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IN THIS ISSUE

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Newest member of the care team guides patients through the maze

Navigators are bridge between MDs, patients

Today's complex healthcare system can be daunting for anyone. But when patients are stressed by being in the hospital, overwhelmed by what they need to do to follow their treatment plan, confused by a complicated medication regimen, and facing psychosocial and financial obstacles as well, you're almost setting them up for failure.

That's where a new member of the healthcare team comes in. Hospitals, physician practices, and health plans are turning to patient navigators to guide patients through the healthcare maze and help them access everything they need to manage their health.

Navigators remove the obstacles patients face in getting access to healthcare and following their treatment plan. They meet face to face with patients and many times develop a close relationship. While clinicians are often rushed, patient navigators have the time to get to know the patients, find out what their living environments and support systems are like, and answer their questions and concerns, forwarding concerns to their providers when needed.

"Patient navigators act as a bridge between patients and healthcare providers. They are someone who can accompany the patient to see the physician after discharge, help them understand their healthcare benefits,

EXECUTIVE SUMMARY
Patient navigators, the newest members of the healthcare team, guide patients through the complex healthcare maze and help them access the resources they need to manage their health.
- Navigators meet face to face with patients and develop a close relationship.
- They act as a liaison between patients and providers, often finding out information the providers would not otherwise know.
- They have the time to gather information about patients and listen to their questions and concerns.

AHC Media

or assist with accessing community resources," says **BK Kizziar**, RN-BC, CCM, owner of BK & Associates, a Southlake, TX-based case management consulting firm.

Many different roles are included under the title of "navigator," and depending on the individual program, navigators may have different educational levels and training, Kizziar points out. "Some navigators are hospital employees who follow patients from admission to discharge to make sure the transition from acute care to home goes smoothly, but navigators aren't necessarily a nurse. They can be savvy lay people with training on the clinical and business side of healthcare," she adds.

"Navigators can be a tremendous asset in the post-acute setting, such as physician offices and outpatient clinics, keeping patients informed of their medical options and helping them understand their conditions and what they need to do to optimize their health," says **Patricia Pittman**, RN, CCM, MHA, independent case management consultant and PRN case manager.

Adding a patient navigator to the inpatient healthcare team allows the inpatient case managers to coordinate the care and the post-discharge services while the navigator steps in as the patient transitions. "We are finding that patients need a lot of hand-holding after discharge. The inpatient hospital case managers simply do not have the time or resources, but navigators are in the perfect position to work with patients after they leave the hospital," Pittman says.

"The new healthcare laws make health systems accountable for patient outcomes like primary care access, quality, and hospital readmissions. To improve these outcomes, it is vital that health systems implement programs that reach beyond their walls and address the root causes of poor health," says **Shreya Kangovi**, MD, MS, assistant professor of medicine at the Perelman School of Medicine at the University of Pennsylvania and director of the Penn Center for Community Health Workers.

After interviewing more than 100 at-risk patients, the University of Pennsylvania Health System developed a model of care that uses community health workers who live in the communities they serve and help patients overcome their challenges in receiving healthcare.

The patients told researchers that they felt disconnected from the healthcare system because providers often didn't understand their living situation. The patients feel comfortable with the community health workers because they share race, culture, and life experiences, says **Casey Chanton**, MSW, project manager for the Penn Center for Community Health Workers.

The team developed a model for community health workers in the hospital setting and in physician offices. *(For details, see related article on page 76.)*

Allina Health, a nonprofit health system of 12 hospitals and 90 clinics in Minnesota and Wisconsin, developed a navigator role — called care guides — as a way to help patients with chronic illnesses meet their clinical goals. Care guides are not clinicians; they are lay health-

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care workers with at least two years of college who undergo two weeks of training. They work in cubicles in physician offices and help at-risk patients access the community resources they need and support them in meeting their healthcare goals. *(For details on the program, see related article below.)*

"Our vision was to find if there is a place in the healthcare system for a variety of healthcare roles. Patients don't always remember everything their doctor told them. The care guides have time to spend with patients to make sure they understand what they should be doing and to support them in meeting their clinical goals," says **Kim Radel**, MHA, director of Allina Health's Care COPILOT Institute. ■

Care guides help patients follow plans

Lay health workers staff MD offices

Allina Health, a nonprofit health system of 12 hospitals and 90 clinics in Minnesota and Wisconsin, has found that lay healthcare workers, called care guides, are helping patients with chronic illnesses meet their treatment goals and keep their conditions under control.

With a grant from the Robina Foundation, Allina developed the care guide program and implemented a pilot project in 2008 with about 300 patients being treated at Abbott Northwestern General Medicine Associates clinic.

In 2010, the program expanded to a randomized controlled study of more than 2,100 patients at six additional clinic locations. Results of the pilot showed that after 12 months, patients who were working with care guides were 31% more likely to meet evidence-based care goals and 21% more likely to quit tobacco than patients who were not part of the care guide program.

"This resulted in significant improvement across all diagnostic groups and demographic categories. Patients with care guides had fewer hospitalizations and emergency department visits," says **Kim Radel**, MHA, director of the Care COPILOT Institute at Allina Health.

After a year, patients working with care guides were more likely to report improved social support, better individualized care, and better understanding of how to manage their illness, Radel adds. She reports that in a post-study survey, 94% of providers and nurses thought that care guides were an effective use of resources.

Now Allina is implementing the program across the healthcare system and has developed the Care COPILOT Institute, which offers resources to help other hospitals and clinic systems develop a care guide program and advance the use of other lay healthcare roles on care delivery teams.

"We knew that a significant portion of patients with chronic illnesses were not meeting their clinical goals. The health system's physicians often say they weren't able to spend the time needed to help patients understand and manage their conditions. Using lay persons as part of the care team to help patients understand and follow their treatment plan is an effective use of resources," Radel says.

Patients targeted for the program have heart failure, diabetes, or hypertension and are struggling with following their treatment plan and keeping their condition under control. When patients are identified for the program, their primary care physicians tell them about the program and introduce them to the care guide.

The care guides are located in cubicles in the primary care physician offices and meet with at-risk patients after their doctor visit and follow up by telephone as needed. Patients can call their care guides at any time and don't need an appointment to see them in the clinic. Patients have their care guide's telephone number and can call whenever they have questions or concerns. "We wanted them to be easily accessible to patients and to meet with them face-to-face in the clinic," Radel adds.

"The care guides sit with patients and talk about how they can help patients navigate the healthcare system and learn to manage their conditions. They help the patients focus on chronic

EXECUTIVE SUMMARY
In a randomized controlled study by Allina Health, patients who work with lay healthcare workers called care guides were 31% more likely to meet evidence-based care goals than those who were not part of the care guide program.
• Care guides act as liaisons between the providers and patients and help at-risk patients meet their clinical goals and follow their treatment plans.
• They meet patients in person in the physician office and follow up by telephone.
• Care guides have at least two years of college and go through an intensive training program.

disease goals based on clinical guidelines, choose which goals they want to start with, and develop strategies on how to meet those goals," Radel says.

The care guides review the treatment plan, talk about why it's important to follow it, reinforce the education patients have received from their doctor or nurse and answer any questions the patients may have about the physician's instructions. They talk about why it's important to meet their goals and have the time to answer any questions the patients may have.

"The care guide acts as a liaison between the care delivery team and the patient. Often, patients don't remember everything the physician tells them during an office visit. The care guides reinforce what their doctors have told them and help them overcome barriers to adherence," she says.

The care guides cannot offer medical advice, but they need to know enough about the patients' conditions to help them find appropriate resources in the clinic or the community, she adds. They help patients sign up for medication assistance and other community resources. They help them follow their treatment plan and help them prepare for their next physician appointment by making lists of questions or concerns.

The care guides are good listeners and are trained to talk to patients as peers rather than using medical language, she says. "They build trust and rapport, and often the patients will tell their care guide things they won't tell their physicians," Radel says.

For instance, one patient with diabetes had been treated by his primary care provider, but after several visits, his blood sugar level wasn't changing. After the care guide started working with him, the patient revealed that he wasn't taking his insulin because of his fear of needles. He didn't tell his provider because he was ashamed and didn't want to disappoint the physician. The care guide shared the information with the primary care physician, who switched the patient to oral insulin.

"The situation could have snowballed and the patient could have gotten sicker while the physician could have continued to waste time and resources. The care guide was able to uncover the problem and that patient began to get his blood sugar level under control," she says.

Allina's care guides have at least two years of college and many have four-year degrees. "We don't require any specific degree and have applicants with degrees in psychology, business, communications, and other fields as well as people who want to go to medical school eventually," she says. They undergo two weeks of full-time training that includes classes on evidence-based care for chronic conditions, motivational coaching, cultural and diversity issues, documenting in the electronic health record, and shadowing doctors and nurses in the clinic.

"We look for people who have the ability to communicate well and form relationships with patients. They are outgoing enough to have conversations with patients and at the same time keep the relationship on a professional level and stay within boundaries," Radel says.

As part of Allina's initiative to become a Pioneer Accountable Care Organization, the care guides are now included in a team that includes RN case managers, social workers, and pharmacists who work together to manage high-risk patients. The care guides are based in the clinic but work closely with hospital case managers and other team members to follow up with patients after discharge and make sure they see their provider in the clinic on a timely basis. ■

Patients stay healthier with peer support

At-risk patients benefit from CHWs

Over the past four years, more than 3,000 at-risk patients treated by providers in the University of Pennsylvania Health System have received consistent primary care, improving their health and avoiding hospitalizations and readmissions with the support of community health workers, trained laypersons who live in the community and understand the challenges the patients face.

"These patients have a lot of barriers to staying healthy, including economic and psychosocial issues such as unstable housing, unstable access to food, and lack of transportation," says **Casey Chanton**, MSW, project manager for the Penn Center for Community Health Workers. "Community health workers are trained lay people, not clinicians, and their role is one of support, advocacy, and navigation. Because they have had some of the same life experiences, patients feel comfortable talking with the community health worker."

A team of researchers at the Perelman School of Medicine at the University of Pennsylvania developed the IMPaCT (Individualized Management for Patient-Centered Targets) model after interviewing more than 100 high-risk patients about their challenges in receiving healthcare and staying healthy and reviewing other community health worker programs.

"A major theme of the interviews was a sense of disconnect from the traditional healthcare staff. The patients told us that the doctors and nurses were from very different backgrounds and didn't understand the world the patients live in. The providers often gave patients health goals that they couldn't possibly meet due to their living situation or other social and economic barriers," Chanton says.

Based on what the patients had told them, the team developed a model of care that uses lay people within the community to work with at-risk patients. "Our community health workers share characteristics with the patients they serve. They live in the same neighborhoods, share race and culture, and have had the same life experiences," he says.

The team conducted a pilot randomized control trial with 446 patients and determined that in just two weeks, the IMPaCT model significantly improved patient activation, access to primary care, mental health status, communication scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and recurrent readmissions.

The health system created the Penn Center for Community Health Workers and adapted the IMPaCT model for the inpatient hospital and clinic setting.

The community health workers meet patients in the hospital or the clinic, visit them at home, and accompany them to clinic visits or community social service agencies. "They serve as a bridge between the healthcare team and the patient," Chanton says.

The community health workers have the time and patience to listen to patients and find out what is going on in their lives. "Many of the issues that make it difficult for patients to stay healthy are not medical issues but are real-life issues such as unstable housing or lack of transportation," he says.

The community health workers ask the patients what they need to do to improve their own health and work with them in meeting healthcare goals, Chanton says. They may help them find childcare, look for a job, or sign up for food stamps.

The community health workers collaborate with clinicians on the treatment team to identify patients who could benefit from the intervention. Community health workers embedded in the hospital setting work on transitions between the hospital and the community and follow patients closely for a minimum of two weeks after discharge, he says.

The health workers meet patients while they are still in the hospital and talk with them about their health issues and what they need to do to get healthy, Chanton says. They may help patients identify a primary care provider and accompany them to their appointment. They work with patients on meeting their healthcare goals and help them access any community resources they need. Because of the intensity of the interventions, hospital-based community health workers carry a caseload of only eight to 12 patients at a time, he says.

Community health workers in the clinic setting have a caseload of 25 to 30 patients and work closely with them for six months, meeting them when they come to the clinic and working with them in person in the community, he says.

"Patients meet with their providers to set healthcare goals. The community health workers help the patients break these goals down into achievable steps, create an action plan, then support them as they meet those goals," Chanton adds.

The community health workers round with the clinical team and often are able to provide useful psychosocial or socioeconomic information that

EXECUTIVE SUMMARY

The University of Pennsylvania Health System has found that interventions by community health workers improve outcomes and reduce hospital readmissions for at-risk patients.

- Community health workers live in the communities of the people they serve and have had the same health experiences.
- They go through four weeks of training that includes peer counseling for behavioral change, how to access resources in the community, how to interact with a medical team, how to work with patients who are in crisis or facing health issues, and help them access the appropriate providers.
- They meet patients in the hospital or the clinic, visit them at home, and accompany them to clinic visits or community social service agencies.

the providers otherwise wouldn't know.

"They visit in the home and see what the conditions and family situation are like. They can give the team a fuller sense of everything that is going on in the patient's life. Because they develop close relationships, patients may share information with the community health worker that they are reluctant to tell their physicians," he says.

Patients targeted for IMPaCT interventions live in five ZIP codes with high rates of poverty where residents are at highest risk for readmissions and chronic diseases. The Penn Center recruits community health worker candidates from the same geographic area.

"We partner with community organizations to help in our recruiting. Our goal is to hire people who are natural helpers in the community. Many of them are already doing similar work, like checking on a sick neighbor," Chanton says.

The community health workers go through four weeks of training that includes peer counseling for behavioral change, how to access resources in the community, how to interact with a medical team, and how to work with patients who are in crisis or facing health issues and help them access the appropriate providers.

The Penn Center for Community Health Workers has developed a tool kit that other providers may use to implement a community health workers program. The tool kit is available at no charge at http://chw.upenn.edu. ■

PCPs, health plans co-manage dual eligibles

Information sharing key to program's success

By sharing information and collaborating on patient care, Atrius Health and two health plans are coordinating care for patients who are eligible for both Medicare and Medicaid benefits.

Patients who are eligible for both Medicare and Medicaid tend to have complex conditions as well as psychosocial issues that interfere with getting care and following their treatment plan, says **Emily Brower**, executive director of Accountable Care Programs for Atrius Health, a nonprofit alliance of six multispecialty medical groups and one home health and hospice agency in eastern and central Massachusetts.

"Our dually eligible patients definitely need a lot of home and community-based support in getting access to care and supporting their care plan," she says.

The organization analyzed its patients who were dually eligible for Medicare and Medicaid and found that they fell into two distinctly different groups, Brower says. Dual eligibles who were over 65 were similar to the rest of the Medicare population, but their chronic diseases tended to be more complex and challenging. Those under 65 had a higher incidence of behavioral health conditions, including substance abuse, she says.

Atrius Health partnered with Commonwealth Care Alliance to provide coverage and services for its dual eligible patients under 65, and Tufts Health Plan for patients over 65, she says. Atrius Health's physician practices provide the medical care for the patients in the program. The health plan case managers see the patients in person, connect them with the social supports they need, and work with the physician practice case managers to make sure the patients get all the services they need. Case managers from the health plans and from the physician practice will have regular conference calls to review cases that are active and collaborate on meeting the patient needs, she says.

Before the recently launched collaboration started, Atrius Health staff held a series of working meetings with representatives from the health plans to develop a model that ensures that the health plans and physician practices share information that enables them both to provide better care and care coordination for the patients in the program, Brower says.

"Communication is the glue that holds this

EXECUTIVE SUMMARY
Atrius Health, an alliance of six multispecialty medical groups and one home health and hospice agency, has teamed up with two health plans to jointly coordinate care for patients who are eligible for both Medicare and Medicaid benefits.
• Atrius Health provides the medical care for patients in the program, and the health plan case managers connect patients with the social support they need.
• Health plan care managers can access the patients' medical records before meeting with them to conduct a thorough assessment.
• The health plans and physician practices share information that enable both to provide better care and care coordination.

model together. With that communication, we'll know what is going on with patients, know the patients' goals, and work together to help the patients meet their goals and stay healthy," Brower says.

Atrius Health gives health plan case managers access to the enrolled patients' medical records so they can understand the clinical picture before contacting the patients, she says.

When patients join the program, the health plan case managers review the medical record and make notes of lab values, blood pressure control, gaps in care, and any services the patient is receiving from the primary care clinic, such as nutritionist visits or a diabetes program, Brower says.

Armed with this knowledge, says Brower, the case managers will visit each patient at home, conduct a comprehensive assessment of medical and psychosocial needs, and review the patient's medication, checking a list from the physician office, and go over it with the patient, adding any over-the-counter medications or other substances he or she is taking.

In the case of people over 65, the case managers may also check for throw rugs, electric cords, and other fall risks and make sure the bathroom is accessible, Brower says.

Case managers work with the patients to set goals, work with them on strategies to meet the goals, and reinforce the information they have received from their physician office, according to Brower.

For instance, if the patient has been meeting with a nutritionist in the physician office, the case manager may ask about the patient's diet, what kind of meals he or she eats and who cooks the food, then go over the nutritionist's instructions.

After the initial meeting in the patient's home, Brower says, the health plan case manager follows up at regular intervals, either in person or by telephone depending on the patient's needs.

Commonwealth Care Alliance has a lot of experience coordinating care for disabled patients who are under the age 65, Brower says. "Many of these patients have behavioral health issues. We partnered with an organization that has a strong relationship with mental health providers to round out our network of service and to complement the services we provide. We are also fortunate to partner with Tufts Health Plan, which has been working with us on other programs for seniors for many years," she says.

When the health plan case managers complete an assessment, they share information about what is going on in the patient's home, what kind of support is in place, safety issues, barriers to care, and other details that will be helpful for the physician to know, she says.

"There's a real benefit to our collaboration because we get the whole picture of a patient. We start with the clinical picture in the patient's medical record and complement it with what the health plan case managers see in the home, such as social support and patient needs," she says.

The physician practice and the health plans manage the patient together and each participates in meeting a common goal, Brower says. "This program integrates medical and clinical needs with the patients' needs at home and in the community and provides care for the whole patient," she adds.

"We are the medical experts and partner with the health plans for expertise in community-based support. In general, we provide the medical services and the health plan provides the community-based support, but there is a lot of overlap," Brower says.

For instance, Atrius Health has a strong program for patients with diabetes, Brower says. Atrius medical group staff provide patient education about the disease and how patients can self-manage. "The health plan case managers reinforce the diabetes education we provide when they see the patients in their homes and work with patients on developing goals that are important to them. We work together to bring in other resources when available, and each organization reinforces the others' work with the patients," she says. ■

State initiative trims ED utilization

Care coordination model does not deny access

While the beginning stages of the effort may not have been pretty, Washington state's coordinated program to tamp down costs related to high ED utilization by Medicaid recipients has not only exceeded expectations in terms of cost savings, now emergency medicine professionals are eager to apply the partnerships formed as part of the approach to other health care problems. And why not? The infrastructure and the relationships are in place. And leaders of the ER is for

Emergencies effort are eager to use the new tools at their disposal to bring more value to the table. With $33.6 million in Medicaid savings to report in the program's first year, it is no wonder why providers and policymakers from other states are eyeing the program as well.

However, it is worth remembering that what prompted the effort in the first place was a proposal made in 2011 by the state's Medicaid chief to put a lid on the number of "non-emergency" ED visits the state would pay for, leaving hospitals on the hook for any additional "non-emergency" visits. The state chapter of the American College of Emergency Physicians (ACEP) filed suit against the state with backing from the Washington State Hospital Association and the Washington State Medical Association.

The proposal was put on hold while hospitals and physician providers came up with an alternative plan involving the implementation of seven best practices. Getting all the hospitals and EDs in a state to act in concert is never easy, but with the threat of non-payment hanging over their heads, they all participated.

Create a shared vision

While tempers were heated at the time, to say the least, emergency providers concede that state pressure is what pushed them to make needed reforms. "It was sort of the sword of Damocles over our heads that motivated change," says **Nathan Schlicher**, MD, FACEP, JD, associate director of the ED at St. Joseph's Medical Center in Tacoma, and one of the leaders of the ER is for Emergencies program. "It allowed us to save costs for the state, but in a way that enabled hospitals to save money by lowering their staffing if their volumes went down. The alternative with the state plan was to say you keep providing care, and you keep paying for it, and we are not going to pay you."

While ED volumes did go down significantly, each hospital was able to change its staffing to meet the new level of care rather than just face less reimbursement while providing more care, explains Schlicher. "With the overcrowding that exists in EDs across the country — and we have it here in Washington — this allowed many institutions to avoid having to do very expensive and massive remodels," he says. "So the incentives aligned well with doing the right thing, and I think that is what we needed: having a shared vision and a shared goal set, but then allowing the experts in the field — the providers of care — to figure out how we get there."

In addition to relieving pressure on the state's Medicaid budget, the "ER is for Emergencies" initiative also helped the state chart impressive gains on several other metrics. The Washington State Health Care Authority reports that an analysis of claims data for ED activity between June 2012 and June 2013 shows that:

- the rate of ED visits by Medicaid recipients declined by 9.9%;
- the rate of visits by frequent utilizers (five or more visits per year) declined by 10.7%;
- the rate of visits resulting in a scheduled drug prescription fell by 24%;
- the rate of visits for a low-acuity diagnosis declined by 14.2%.

Anticipate challenges

From the start of the initiative, the biggest challenge was obtaining administrative buy-in to implement the seven best practices, explains **Stephen Anderson**, MD, FACEP, an emergency physician at MultiCare Auburn Medical Center in Auburn, and past president of the Washington chapter of ACEP. "We were going to administrations and saying that we needed them to spend money on infrastructure, and what we also needed them to anticipate is that by doing so, they would also see a drop in volume," he says. "That doesn't play out in the economic back rooms real well, so it was really critical that we had the whole team on board. We had the back-up of the Washington State Hospital Association going into this."

A second challenge involved getting all the primary care providers (PCPs) in the state to understand the process, and this continues to be a work in progress, made more difficult by the fact that Medicaid does not reimburse well for primary care visits, says Anderson. "Clearly, it is a challenge to see some of the high utilizers that we have; they are high time-intensive patients," he says. "So explaining the seven best practices — [and in particular] what is called the PRC program — patients requiring coordination to primary care, and really pushing for that early follow-up within 72 hours was difficult." However, Anderson adds that the task was manageable because the initiative had the backing and support of the Washington State Medical Association.

Getting all the emergency providers in the state to support the initiative did not take long, given that they were well aware of the state's non-payment alternative, says Anderson. But he also notes that providers were getting some tools that they had long requested, including the state's new prescription monitoring program (PMP) and the Emergency Department Information Exchange (EDIE). These tools give providers information about a patient's previous prescriptions and previous visits to EDs throughout the state.

Further, anticipating some of the issues that could result in cases in which emergency physicians decline to write prescriptions for patients identified as drug seekers, leaders of the initiative coached emergency providers with sample conversations, and they also created a letter providers can give to their administrators in anticipation of any patient complaints related to the denial of narcotic prescriptions. (To view the letter, visit http://www.washingtonacep.org/educationresources.html. Find the link at the bottom of the page.)

"Once we gave our providers the tools they were asking for, they bought into this really quickly, and part of that was having the Washington State Chapter of the American College of Emergency Physicians behind the effort," says Anderson.

Making sure consumers understood the initiative created some hurdles, says Anderson. For instance, in consultation with the Centers for Medicare & Medicaid Services (CMS), providers worked and reworked an educational poster to make sure that it didn't present any obstacles to patients prior to the medical screening exam. They also created pamphlets and videos to explain the initiative to patients.

Consider impact on patient volume

Interestingly, while state-level numbers show that ED volume is down, it's clear that the initiative did not affect all EDs in the same way. For instance, ED volume is up slightly at Providence Regional Medical Center (PRMC) in Everett, ccording to **Enrique Richard Enguidanos,** MD, FACEP, an emergency physician at PRMC and president-elect of the Washington chapter of ACEP. He attributes at least some of that uptick in volume to implementation of the Affordable Care Act (ACA). "That has been our experience," says Enguidanos. "We have seen a bit more utilization in the last three or four months. We are monitoring it very closely."

Another potential reason for the consistent volume at PRMC is that the ED was already actively involved in case management when the ER is for Emergencies initiative was launched. "We are probably the biggest ED that does case management in the state. And we already had that going, so that [aspect of] the initiative wasn't as important to us," says Enguidanos. "However, what really helped us was the state implementation of the Emergency Department Information Exchange [EDIE], which allowed us to view cases from across the state for individuals who came in. We knew if they had a management plan, and we knew how to get a hold of their provider, so that was extremely helpful, and it provided much better care for patients."

While PRMC saw little change as far as patient volume is concerned, the ED at MultiCare Auburn Medical Center in Auburn saw volume drop by more than 13%. Anderson suggests this is because the hospital serves a largely blue collar population that includes a high number of Medicaid recipients. "We actually even closed our fast track because our low-acuity visits decreased by at least 15%," he says. Anderson adds that his ED saw a reduction of at least 12% in visits by frequent utilizers.

Anderson does not attribute all of these decreases to the ER is for Emergencies initiative. There were also new care options available to consumers when additional urgent care centers opened in the region. Further, he notes that the hospital was in the process of being sold, and providers were also just going live with a new electronic medical record system.

While there were many contributing factors, Anderson acknowledges that providers did have to accept a loss in income from the reduced volume. "We made a conscious decision that we were going to do this right because we ultimately hoped if the ACA took off and was successful in our state, then the number of our private pay/no insurance patients would decrease," he says. "And now our volumes are starting to go up a little bit."

Patient volumes could well continue to rise. Reports suggest that by the end of March, more than 285,000 newly eligible adults had signed up for Medicaid coverage in Washington this year — far more than the state had anticipated.

There is more to do. Technical improvements to make the information-sharing aspects of the initia-

tive faster and more efficient are planned. Further, there is currently nothing to stop drug-seeking patients from crossing state lines to visit EDs that do not have access to Washington state's EDIE, but such behavior may be short-lived. "Oregon is looking at implementing our program, and possibly even integrating with the system we use so that we would have shared visit records, and that way we would be able to see beyond those border communities," says Schlicher. "The key thing is that through all of this no one has been denied access or care. No one has been told they shouldn't be in the ED. Instead, we have created an environment that says the place for primary care is your PCP's office, and we would like to make sure that we get you there."

Anderson's advice to providers and policymakers in other states that are struggling with the same issues is to remember that success comes not from blocking access, but from coordinating the care of patients. "You really need to build an infrastructure that allows hospitals, PCPs, and care managers to coordinate the care — initially of high-utilizers and then all ED patients," he explains.

Further, while some economic input is needed to build the infrastructure, Anderson stresses that all the interested parties need to participate to make it work. "Get them to the table because cooperation is going to get you a whole lot further than arguing your own point without being able to realize that times are changing," he says. "When we stopped fighting in the media and the courts, and finally sat down and considered what will work to decrease low-acuity visits and high-utilizer return visits, it wasn't rocket science."

Enguidanos offers similar sentiments. "There is so much that gets done in medicine where all the parties involved think they are doing the right thing, but they don't understand the nuances of the other entities involved," he says. "In our case, Medicaid really had great things in mind, but I don't think they realized how their initial proposal was truly going to impact the patient coming into the ED and ED care. But once we were able to get Medicaid to sit down with the ED physicians, and then the hospital and medical associations, then we all started to understand the different perspectives."

With the results thus far exceeding expectations, emergency providers are eager to see colleagues in other states follow a similar path. "Right now, the system we have in Washington in terms of the EDIE, the prescription drug monitoring program, and the feedback reports, is arguably the envy of emergency medicine," says Schlicher. "It is what we have always dreamed of: the ability to know what is best for our patients, and to be able to get data on their medical history so that we can provide the best, most accurate care. Now we have that option." ■

Access can prevent 30-day readmissions

Collaborate with clinical leaders

Most readmission efforts are focused on patient education and engagement during and after discharge, says **Paul Shorrosh**, founder and CEO of AccuReg Patient Access Solutions in Mobile, AL.

"But to effectively avoid readmission penalties requires intervention at the front door, in addition to education at the back door," he says. Shorrosh recommends these approaches:

The patient access team should be empowered to detect and alert clinicians prior to an admission.

"But how will registrars know when a patient has been in the hospital within the past 30 days? The answer is automation and exception-based workflow technology," says Shorrosh.

In real time, after a Medicare patient is registered, systems can automatically check against the hospital's historical accounts to determine if the patient has had an inpatient stay in the past 30 days. "If diagnosis codes are captured in scheduling or registration from physician orders, the results can be narrowed down to the 'big four' conditions CMS [Centers for Medicare & Medicaid Services] is targeting in 2014," says Shorrosh. These are heart attack, heart failure, pneumonia, and chronic obstructive pulmonary disease (COPD).

"Even without diagnosis codes, an automated process can effectively flag patients who have been inpatients in the past 30 days in a work queue, with priority alert pop-ups," says Shorrosh.

Scripting can be provided on what to do next, such as to inform the physician, nurse, or case manager. "The appropriate person can confirm and manage the situation, with the option to change the admission plan to observation, a treat-

and-release plan, or a home health plan," says Shorrosh.

Establish protocols

Patient access leaders need to work with clinical leadership to understand the transition of care from the inpatient setting to the ambulatory setting, says **Larry E. Stuckey II**, managing director of the Huron Consulting Group.

"Through this understanding, these two areas can work together to establish the appropriate scheduling protocols to ensure that a patient's post-discharge care is scheduled timely," he says.

In organizations with highly efficient patient access areas, he says, patients can access post-acute care follow-up visits with primary care and specialty physicians within 48 to 72 hours. "Quick follow-up post hospital stay is key to ensuring a patient's understanding of medications and coordination of ongoing testing and outpatient care," says Stuckey.

Adherence to the scheduling protocols should be one of the metrics that is measured as a strategic initiative is developed and implemented to decrease readmissions, he says.

"Patient access can impact the availability of care post-discharge to determine if this adherence is yielding fewer readmissions," Stuckey says. ■

HHS to survey 1,200; audits might follow

The Department of Health and Human Services' (HHS') Office for Civil Rights (OCR) announced that it will survey up to 1,200 covered entities and business associates to find those in need of a full HIPAA compliance audit.

The survey will collect information such as the "number of patient visits or insured lives, use of electronic information, revenue, and business locations." The Health Information Technology for Economic and Clinical Health (HITECH) Act requires OCR to conduct periodic audits to ensure that covered entities and business associates are complying with the HITECH Act and its implementing regulations.

An audit of 115 covered entities in 2012 found compliance issues with the HIPAA Security Rule. About two-thirds of audited entities did not have a complete and accurate risk assessment, and many entities were unaware of specific HIPAA Privacy Rule requirements, such as the obligation to provide a notice of privacy practices to individuals. ■

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

- How your peers are reducing readmissions
- Opportunities for case managers in medical homes
- The trend toward providing home-based care
- Discussing options for end-of-life care

CNE QUESTIONS

1. According to BK Kizziar, RN-BC, CCM, owner of BK & Associates, many different roles are included under the title of "navigator," and depending on the individual program, navigators may have different educational levels and training.
A. True
B. False

2. What kind of education do Allina Health's care guides need?
A. A college degree
B. At least two years of college
C. A high school diploma
D. An LPN or LVN degree

3. What is the caseload of the University of Pennsylvania Health System's community health workers who work in the hospital setting?
A. Eight to 12 patients
B. 10 to 15 patients
C. 20 to 24 patients
D. 25 or more patients

4. In the partnership between Atrius Health and two health plans to coordinate care for dual eligible patients, which clinician follows up with patients periodically either in person or by telephone?
A. The nurses at the physician practice
B. The case managers at the physician practice
C. The case managers at the health plan
D. The patient navigators at the health plan

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Lee Landenberger
Editorial & Continuing Education Director