls, according to the manufacturer.

EarlySense, based in Waltham, MA, announced the results of a multi-center clinical study demonstrating that the system helps medical teams at rehabilitation centers to reduce patient falls as well as the number of patients transferred back to the hospital.

The technology involves continuous patient monitoring in hospitals and rehabilitation homes by monitoring patients' heart rate, respiration, and movement without touching the patients. Eight hundred and thirty-three patient records at The Dorot Geriatric Center, a 374-bed facility in Netanya, Israel, and 773 records at the Hebrew Home at Riverdale, an 870-bed skilled nursing facility in Riverdale, NY, were collected and reviewed over six months. The transfer rate to the hospital decreased by 21% at Dorot, and the falls rate decreased by 38.5% at the Hebrew Home.

The contact-free sensing capabilities and immediate data transfer enable nurses to proactively provide personalized patient care and potentially prevent adverse events, the company says. Through continuous patient supervision, the system can help staff reduce the risk of patient falls and effectively work toward decreasing other adverse events, such as pressure ulcers.

The data was presented recently at the 2013 Annual Scientific Meeting of the American Geriatrics Society (AGS) by Hebrew Home medical director and study principal investigator **Zachary J. Palace**, MD.

"The system also alerted regarding early warning signs of patient deterioration, which enabled our medical team to proactively respond and literally save four lives," Palace adds. ■

COMING IN FUTURE MONTHS

- How your peers are working to reduce readmissions
- Why culturally competent care is so important
- How to promote patient-centered care in your organization
- Coordinating care across the continuum

CNE QUESTIONS

1. According to Adele Spallone, LMHC, LMFT, clinical services head for Aetna Disability and Absence Management services, employees who are out of work for a physical issue may have psychosocial issues that could exacerbate their physical condition and prevent a return to work.
   A. True
   B. False

2. When do Optum's Field Care Advocates aim to contact patients who are hospitalized with behavioral health condition?
   A. While they are still in the hospital
   B. Within 24 hours after discharge
   C. When they have their first follow-up visit
   D. Within 48 hours after discharge

3. How long do Optum's Peer Specialists work with patients on average?
   A. Six weeks
   B. 90 days
   C. 120 days
   D. Six months

4. According to James Schuster, MD, chief medical officer for Community Care Behavioral Health Organization, what wellness and physical health issues do people with serious mental illnesses tend to have?
   A. Smoking
   B. Being overweight
   C. Chronic diseases
   D. All of the above

CNE OBJECTIVES

After reading this issue, continuing education participants will be able to:
1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.

CNE INSTRUCTIONS

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