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

April 2014: Vol. 25, No. 4
Pages 37-48

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Financial disclosure:
Editor **Mary Booth Thomas**, Associate Managing Editor **Jill Drachenberg**, Executive Editor **Russ Underwood**, and Nurse Planner **Kay Ball** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

It takes creativity to help the chronically ill adhere

Cookie-cutter solutions just won't cut it

Recognizing the importance of helping people with chronic conditions keep their conditions under control and maximize their health, health plans and providers are trying innovative ways to persuade the chronically ill to adhere to their treatment plans.

Chronic diseases are the nation's leading cause of death and disability and account for about 75% of all healthcare expenditures, according to the Centers for Disease Control and Prevention in Atlanta.

Although chronic disease is largely preventable, seven in 10 deaths in this country are caused by chronic disease, the CDC says.

"Since 75% of healthcare spending is on chronic diseases, prevention and cost-effective treatment are essential. It's more than just a fiscal issue, but perhaps is even a national competitive and security issue," says **Bern Shen**, MD, chief medical officer of HealthCrowd, a Silicon Valley-based mobile health company.

Helping people manage their chronic diseases is our country's biggest healthcare challenge, says **Marcia Diane Ward**, RN, CCM, PMP, a case management consultant based in Columbus, OH.

EXECUTIVE SUMMARY
Chronic diseases are the nation's leading cause of death and most are preventable, but helping people keep them under control is a challenge for the healthcare industry.
• There's no one-size-fits-all solution. Case managers need to take an individual approach, experts say. For example:
• Drill down and find out everything you can about your patients and identify any roadblocks to adherence, such as social needs and psychosocial problems.
• Take the time to make sure patients really understand their disease and how to manage it.
• Leverage technology to stay in touch with at-risk patients.

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There's no one-size-fits-all solution, Ward points out. "Human beings are all unique, not just physiologically but in how they manage their health. You can't expect cookie-cutter disease management to work," she says.

Recognize that people are individuals and need an individual approach, she says. Talk to your patients and drill down to determine their situation at home and any psychosocial needs.

"Patient engagement has been called the blockbuster drug of the 21st century," Shen says, quoting Leonard Kish, a healthcare information technology strategy consultant.[1]

Case Management Advisor™ (ISSN# 1053-5500), is published monthly by AHC Media LLC, One Atlanta Plaza, 950 East Paces Ferry Road NE, Suite 2850, Atlanta, GA 30326. 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 550669, Atlanta, GA 30355.

Subscriber Information

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

Subscription rates: U.S.A., **Print:** 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $419. Add $19.99 for shipping & handling. **Online only, single user:** 1 year with free Nursing Contact Hours or CMCC clock hours, $369. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Back issues, when available, are $75 each.(GST registration number R128870672.)

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This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.
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EDITORIAL QUESTIONS

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

"Adherence to medication regimens, diet, exercise, and other behavioral prescriptions is key for both primary and secondary prevention," Shen says.

Non-adherence is not often a problem when the medical condition is acutely painful, Shen points out. On the other hand, many chronic diseases, such as hypertension, are relatively asymptomatic, and it's a challenge to keep patients from making unhealthy choices. "Often, short-term rewards trump long-term ones," he says.

One of the most challenging populations to engage are people who are barely scraping by and who need social support, Ward adds.

"When people are about to be evicted or have no food in the house for their children, checking their blood sugar or taking their medication is not going to be a priority," says **Pamme Taylor**, vice president for advocacy and community-based programs for WellCare Health Plans, headquartered in Tampa, FL.

WellCare is contracting with social safety net organizations to implement the Stanford Chronic Disease/Diabetes Self-Management Program. "It's a situation that benefits everyone. The organizations get much-needed funds. We get disease management services for our members, and the members receive the training they need to stay healthy from an organization they know and trust," Taylor says. *(For details on how the program works, see related article on page 43.)*

Some patients don't understand the consequences of not taking their medication or not following through with their discharge plan, Ward points out. "Many times they're given the information in a hurry at the point of discharge when they are thinking about going home and they may be under the effects of medication. It may take a number of sessions with a case manager for the information to sink in," she says.

Physicians simply don't have the time it sometimes takes to teach patients how to manage their condition and how to take their medication, Ward adds.

That's why Capital District Physicians' Health Plan (CDPHP), headquartered in Albany, NY, developed a medication therapy management program in which pharmacists meet face-to-face with patients in patient-centered medical homes or community pharmacies, conduct medication reconciliation, and educate patients on their medication. When needed, the pharmacists teach patients how to give themselves injections, use inhalers,

or use other medical devices. "This approach is improving quality of care and reducing preventable hospital admissions and readmissions," says **Eileen F. Wood**, RPH, MBA, vice president for pharmacy and health quality programs for CDPHP. *(For details on the program, see related article on this page.)*

The aging population means a surge in the need for healthcare as clinicians are aging out of the workforce, Shen says. "This means our society will have to do more with less. Technology is no panacea but it can help leverage scarce resources. Rapid technological innovation has so thoroughly permeated our everyday lives that consumers have come to expect similar levels of connectivity, information liquidity, and convenience in healthcare," he says.

Patients in the University of Iowa Hospitals and Clinics cardiac rehabilitation program who receive three to five weekly text messages complete more rehab sessions than people who do not participate in the text message program, says **Patricia Lansbury**, RN, BSN, Med, CCRN, cardiac rehabilitation consultant for the Iowa City-based hospital. The messages are a combination of heart healthy tips and requests for information on their activities.

"Text messages help us stay in touch with patients between sessions and alert us if the patients are getting into trouble. It takes less than five minutes twice a day to check the replies to the questions and intervene if there are problems," she says. *(For details on the program, see article on page 42.)*

UCare has found similar success with its telemonitoring program for at-risk heart failure patients, says **Jodie Milner**, RN, CHC, manager of health improvement for the Minneapolis-based health plan. *(For details, see related article on page 41.)* "People like the program so much they don't want to leave it," she says.

Some people are non-adherent because they have an altered mental state, such as dementia, addiction, or bipolar disorder, which makes it impossible to follow their treatment plan, Ward says. Depression is often a comorbidity in the chronically ill and can affect adherence, she adds. In those cases, case managers need to find out if their patients have caregiver support and engage them in the treatment plan and/or get patients connected to mental health services, she adds.

Other patients may not follow their treatment plan because they are recalcitrant to treatment, Ward says. "They don't believe what their doctor tells them or they just aren't committed to following the treatment plan. They can logically process the information they are given, but they simply are not going to comply," she says.

REFERENCE

1. Kish L. The Blockbuster Drug of the Century: An Engaged Patient. *HL7 Standards*, 28 August 2012. http://www.hl7standards.com/blog/2012/08/28/drug-of-the-century/ ■

Pharmacists provide medication guidance

Program also helps primary care providers

To help chronically ill members adhere to their medication regimens, Capital District Physicians' Health Plan (CDPHP) provides personalized support from pharmacists for members taking multiple medications in patient-centered medical homes and at community pharmacies.

"We started our medication therapy management program in 2007 to meet the Centers for Medicare & Medicaid Services (CMS) requirements for Medicare Part D. Initially, it was difficult to see the value of our efforts, but we quickly realized that our members and our primary care network could benefit from expanding the program. Our vision is to add the value of the pharmacists' expertise to the healthcare delivery system as a service beyond medication dispensing," says **Eileen F. Wood**, RPH, MBA, vice president for pharmacy and health quality programs with the Albany, NY-based health plan.

The health plan uses two approaches to providing medication therapy management to members. As part of the its Enhanced Primary Care initiative — a patient-centered medical home model — CDPHP has embedded pharmacists in large primary care practices to be a resource for physicians and meet with patients to discuss their medications and educate them on the proper way to take them. In addition, CDPHP has contracted with community pharmacists who provide face-to-face support to patients in retail settings.

Originally, to meet Medicare Part D requirements, CDPHP provided telephone counseling for patients. "We determined that community pharmacists were willing to collaborate with the health plan and primary care physicians, and redesigned

the program, giving patients the opportunity to meet with pharmacists face-to-face," Woods says.

The health plan started its enhanced medication therapy management program as a pilot and has expanded it beyond the CMS requirements. It now offers the program to any patient with complex medication regimens and chronic diseases, as well as anyone referred by a case manager, a physician, a pharmacist, or who refers him- or herself, she says.

The pharmacists in both settings review the patient's record to identify gaps in evidence-based care, safety risks from drug-drug or drug-disease interactions, medications that can be dangerous for the elderly, and opportunities to simplify medication regimens or save members money by recommending generic medications in lieu of more expensive name-brand drugs.

The pharmacists conduct a comprehensive review of prescribed medications before they meet with patients. During the meeting, they find out what over-the-counter medications and supplements patients are taking and give them a comprehensive list of medications they can take with them to all healthcare encounters. They verify that patients are taking their medications as prescribed, explain why they are taking the medication, discuss side effects and other problems they may be experiencing, and answer questions. They may provide patients with pill boxes to help them organize their medication, and provide one-on-one instruction on how to use an inhaler or self-administer injections.

EXECUTIVE SUMMARY

Through Capital District Physicians' Health Plan's medication therapy management program, pharmacists in the community and embedded in large primary care practices work with patients to help them adhere to their treatment plan.

- Pharmacists review patients' records to identify gaps in evidence-based care, safety risks from drug-drug or drug-disease interactions, medications that can be dangerous for the elderly, and opportunities to simplify medication regimens or save money.
- They meet face-to-face with patients, conduct medication reconciliation, educate them on how to take their medications, and answer questions.
- Pharmacists can also be a resource to physicians, providing comprehensive information about therapy choices for patients with complex conditions, eliminating or postponing the need for a referral to a specialist.

The embedded pharmacists work closely with physicians at the primary care practices and sometimes round with them. They collaborate with the practice case managers and have the option of bringing in a behavioral health case manager when needed.

The pharmacists are a resource to the physicians if they have a difficult or complex case. In addition, they review the charts of patients coming in the next day, perform comprehensive medication reviews, and offer suggestions for physicians based on nationally recognized guidelines, evidence-based standards, and the health plan's formulary.

By taking advantage of the pharmacists' expertise, primary care physicians can continue to provide timely care for complex patients, eliminating or delaying the need for more intensive or specialist care, Wood points out. For instance, teenagers with acne typically have to wait eight to 10 weeks to see a dermatologist. When they have mild to moderate acne, the pharmacist can provide comprehensive information about therapy choices, relative costs, and up-to-date medication protocols.

In the case of patients with newly diagnosed diabetes, the pharmacists provide support to primary care practitioners in initiating and adjusting insulin dosages, reserving endocrinology referrals for complex and difficult cases.

"This means that primary care practitioners can continue to take care of their patients, reserving referrals to specialists only when necessary. This provides patients and families with timely access to the care they need in the primary care setting that is familiar to them," she says.

When CDPHP set up its community-based medication therapy management program, it invited pharmacists from supermarkets, drugstore chains, and independent pharmacists to participate in the program. Participating community-based pharmacists go through a full day of orientation to learn about how the health plan operates and how to interact with members and their physicians. "We want the pharmacists who work in retail to learn about the health plan's care management programs and the importance of supporting primary care," Wood says.

The pharmacists work in conjunction with patients' primary care physicians and other CDPHP programs.

"Aside from the medication therapy management program, we have medical case management and behavioral case managers for our members

who need those services. If pharmacists in the community identify social, behavioral, medical or other health challenges, they can contact the case managers, who will intervene," Wood says.

When members are referred to the pharmacy program, they receive a welcome letter explaining the program and telling them to expect a call from a pharmacist. When the health plan identifies patients who need medication therapy management and who already are working with a CDPHP case manager, the case managers can contact a pharmacist for assistance.

The community pharmacists receive referrals from the CDPHP pharmacy department and contact the patients by telephone to set up a time for a meeting. "The ideal engagement is face to face so members can bring in all their medications for the pharmacist to review. If patients prefer to talk on the telephone, the pharmacist can accommodate them," she says.

Pharmacists provide each patient's physician with a comprehensive medication list, including medications prescribed by other providers along with observations and recommendations. If there are urgent patient safety concerns, such as dangerous drug combinations, the pharmacists call the physicians directly.

Pharmacists follow up each quarter and review each member's records to identify new medications and call the patients to make sure they are following their medication regimen. ■

Telemonitoring reduces HF readmissions

Program monitors weight, answers questions

UCare's telemonitoring program for at-risk members with heart failure has resulted in a 40% reduction in inpatient admissions and a 26% drop in emergency department visits.

Patients are eligible for the high-intensity program if they have had two or more hospital admissions or emergency department visits for heart failure in the past 15 months. Some patients are referred to the program by their primary care physician or the UCare health coaches, who review monthly claims reports and call members with heart failure and screen them for their risk level, according to **Jodie Milner**, RN, CHC, manager of health improvement for the Minneapolis-based health plan.

Members with heart failure who are considered at-risk are offered the health plan's Healthy Heart program, which includes telephonic health coaching.

UCare sends referrals for the program to a vendor which administers the telemonitoring program. Patients receive a welcome letter that explains the program and how they were identified, and gives them an opportunity to opt out. An enrollment specialist calls patients who want to participate, and explains the program. Participants receive a telemonitoring device along with detailed, easy-to-understand instructions on how to hook the device into a telephone jack and electrical outlet. Members who don't have a land line receive a device that works with a cellular telephone.

The telemonitoring scale is available in a number of languages.

Members weigh themselves daily on the scale and answer a series of 13 to 15 questions related to heart failure that can be answered "yes" or "no." Questions include:

- Are you more short of breath today?
- Are your ankles more swollen today?
- Have you taken all of your medicine?
- Are you coughing?

The questions may change on a daily basis depending on the member's response. In addition, the vendor nurse can send targeted messages across the screen on the device.

When the member answers "yes" to any question, the device, using branching logic, asks more questions that drill down to determine the cause of the symptom.

EXECUTIVE SUMMARY

At-risk members with heart failure are eligible to participate in UCare's telemonitoring program, which has dramatically reduced inpatient admissions and emergency department visits.

- Members receive a telemonitoring device that plugs into a phone line and transmits the members' weight and answers to a series of questions about their conditions and overall health.
- The device uses branching logic to drill down and ask more questions to find the cause of problems when members answer yes to questions.
- When patients have gained weight or their answers indicate problems, the nurse monitoring the system gets a red alert and intervenes.

The member's weight and the results of the questions are transmitted over a toll-free line to a computer screen that is monitored by a nurse. If members report symptoms that are outside the normal parameters, the nurse receives a red flag alert.

"If a member has gained or lost weight or reports a symptom that could indicate a red flag, the nurse follows up by telephone and asks more questions to find out what is going on," Milner says. For instance, if members have gained weight, the nurse may ask about recent meals to determine if they need to reduce their salt intake.

The nurse follows up with any patient who appears to be experiencing problems. The nurse may manage the problem by telephone or refer the member to his or her primary care physician for a same-day appointment.

If members do not weigh in, the nurse calls them to find out why. Members who have been doing well receive a call from the nurse each month. During the phone calls, the nurse educates patients on managing their disease, diet and exercise, smoking cessation, the importance of getting flu and pneumonia shots, and tips for healthy living.

When members have had their weight under control and haven't reported any symptoms for a period of time, they will be discharged from the program.

"Patients often don't want to leave the program. They get used to using it as a safety net, but we want them to get in the habit of weighing themselves daily, eating right, exercising, and taking their medication on their own," Milner says. ■

Cardiac patients get help via text message

Program improves patient communication

As a way of prompting patients to attend more cardiac rehabilitation sessions, the University of Iowa Hospitals and Clinics in Iowa City has implemented a text message program that gives patients in the cardiac rehab program heart-healthy tips and reminds them of the sessions.

"We know that the more sessions a patient completes, the better the outcomes, but it's a challenge to keep the patients engaged in the program. We have found that few patients attend all 36 sessions, and many of them drop out too early," says **Patricia Lounsbury**, RN, BSN, Med, CCRN, FAACVPR, immediate past program director for cardiac rehabilitation, known as CHAMPS (Cardiovascular Health, Assessment, Management, and Prevention Services) at the University of Iowa Hospitals and Clinics.

The organization offers patients who have been hospitalized for heart attacks, coronary bypass or heart valve surgery, or heart disease up to 36 sessions of rehabilitation after they are discharged from the hospital.

Increasing participation

Patients who are in the texting program complete significantly more sessions than patients who are not in the program, even if they don't complete all 36 sessions, Lounsbury says.

"Cardiac rehabilitation is as good as other cardiac treatments, including medication, in preventing patients from having another cardiac event. We want to get patients engaged in the program so they will complete as many sessions as possible," she says.

The cardiac rehab staff offers the program to all patients during their first visit and signs up those who have text messaging capabilities on their phone and who want to participate. Most of the patients who sign up are under age 70, Lounsbury says.

The clinic contracts with a technology company that provides three to five interactive text messages to participants each week. The messages are a combination of heart healthy tips and requests

EXECUTIVE SUMMARY
Patients who participate in the University of Iowa Hospitals and Clinics' text message program attend more rehab sessions than patients who do not participate.
• Patients receive between three and five interactive messages a week that include heart-healthy tips along with requests for information on their condition.
• The clinic staff monitor the patients' answers using a laptop computer and intervene when answers indicate the patient is having problems.
• The staff may use a chart of the patients' answers to show their progress on weight loss or managing their blood pressure.

for information, such as, "How many minutes did you exercise today?" or "What is your blood pressure today?" The patients text back their answers to a computer program that is accessible to CHAMPS staff members at any time.

One of the nurses in the cardiac rehabilitation clinic checks the text message replies in the morning and afternoon via laptop computer. If any of the responses indicate the patient is having problems, the nurse either intervenes or alerts someone else on the staff.

In addition, the vendor takes patient answers to questions such as weight, blood pressure, and time spent exercising, and turns them into a graph that shows patient progress, which can be shared with the patient during the cardiac rehab session.

"We can show patients their weight loss or how their exercise has increased or blood pressure has decreased. This is a real motivator, and it helps them stay responsible for their own care," she says.

An added benefit to the texting program is that it allows the cardiac rehab staff to be in touch with patients between weekly sessions, Lounsbury says. For instance, one question is, "Did you take your medication today?" If a patient texts "no," someone in the clinic texts them back and asks if the doctor told them to stop and, based on the patient's answer, may intervene.

"Medication adherence is a big factor in managing this population of patients. We have contacted patients' physicians when they weren't taking their medication. In one case, when a patient said he couldn't afford his medication, we were able to get social services to help him connect with medication assistance," she says.

Another benefit to the texting program is that patients often text the clinic to say they won't make it to the next session.

"In the past, some patients were just no-shows. Texting is an easy way for them to let us know not to expect them. We text them back and ask them when we will see them again," Lounsbury says. When patients don't contact the clinic and don't reply to the texts for a while, the clinic staff send them a text message asking if they want to stay with the program, she says.

Once patients are in the program, they can continue to receive text messages as long as they like, or they can drop it when they finish cardiac rehab, she says. ■

Health plan, community team up for DM

Patients receive education in a familiar setting

In addition to developing its own disease management programs, WellCare Health Plans is partnering with organizations that provide social safety net services to implement the programs for their members with diabetes.

The arrangement is a win-win situation for all the parties, says **Pamme Taylor**, vice president for advocacy and community-based programs for WellCare Health Plans, headquartered in Tampa, FL. "Our members receive education on managing their conditions from an organization they trust, the organizations receive funds they need to stay afloat, and we have an effective disease management program," Taylor adds.

The program began as a unique private/public/academic venture. WellCare worked with Texas A&M Health Science Center to establish a partnership with community organizations to train individuals to implement the Stanford Chronic Disease/Diabetes Self-Management programs.

"When we started the initiative, we looked for partners that provide essential services in the community and identified programs that used evidence-based protocols. We chose to use a network of organizations with public assistance programs," Taylor says.

After the successful pilot with Texas A&M, WellCare began contracting directly with the agencies to provide the program using the Stanford Diabetes Self-Management curriculum.

The staff at the social safety net organizations undergo extensive training on how to administer the program.

The economic downturn in recent years has resulted in spending cuts for social safety net organizations at the same time that more people are seeking assistance, Taylor points out.

"Funding cuts make it harder for people in great need to access social services, which ultimately has an impact on health conditions. We need those organizations to serve our patients and help them access the social assistance they need so they can concentrate on their health," she says.

An added benefit of partnering with local social safety net organizations is that many people that WellCare serves are already receiving services from those organizations in their community, Taylor

says. They are familiar with the organizations, trust them, and know where they are located. "People are more likely to follow advice if they receive disease management education from organizations where they already receive services," she says.

The Diabetes Self-Management Program is a series of classes that aim to help members take control of their health and achieve a better quality of life, Taylor says. The classes involve more than just lectures. Participants learn how to apply the lessons they learn. For instance, a dietician teaches how to make healthy food choices on a budget, and a professional chef comes in to teach healthy cooking techniques.

"The program is designed to give people with diabetes the knowledge and skills needed to modify their behavior and successfully self-manage the disease and its related conditions," Taylor says.

WellCare identifies members eligible for the program through claims data and referrals from case managers and disease managers at the company. Each member completes a health risk assessment that guides the level of the interventions, she says. In addition, WellCare has informed providers in the community about the program and encourages them to refer eligible members.

The interdisciplinary case management team at WellCare stratifies members with chronic diseases to determine their need for interventions and develops an individual plan for those who are at risk. "Members with chronic illnesses have very different needs. The plan depends on their conditions, their overall health, and caregiver support, and may or may not include the community-based classes," Taylor says.

When members are identified as eligible for the program, a WellCare case manager contacts them and explains how the program works.

Whenever possible, the health plan refers members to an organization in their community for the diabetes disease management classes. If there isn't a program available in their community, the members are referred to WellCare's own disease management program.

"Whenever possible, we try to use what exists in the community. Members are familiar with the community organization and it's more effective for them to receive education from an organization in their local area," she says.

WellCare tracks the number of members referred to the program, the number of members who enroll, and how many completed the program in the pilot phase. It's too soon for statistical outcomes, Taylor says, but anecdotally, the program has been a success.

"Through our partnership with Texas A&M Health Science Center, we originally planned to implement the program in 20 sites. We now are up to 84 and we are expanding the program to all markets, not just members receiving Medicaid benefits. Our goal is to quantify the impact of the social safety net on health outcomes, while we help our members live happier, healthier lives," she says. ■

EXECUTIVE SUMMARY

WellCare Health Plans is partnering with community-based organizations that provide social safety net services to provide a diabetes management program for its members.

- The initiative gives the financially strapped organizations the funds to keep providing services to those in need and provides education in a setting familiar to patients.
- Organizations are trained to implement the Stanford Diabetes Self-Management Program, a series of classes that aim to help members take control of their health and achieve a better quality of life.
- When eligible members are identified, if there isn't a program in their community, they are referred to WellCare's own disease management program.

Findings underscore value of palliative care

Experts: Begin goal discussions earlier

There is new evidence that initiating palliative care consults in the ED results in shorter hospital lengths of stay (LOS) than when palliative care consults are not provided until after admission. Researchers looking specifically at the impact of earlier palliative care consults report that in an analysis of 1,435 palliative care consults, 50 of which took place in the ED over a four-year period, consultation in the ED was associated with hospital stays that were 3.6 days shorter, on average, than the hospital stays of patients who received palliative care consults following admission.[1]

While the study is small, it reinforces the observation that the longer palliative care

consultation is delayed the less impact it has, explains **Abraham Brady**, RN, PhD, GNP-BC, an assistant professor at New York University College of Nursing in New York City, and a co-author of the study. "There are certain patients who come into the ED who really should have been seen by palliative care [clinicians] sooner," he explains. "If we start their [palliative care consult] in the ED rather than waiting until they are up on the floor or in the ICU [intensive care unit], we might be able to improve their quality of life or quality of care within the hospital and meet their needs and goals better."

What should trigger a palliative care consult in the ED? In the study, the mechanism was fairly straightforward, explains Brady. "We gave every provider within the ED, both physicians and RNs, a set of guidelines for patients who would be appropriate [for a palliative care referral]," he says. "Providers could refer patients outside of that set of guidelines, but the guidelines focused on the groups of patients we believe are seen most heavily in the ED."

For instance, patients with metastatic cancer, advanced congestive heart failure, advanced chronic obstructive pulmonary disease, or advanced dementia were candidates for palliative care consultation, says Brady. "These are probably the four top groups of patients who can best use goals-of-care discussions, quality-of-care discussions, and other quality-of-life services offered by palliative care teams," he adds.

Focus on goals of care, patient needs

The aim of palliative care is to be holistic, to improve the quality of life of patients, and to meet the needs of patients and their families; consequently, a palliative care consult needs to include several components, explains Brady. "The palliative care provider will have an extensive goals-of-care discussion with the patient or a family member to try to ascertain what the needs of the patient are," he says. "The provider will also make sure that the patient's symptoms are managed appropriately, and then they will bring in other areas of care."

For instance, many palliative care teams have chaplains or other spiritual advisors, and some have social workers or psychologists involved as well. Also, many palliative care teams are led by nurses or nurse practitioners rather than physicians. "The overall goal of this comprehensive team is to help make sure that the patient's needs are met, so it is all about patient-centered care, and making sure that the patient has their needs met rather than the health system having its needs met," says Brady.

When patients present to the ED, for example, one goal of the ED clinicians is to get the patients out one way or another to make way for incoming patients, explains Brady. "Whether a patient is discharged or sent up to the ICU or one of the other medical units of the hospital, that is the traditional pathway," he says.

However, the traditional pathway is not always the best or the preferred approach for some patients, says Brady. For instance, he recalls the case of a patient with advanced dementia who could have been admitted to the hospital. "That would have been the easy way to go," he says. "But the palliative care team involved was able to arrange for the patient to go directly back home with home hospice services to prevent an admission to the hospital and ensure that the patient was cared for in the setting he wanted," he says.

Address barriers

Integrating palliative care into the emergency setting isn't always an easy fit, says Brady. "The way the business model is set up within an ED is that you have to get the patients out the door into a more appropriate environment, whether that is the home environment or the hospital," he says. "At the same time, however, ED physicians and nurses get very frustrated when they see the same patients returning again and again."

Consequently, while there can be some resistance to palliative care in the emergency setting, Brady observes that emergency clinicians may also see palliative care services as being a solution for some of the patients who frequent the ED, but do not necessarily require emergency care. "Emergency clinicians don't want to see patients coming back again and again for a heart failure exacerbation — something that should be managed in an outpatient setting, so there is some buy-in [for palliative care consults in the ED]," adds Brady.

However, even when there is ample buy-in, the availability of on-site palliative care clinicians is less than optimal. In the study, there

were many patients who met the criteria for palliative care consults, but they were not referred, explains Brady. "A lot of these cases were on nights and weekends when there was no palliative care coverage … so one of the biggest barriers was that there wasn't 24/7 on-site availability of palliative care team members in the hospital," he says. "Most palliative care teams have 24/7 coverage in that someone is available by phone, but most do not have a 24/7 presence in the hospital."

Given the significantly reduced LOS of patients who received palliative care consults, it is possible that it would be cost-effective to provide 24/7 on-site palliative care coverage in the ED, acknowledges Brady, but he notes that studies need to be done that show this is the case.

Another barrier is the dearth of clinicians equipped with palliative care training. "We can just about meet the needs in the inpatient setting, but as we move into having more and more palliative care clinicians in the outpatient setting, that is something where we don't have enough training slots to meet those needs," explains Brady.

Identify palliative care resources

The American College of Emergency Physicians (ACEP) is fully on board with efforts to integrate palliative care treatment options into the treatment of appropriate patients who present to the ED with chronic or terminal diseases. In October, ACEP cited the early introduction of palliative and hospice care services as one of the organization's five top recommendations as a co-sponsor of the "Choosing Wisely" campaign, a multi-year effort of the American Board of Internal Medicine (ABIM) Foundation aimed at promoting conversations among physicians and patients about the appropriate use of tests and procedures, and avoiding care when harm may outweigh the benefits.

"Palliative care has risen to the top of the radar screen for emergency medicine," says **Tammie Quest**, MD, an emergency medicine physician and director of the Emory Palliative Care Center for Emory University's Woodruff Health Sciences Center in Atlanta. "What has happened is a growing awareness of the role of palliative care and end-of-life support services."

While it is not clear how many EDs thus far have integrated palliative care into their service options, Quest stresses that when emergency clinicians have resources such as palliative care units, consultants, or hospice services available to them, they will use them. "Culturally, the field is very open to change. Emergency medicine is one of the most flexible and adaptable specialties," she says. "My own experience is that when you teach emergency providers what the resources of palliative care are, either by them learning additional skills themselves or by utilizing skills that may be in a system, there is very good uptake of these skills and/or resources."

Find a champion

At Emory, there is no formal list of triggers to prompt an emergency provider to call for a palliative care consult. "After more than a decade of education between our residents and faculty, we have very good emergency clinicians who can recognize the need for palliative care in seriously ill patients," says Quest. "More than 10% of admissions to our hospice unit are sent directly from the ED, so our emergency providers here are very good at goals-of-care conversations and assessment of patient and family needs, so they will often call with people who they feel are appropriate."

However, in systems where primary palliative care may not be as rich, it can be helpful to have a palliative care specialist available to emergency clinicians when they have a patient who could benefit from palliative care services. In fact, Quest is director of Improving Palliative Care in Emergency Medicine (IPAL-EM), an effort to equip EDs with the tools and knowledge required to improve palliative care in emergency settings. She advises administrators to begin the process with a needs assessment.

"Sit down with a group of people who are in the ED, figure out where the greatest need is, and find an ED champion," says Quest, noting that the needs assessment form is just one of a number of tools that are available free of charge through the IPAL-EM website, which is operated by the Center to Advance Palliative Care (www.CAPC.org), headquartered at the Icahn School of Medicine at Mount Sinai in New York City. "You need an ED champion who will peel the onion back layer by layer, and just take a deeper look to determine, of all the

things that need to be done, what really needs to be prioritized."

Once palliative care priorities are established, you can create an action plan for how to achieve them, says Quest. "I would suggest that emergency clinicians reach out to their hospital-based palliative care services or their community hospice providers to see what partnerships can be forged to get their needs met."

Consider new payment models

Accountable care organizations (ACOs) and other new payment models that reward quality and efficiency are likely to focus more attention on the benefits of palliative care. In the case of ACOs, for example, providers who are successful at keeping patients out of the hospital and the ED are able to share in the savings that result from the avoidance of unnecessary, expensive care. "Similarly, if patients go on hospice earlier, that saves money because in order to get the full benefit of hospice you need [patients in the program for] 50 to 100 days at least. And right now, patients are in hospice for about seven days, on average," says Brady.

Another positive financial impact comes from the avoidance of the penalty Medicare imposes on hospitals that have elevated readmission rates. "Palliative care teams have been shown to reduce readmission rates," adds Brady.

While financial considerations are not what drive decision-making in palliative care, the model is aligned with an ACO's emphasis on better resource utilization and better outcomes, says Quest. The decreased costs and more effective use of resources do not come from withholding care, but rather by aligning patient-centered goals around whatever the care and treatment options are, she says. "I think that the way palliative care stands to benefit emergency care providers, patients, and ACOs is really by consistently using patient-centered models of assessing what patient goals of care are, what the outcomes and perceived expectations are from the patient and family, and what we are clinically able to deliver."

REFERENCE

1. Wu F, Newman J, Lasher A, Brody A. Effects of initiating palliative care consultation in the emergency department on inpatient length of stay. *Journal of Palliative Medicine* 2013;16:1362-1367. ■

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's free blog at http://hospitalreport.blogs.ahcmedia.com/. *Case Management Advisor*'s executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute. ■

COMING IN FUTURE MONTHS

- Your opportunities in a health home
- Care coordination for dual eligibles
- Tips on providing culturally competent care
- Counseling patients on palliative care

CNE QUESTIONS

1. According to the Centers for Disease Control and Prevention, what percentage of healthcare expenditures is spent on chronic disease?
   A. 50%
   B. 60%
   C. 75%
   D. 80%

2. After the initial review of medications, how often do pharmacists in Capital District Physicians' Health Plan's medication therapy management program contact members?
   A. Every month
   B. Every two months
   C. Every quarter
   D. Twice a year

3. What are the criteria members with heart failure must meet to be in UCare's telemonitoring program?
   A. Two or more hospitalizations or emergency department visits for heart failure in a 15-month period
   B. Two or more hospitalizations or emergency department visits for heart failure in a 12-month period
   C. Three or more hospitalizations or emergency department visits for heart failure in a 15-month period
   D. Three or more hospitalizations or emergency department visits for heart failure in a 12-month period

4. According to Patricia Lounsbury, RN, BSN, Med, CCRN, FAACVPR, immediate past program director for cardiac rehabilitation, known as CHAMPS (Cardiovascular Health, Assessment, Management, and Prevention Services) at the University of Iowa Hospitals and Clinics, patients who receive three to five text messages a month complete significantly more sessions than patients who are not in the texting program.
   A. True
   B. False

CNE OBJECTIVES

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

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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. Scan the QR code below or 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. ■