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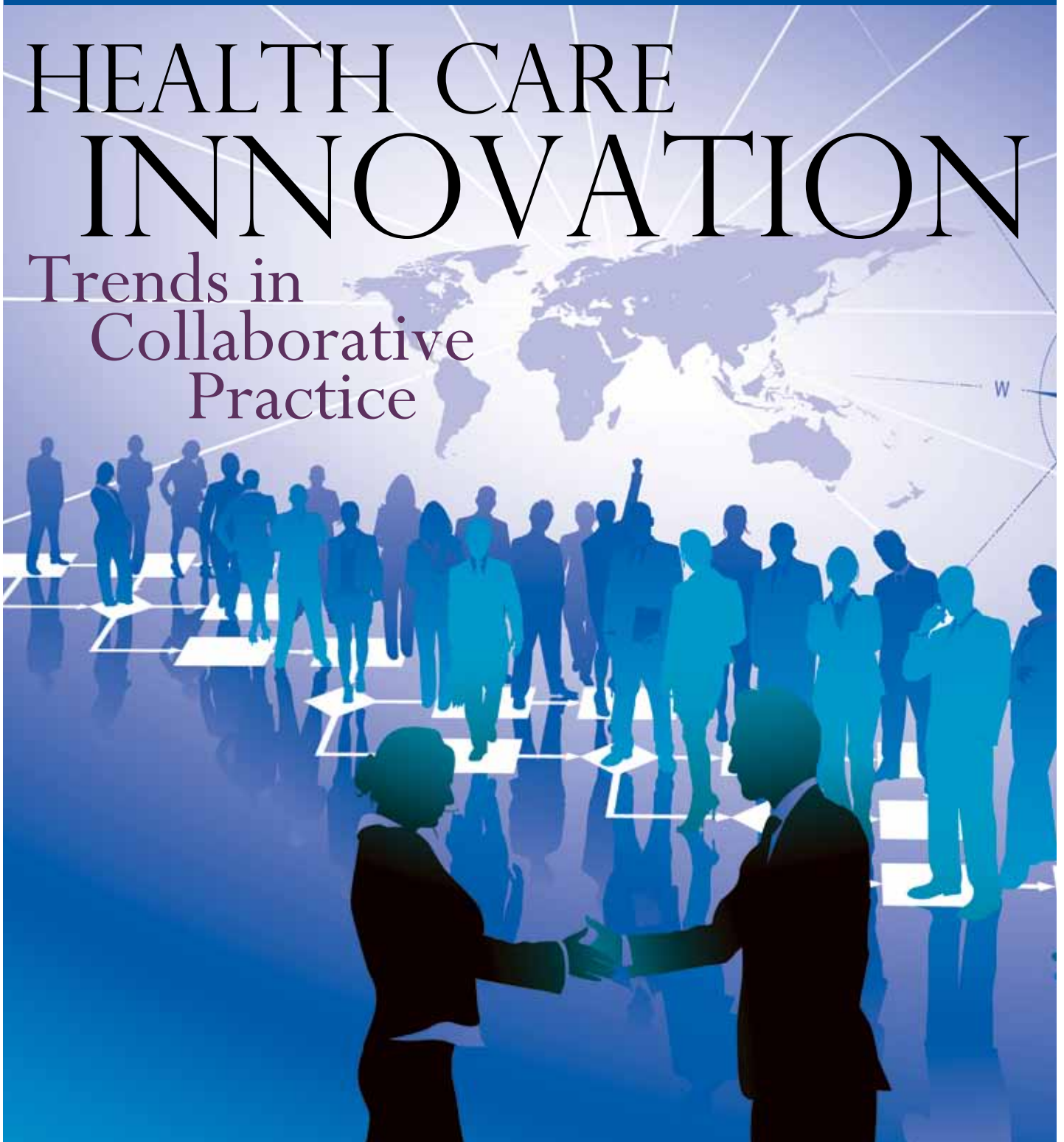
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CASEINPOINT

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An Inside Look



In early March the Case Management Society of America sponsored the 2nd Collaborative Practice Summit, a unique symposium held in San Antonio that brought together a diverse group of leaders to share ideas on innovative practices that are at the forefront of health care reform efforts. Distinct from the annual CMSA conference, the Summit presents a smaller, more intimate atmosphere where novel ideas and forward-looking trends take center stage.

Those who attended this year's Summit are leaders holding positions within various provider and payer settings, certification organizations, and accreditation bodies. As literal agents of change, they were able to share ideas, raise challenges, ask questions and collaborate with the distinguished speakers, who brought their own unique perspectives on industry trends and predictions for the future. A "resource room" served as a forum in which an exclusive group of invitation-only representatives, or "innovators," from select health care-related companies and organizations could present some of the most innovative products and services on the market.

In order to provide a glimpse of the Summit to those who were unable to attend, the editorial staff of *Case In Point* has developed this special issue, the Collaborative Practice Supplement, to share highlights from the meeting. This Supplement will grant you an insight into the distinct sessions — models of care, performance measures and technology — that comprised the Summit. We have tried to capture the meeting's essence in order to provide professionals involved in medical management with the most recent discussions on what constitutes the vanguard of the industry.

Also within these pages, Cheri Lattimer, executive director of CMSA, shares her own take on both the meeting and the future of collaborative practice. Kevin Marcum, CEO and publisher of *Case In Point*, shares his thoughts on the innovative opportunities that are available today to deliver information and keep the practice of case management informed, educated and clinically competent. And to blend research with practice, we share two articles demonstrating best practice that show how technology can improve effectiveness and efficiency.

In keeping with the theme of innovation, we are presenting the Collaborative Practice Supplement in a new format. With a digital presentation, you can click on links to further investigate information presented, make contact with leaders, or make comments as you review the material — all with a click of the mouse. We look forward to your comments on this new format and wish you the best in collaboration.

A handwritten signature in black ink that reads "Anne Llewellyn". The signature is fluid and cursive.

Anne Llewellyn, RN-BC, MS, BHSA, CCM, CRRN
Editor in Chief
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MODELS OF CARE



ERIC A. COLEMAN, MD, MPH, is Professor of Medicine within the Divisions of Health Care Policy and Research and Geriatric Medicine at the University of Colorado at Denver and Health Sciences Center. Dr. Coleman is the Director of the Care Transitions Program™, aimed at improving quality and safety during times of care “hand-offs.” He is also the Executive Director of the Practice Change Fellows Program, designed to build leadership capacity among health care professionals who are responsible for geriatric programs and service lines.

For more information please go to www.caretransitions.org or www.practicechangefellows.org.



CAROL LEVINE is the Director of the United Hospital Fund’s Families and Health Care Project. She also directed The Orphan Project: Families and Children in the HIV Epidemic, which she founded in 1991. She was the Director of the Citizens Commission on AIDS in New York City from 1987 to 1991. As a senior staff associate of The Hastings Center, she edited the Hastings Center Report.

In 1993 she was awarded the MacArthur Foundation Fellowship for her work in AIDS policy and ethics. Levine is the editor of *Always on Call: When Illness Turns Families into Caregivers* (2000) published by the United Hospital Fund.



Since 1990, **DR. MARY D. NAYLOR** has led an interdisciplinary program of research designed to improve quality of care, decrease unnecessary hospitalizations, and reduce health care costs for vulnerable community-based elders. To date, Dr. Naylor and her research team have completed three randomized clinical trials funded by the National Institutes of Health testing the Advanced Practice Nurse Transitional Care Model, an innovative approach to addressing the needs of high-risk, chronically ill elders and their caregivers.

Dr. Naylor is also the National Program Director for the Robert Wood Johnson Foundation program, Interdisciplinary Nursing Quality Research Initiative (INQRI).



W. JUNE SIMMONS is a visionary in developing innovative approaches to health care delivery in the 21st century. As founding President/CEO of Partners in Care Foundation, Simmons believes that health care and social delivery of services need to change, especially in community and home settings. She takes an active role in developing initiatives that meet the mutual needs of patient populations, providers, and health care delivery networks.

Under her leadership, Partners has grown ten-fold since its establishment in 1998 and has been awarded major grants to investigate and evaluate new models of health care and social service delivery, including managed care environments.

PERFORMANCE MEASURES



DR. CHAD BOULT, MPH, MBA, is the Eugene and Mildred Professor of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health, where he directs the Roger C. Lipitz Center for Integrated Health Care and holds joint appointments on the faculties of the Johns Hopkins University Schools of Medicine and Nursing. A geriatrician for 20 years, he has extensive experience in developing, testing, evaluating and diffusing new models of health care for older persons.

His current research includes “guided care,” a novel, multidisciplinary model of primary care for older people with multiple chronic conditions. Additional information is available at www.jhsph.edu/LipitzCenter and www.guidedcare.org.



DEL M. CONYERS, MPH, is the Senior Program Director for Performance Measures at The National Quality Forum (NQF), a private, not-for-profit membership organization established in 1999 to develop and implement a national strategy for health care quality measurement and reporting, where he is responsible for the execution and oversight of NQF projects, including consensus development projects, special projects and workshops.

Since joining NQF in 2004, Mr. Conyers has overseen numerous projects relating to cancer care quality, emergency care, and diagnostic imaging efficiency. Most recently, he began directing a project to endorse a set of preferred practices and performance measures in care coordination.

TECHNOLOGY



BILL CROUNSE, MD, is Senior Director, Worldwide Health for the Microsoft Corporation. He is responsible for providing thought leadership, vision, and strategy for Microsoft technologies and solutions in the health care provider industry. He is also responsible for working with industry partners and health care organizations to help them benefit from using Microsoft technologies and solutions as an essential platform for line-of-business applications in the healthcare industry.

Dr. Crouse is known locally and nationally for his work in medical communications. He has written and produced dozens of articles, audio-casts and videos for www.microsoft.com/health and is the primary contributor to Microsoft's Health Blog, <http://blogs/msdn.com/healthblog>.



DAVID C. KIBBE, MD, MBA, is well known as an innovator and independent mind in the field of health information technology. A respected technologist, entrepreneur and co-developer of the ASTM Continuity of Care Record (CCR), he is also an experienced clinician and has taught informatics at the School of Public Health, University of North Carolina at Chapel Hill.

From 2002 until 2006, Dr. Kibbe was the founding Director of the Center for Health Information Technology for the American Academy of Family Physicians. He has started two medical software companies, and in 2005 was voted one of the 50 Most Powerful Physician Executives in Healthcare by readers of the magazine *Modern Physician*.



HUGH LEE is President of Fusion Productions, a company that integrates design, production and technology services for the meeting and incentives industry. Some of Lee's industry involvements and accomplishments include: Chairman of the Board, 2004-2005, Meeting Professionals International; Inductee to the 2002 Convention Industry Council Hall of Leaders; Inductee to the American Society of Association Executives' Academy of Leaders; Member of the Executive Committee for Meeting Professionals International; Recipient of the 1996 Industry Award from Meeting Professionals International; and Keynote at AsiaPacific Incentive & Meetings Expo in Melbourne, Australia, addressing the convergence of technology and its impact on the meeting industry.



DONALD DEA has a record of high-level success in the global technology, marketing and business development areas. He has an MBA from the Fuqua School of Business, Duke University, and graduated from MIT's distinguished Sloan School of Management's Senior Executive Program. Mr. Dea served as Special Assistant to the Attorney General in the President's Executive Exchange Program.

Mr. Dea has served as the General Manager of U.S. Customer Operations for the Xerox Corporation, is co-founder of Alaris Corporation, has developed a family of 486 and Pentium PCs, and established a global distribution network that included Europe, U.S., South America, Pacific Rim, and the Middle East.



As a partner in the research and patient care consulting firm Insight Therapeutics, **H. EDWARD DAVIDSON, PHARM D, MPH**, is also an Assistant Professor at the Glennan Center for Geriatrics and Gerontology at Eastern VA Medical School. In addition, he is Editor in Chief of *The Consultant Pharmacist*, the journal of the American Society of Consultant Pharmacists representing pharmacists providing care to seniors in organized and other health care settings. Mr. Davidson also serves on the National Transitions of Care Coalition (NTOCC) Advisory Task Force.



ANNE JONES, RN, MBA, CMCN, CPUM, is a Director at Humana Inc. in Louisville, Ky., which is a group health insurance organizations committed to helping employers manage their health care costs, guiding consumers to make informed health and benefits decisions, and giving back to the communities they serve. Ms. Jones attended Sullivan University from 2003-04.

The Online Race



I'm a runner. Now, I'll be the first to admit it: I'm not the fastest runner. And I may not have the typical body of a runner. But I do enjoy the act of running. It is therapeutic, particularly in the early morning when I run four or five days out of the week. A simple joy waits for me at the end of runs, too. When I return home I look forward to seeing the morning newspaper delivered to my door. I enjoy the opportunity of decompressing and relaxing from the morning workout while allowing my mind to pick up speed by perusing the major headlines of the day. Having been in publishing the past 16 years, I have a natural tendency toward getting my information fix in the form of print newspapers, magazines and books. As we read your letters and emails to us, we believe many case management professionals feel the same way about *Case In Point* magazine.

But the evidence is clear that almost all of us are finding more and more of our information diet fed to us by electronic means. At *Case In Point*, we began addressing this need over one year ago with the introduction of the weekly email newsletter, *Case In Point Weekly* (www.cipweekly.com). Readership of *Case In Point Weekly* has doubled in the past 10 months as more and more case management professionals seek to find quick and useable snapshots of information that help them coordinate care and change lives.

We recently relaunched our new website for case managers at DorlandHealth.com with great success and accolades from readers who have wanted us to provide timely, relevant and up-to-date information on a host of information topics critical to them. Now we are pleased to introduce our first foray into electronic magazine publishing by taking *Case In Point* into the digital age. We hope you enjoy it. As is evident with all of our earlier online publishing efforts, we believe this provides an increased opportunity to provide useful information on yet another platform.

I don't foresee the day when *Case In Point* magazine will become an online-only product. Readers consistently tell us they use it and enjoy the opportunity to read its unique and helpful articles. Much like my love-affair with my morning newspaper, case managers seem to find real value in not just the information but the *experience* of reading the printed magazine (and our advertisers agree). However, Dorland Health is committed to providing the information you need in a host of environments as we continue to seek to meet the information requirements of you, our readers.

A handwritten signature in black ink, appearing to read 'Kevin Marcum'.

Kevin Marcum
CEO and Publisher
Dorland Health, a Contexo Media Company

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CCMC would like to congratulate CMSA on a great networking and educational event at the Collaborative Practice Summit.



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Growing Collaborative Practice for the Future



BY CHERI LATTIMER, RN, BSN

Health care professionals frequently talk about the silos and the fragmentation of care we see and experience with our patients every day. We consider how we can improve care delivery by looking at new collaborative models and innovative business practices. Yet, as providers and leaders we still do not know what these new models may mean for ourselves or our organizations.

Collaborative practice is not a new concept in health care. Nationwide, we see physicians, case managers, pharmacists, social workers, nurses and related professionals partnering with others in health care to provide optimal care to patients, family caregivers and communities.

What has dramatically changed is the environment in which that care is provided and the movement for proven performance measures. Improvement in care coordination, transitions of care, and patient-centered engagement will require behavior change not only for individuals, but also in structure and process. So the question remains — where can decision makers go to get answers and find a network of colleagues to achieve improvements in collaborative care and sustain change?

The Case Management Society of America (CMSA) identified this need from executives and care management members across America's health care continuum and took a

step to address the issue. Following the vision that CMSA's Board set for the association — “we envision case managers as pioneers of health care change...Key initiators of and participants in the healthcare team who open up new areas of thought... research and development... Leading the way towards the day when every American will know what a case and care manager does and will know how to access case and care management services” — they launched the Collaborative Practice Summit (CPS) in 2007. For the 2009 CPS, CMSA partnered with DMAA: The Care Continuum Alliance, the National Association of Social Workers (NASW), and the American Board of Quality Assurance and Utilization Review Physicians (ABQAUROP) in the effort of bringing together thought leaders in patient-centered models of care, care coordination performance measures and technology to discuss improving collaborative care with industry leaders.

The Summit engaged 100 leaders from multiple aspects of health care. During an exciting two days of networking and sharing operational concepts, process change and research, leaders formed ideas and interventions to meet the challenge and opportunities of the future. The Summit set four principal objectives:

- Assess and evaluate what will work in your programmatic development to support both your member and provider networks.
- Engage thought leaders to understand and create conceptual collaborative practice models.
- Demonstrate innovation and critical leadership in the development of collaborative practice in the next generation health care system.
- Create a forum for understanding the team model concept in collaborative practice.

These issues were addressed in three “super sessions,” each one focusing on a different aspect of collaborative care — existing models of collaborative care, measuring performance of coordinated care models, and technology that will facilitate care coordination moving forward. A primary theme heard throughout the Summit was

the goal of not reinventing the wheel. We should, rather, focus on learning from the experience of the thought leaders working to address health care change. Dialogue during the question and answer period of the super sessions brought additional opportunity for a creative and dynamic thought exchange and occasional challenge. Participants wanted to continue this dialogue, and CMSA is planning to launch an open online community beginning April 1, 2009, aimed at advancing collaborative care.

The takeaways from the Summit were many, but three main themes seemed to emerge:


1. Patients and their family caregivers are part of the collaborative practice model and need tools and resources to be actively engaged.
2. Performance measures for care coordination and patient engagement will be

an important outcome all providers will need to address.

3. Technology will play an active role in the growing consumer movement in enabling coordination advances for professionals but also engaging consumers in monitoring, measuring and directing more of their own care.

Jeff Frater, the president of CMSA, summed up his experience with the following: "One of my favorite quotes is by Hippocrates of Kos (c. 460-370 BC), the ancient Greek physician, who mused, 'The life so short, the craft so long to learn.' I appreciate this sentiment so much so, that it is included in the signature on all my email correspondence. It is my belief that the recent Collaborative Practice Summit served to enlighten its attendees and inspire us to come together in our view of the craft of caregiving as one in which the opportunities for successful

engagement, teamwork and leadership are truly attainable. After attending the summit and interacting with the many types of leaders there, I feel confident that the collaborative practice models created and shared in such a positive team environment have made and will continue to make the craft that is health care more efficient and effective as we continue to build upon them in the future."

Please save the date for the next Collaborative Practice Summit on March 2-4, 2010. There is a sign-up on the CMSA website (www.cmsa.org) for all who would like to receive an invitation to the Summit — the event of the year for engaging leaders and change agents for improved collaboration through partnership. 

Cheri Lattimer is the executive director of CMSA.



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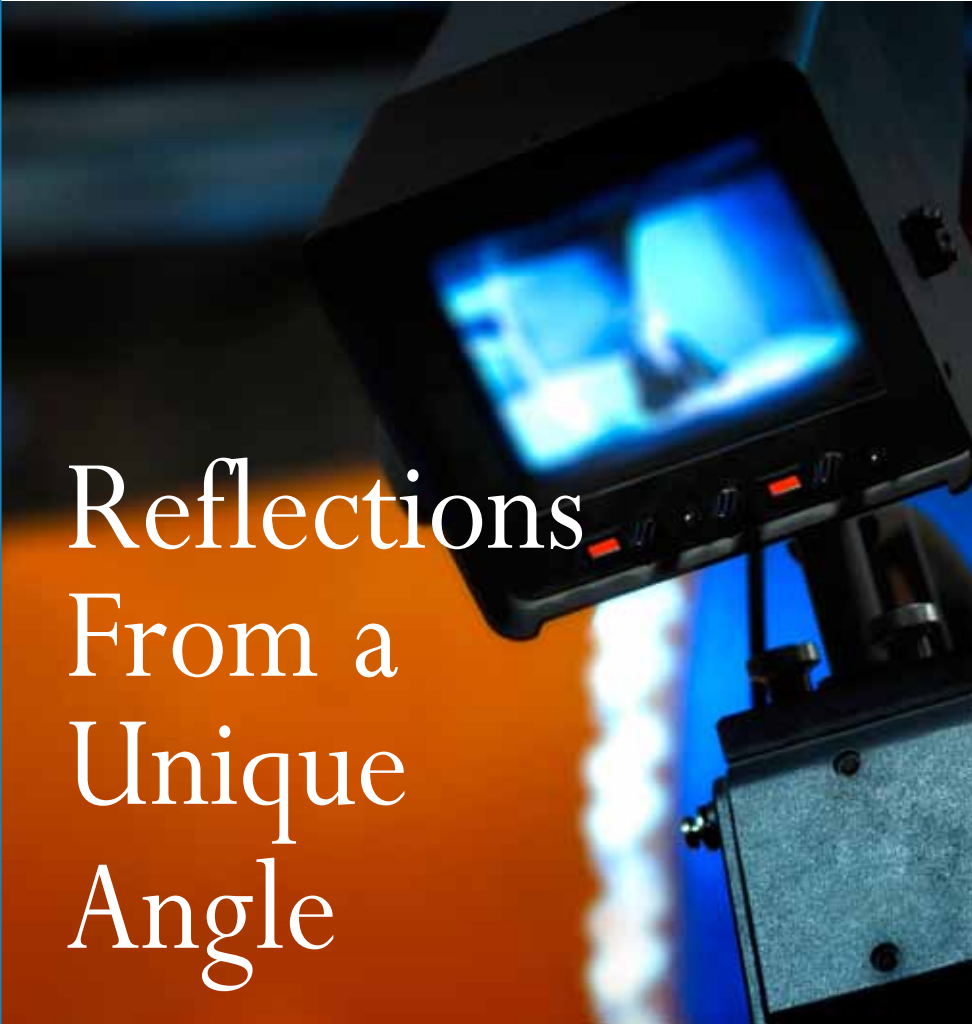
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Reflections From a Unique Angle

BY GARRY CARNEAL, JD MA

During the Collaborative Practice Summit (CPS) in March, I witnessed the session presentations from both a traditional and a novel perspective. Not only did I participate in the conference as an attendee, but — as I filmed each session for CMSA — I also saw the speakers through the lens of my high-definition camera.

As I listened to and videotaped the talented and knowledgeable speakers, I heard many interesting theories and experiences relating to collaborative practice strategies that can promote healthier outcomes. Among other takeaways, I was struck with how many of the conference themes centered on patient engagement and leveraging technology to achieve key collaborative practice goals.

TRANSITIONS OF CARE

Anyone who cares for an older relative or someone who is chronically ill knows that a central challenge to providing high quality care is dealing with our fragmented delivery system — including how, when and where care is delivered over a course of time.

Dr. Eric Coleman, MD, MPH, who kicked off the conference with an overview of his Chronic Care Model, showcased self-care strategies. Among other elements, he noted how important it is to engage the patients and their families to promote self-management skills in part through a “transition coach.”

By focusing on specific areas of care, quantifiable positive outcomes are generated, as reported in Dr. Coleman’s studies. One of his primary takeaways is that transition coaches can become an effective resource for patients and their extended families.

Several comments made by Dr. Mary D. Naylor, who is affiliated with the University of Pennsylvania School of Nursing, also struck a chord with me. She observed that medical management programs are often inconsistent in part because of the lack of systems to bridge transitions. She elaborated that there are several barriers to promoting effective transitions of care, including how the current system is organized and the lack of financial incentives to promote collaborative practice. She also articulated a strong case for transitional care to address the:

- High rates of medical errors.
- Serious unmet needs.
- Poor satisfaction with care.
- High rates of preventable readmissions.
- Tremendous human and cost burden.

Dr. Naylor’s model of “Transitional Care” takes a holistic approach to managing the chronically ill. Among other attributes, care managers should be adaptable and flexible, but also make sure the patient and caregiver’s roles and responsibilities are clearly defined. She also noted it is important to become a strong champion and be responsive to the external climate.

TRANSITION TO THE NEW DIGITAL AGE

Several conference speakers also noted how technology can improve collaborative practice models of care. This point was highlighted by both Donald Dea and Hugh Lee, with Fusion Productions, when they noted in their joint presentation how the World Wide Web is connecting us with other social media and networking communities such as Facebook and Twitter at a pace that no one could have imagined just a few years ago.

One of their PowerPoint slides highlighted the evolutionary and overlapping phases of the Web which reinforces this point:

1. Web 1.0: The Web (1990-2000).



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Schooner staff and clients attending an international business event with Maryland Governor O'Malley and Dr. Robert C. Gallo

The staff and strategic partners of Schooner Healthcare Services recognize the importance of collaboration, and they would like to congratulate CMSA and the organizers of the Collaborative Practice Summit for a job well done!

For detailed information about the healthcare consulting services offered by Garry Carneal, JD, MA and the partners of Schooner Healthcare Services, LLC, please visit our website: www.schoonerhealth.com or call 410-280-0025

SUMMIT OVERVIEW

2. Web 2.0: The Social Web (2000-2010).
3. Web 3.0: The Semantic Web (2005-2020).
4. Web 4.0: The Ubiquitous Web (2015-2030).

Most of us are familiar with Web 1.0, which offers information through websites and other resources on the Internet. In terms of health care, a provider network directory, fee schedules, health content, traditional Google-type searches and other informational websites are good examples of how Web 1.0 promotes knowledge-sharing.

Web 2.0 refers to a perceived second generation of Web development and design, which is geared toward facilitating communication and collaboration through the Internet. For example, Web 2.0 concepts have led to the development of Web-based communities, blogs, and social networking sites and so on, as highlighted in Dea and Lee's presentations. Without a doubt, patients can choose to participate in self-help groups and other online communities. In addition, care managers are relying on these types of resources as well to help care for their patients.

Web 3.0 is an evolving extension of the World Wide Web in which the "semantics" of information and services on the Web are further enhanced, making it possible for the Web to understand and satisfy the requests of individuals and computers using its content. At its core, Web 3.0 comprises a set of design principles, collaborative communi-

ties, and a variety of enabling technologies. Some elements of the Web 3.0 are expressed as future possibilities that are yet to be fully understood.

However, I have recently observed online health care risk assessments that are generating customized care treatment plans for patients that account for their respective co-morbidities (these applications are being offered by several care management software companies). This appears to be a Web 3.0-like data exchange with some limited artificial intelligence.


Whereas Web 1.0, 2.0 and 3.0 phases connect and leverage knowledge, Web 4.0 connects and creates real intelligence — which can take patient care to a whole other level. Although still a little fuzzy and futuristic, some believe the Web 4.0 will lead to a point that the Internet becomes the planetary computer, a massive web of highly intelligent interactions. Could case managers in the future evolve into highly sophisticated robots? It is a subject for another day, but it is plainly evident that the digital world is upon us.

MY EXPERIENCE AT THE CPS CONFERENCE

All of the conference sessions were insightful and informative. As a result, I came away from the conference thinking of it as a great experience. I couldn't help but draw some comparisons between the lessons taught during the conference in identifying and implementing collaborative practice strategies with what I experienced as an active conference

participant.

More specifically, I couldn't help but think how my role as a camera operator did a couple things for me. First, I had to attend all the sessions and had to pay attention for fear that I would not provide good footage to CMSA — yes, I was fully engaged. Secondly, I could use my high-tech camera to zoom in and out to enhance the parts of the presentations as I deemed appropriate. In other words, I was using technology to enhance and record the sessions for myself (and hopefully others who would view the sessions in the future). In a way, I became part of each session as I recorded each speaker.

Motivating the patient through collaborative practice models and technology appears to be a key strategy to improving health and financial outcomes. I can apply this on a personal level. Let's say I've decided it is time to lose 20 pounds. Maybe I should just film myself to really get motivated. Better yet, maybe I could implement a comprehensive strategy to shed those pounds. This year's Collaborative Practice Summit made it clear which is the best choice. 

Garry Carneal, JD MA, is the president and CEO of Schooner Healthcare Services. [garrycarneal@comcast.net]



LAUDATORY REMARKS ON THE COLLABORATIVE PRACTICE SUMMIT

"I want to thank you for the well run and very useful conference this week. For someone who is in primary care and simultaneous team collaboration, the world of sequential collaboration I learned about, especially in the transition of care presentations, was very important in expanding my understanding."

Alexander Blount, EdD
Clinical Professor of Family Medicine and Psychiatry
University of Massachusetts Medical School
Worcester, Mass.

"The Summit was very interesting and the speakers were excellent. The ability to network in the smaller, more intimate environment was better than the huge crowds of national conferences. At national conferences you might never have the chance to speak with someone in management or at the same level you are at. All in all it was very worthwhile and the warmer temperatures were appreciated also!"

Sue Finch Brown, RN, A-CCC, CCP, CMCN
Vice President of Care Management
CH Mack, Inc.
Cincinnati, Ohio

AUGMENTING TRANSITIONS

A unique and effective approach
to securing fluid transitions

BY RICHARD SCOTT

Should a patient gain a prominent understanding of his or her health situation and with it the knowledge that can lead to improved functioning and self-monitoring, that would mark a tremendous advantage for health care, wouldn't it?

The answer to the question, rhetorical though it may be, is at the center of what is proving to be a successful campaign to address the thorny issue of transitions — a campaign that pushes for a more active role of the patient during today's often less-than-fluid embarkation from one setting to the next.

Dr. Eric Coleman of the University of Colorado at Denver has developed a model to encourage patients and families to assert a more active role as they move through the health care continuum, including a nod to where they have been, where they are going, and what they can expect along the way. His system, known as the Care Transitions Intervention™, is aimed at decreasing the rate of readmissions, which prove not just financially burdensome but also can serve as a key indicator of a poor understanding of one's condition and potential complications.

The intervention model, according to Dr. Coleman, has been adopted by more than 140 health care organizations or affiliated programs, including large health plans, hospitals and home health agencies.

Last summer, the Centers for Medicare and Medicaid Services (CMS) funded a study in Colorado that, while utilizing the model with a targeted population, turned in some impressive results. The marker at the two-month period for this CMS-funded study is perhaps the most notable. Patients who received direct intervention based on the model's approach to "coaching" were nearly 50 percent less likely to be readmitted than were their peers who did not receive an intervention.

To case managers and other health care professionals who reach out to patients during transitional periods, the scope of the model may sound familiar. It calls for a coach — a nurse or social worker — to engage with patients as they transition from the a hospital setting back into

MODELS OF CARE

the community. The true paradigm shift occurs in the way the coach spends his or her time. Transition coaches do not perform assessments, create care plans, or provide skilled services; rather, they impart transition-specific self-management skills, tools and confidence. The coach visits the patient twice in person — once in the hospital and once at the patient's home within 48 hours of discharge — and communicates with the patient an additional three times over the phone. The entire coaching period is normally completed in less than one month.

Charged with involving patients in the upkeep of their own care as opposed to providing care to them, the coach concentrates on “four pillars,” as defined by the intervention model. These pillars consist of attention to medication self-management; the use of a patient-centered record, in which a patient can record his medical history, medications and other influences; timely care with a primary care physician or specialists; and an understanding of “red flags” that may indicate a patient's condition is getting worse, along with how to respond.

The implementation of these four pillars seeks to address what often constitute the main reasons for readmissions, which are seen as a lack of continuity of care as patients transfer from one point to the next; an extended duration between the moment of discharge and the initial visit with the proper physician; and a vague understanding of medications, including use and potential contraindications.

As CMS expands its Quality Improvement Organization projects into new sites around the country, the Care Transitions Intervention is gathering more data and its practitioners more experience as to how it performs in diverse settings. To gain an understanding of its current status, I sat down with Dr. Coleman to find out the latest on his increasingly prevalent approach to smoothing transitions and thwarting readmissions.

RICHARD SCOTT: The Care Transitions Intervention has turned in some exceptional results. At its most basic level, why is it so effective?

ERIC COLEMAN: The Care Transitions Intervention has been successful because it recognizes the fact that patients and their family caregivers perform a significant amount of their own care coordination, even when they are fortunate enough to have a case manager. In keeping with true patient-centered care, The Care Transitions Intervention was designed with the help of patients with complex care needs and their family caregivers.

These patients and families identified the areas in which they needed to become more proficient from a self-care perspective. They identified four areas in particular that were subsequently operationalized as the “four pillars” — medication management/reconciliation, overcoming barriers to obtaining a follow up appointment, knowing not only the signs and symptoms that their condition may be worsening but also who to contact, and the development of a personal health record to help them communicate their goals and questions to health care professionals. Further, the model encourages patients to identify short-term (30-day) goals of care and explicitly incorporates this goal into coaching them how to get their needs met during this vulnerable time.

RS: In 2008, the Care Transition Intervention was expanding. Where does it stand now?

EC: To date, over 135 of the nation's leading health care organizations have adopted the model. Partners to date include large health plans, CMS and many of the nation's QIOs, home health care agencies, hospitals, large physician practices, and community based agencies.

RS: Let's talk about the transition coach. Who plays this role? Has it been a case management role?

EC: Initially, the role of the transition coach was conceived to be an advance practice nurse or registered nurse. Both of these professionals demonstrated remarkable expertise and achieved positive results. As we have disseminated this model to a wide variety of practice settings, we have begun to realize that a wider array of professionals can also perform the transition coach role, including case managers.

We have now moved toward identifying key attributes that predict success as a transition coach. The most important key attribute is the ability to make the shift from being a “doer” (and most health care professionals are naturally doers and

in some respects are attracted to their respective fields because of this trait) to being a coach. The key distinction is that coaches do not fix problems, per se, but rather model the behavior for patients so they can address common transition related problems themselves.

The focus is less on assessment or developing the care plan and more on skill transfer, building confidence, and demonstrating patient-friendly tools. We have learned that many health care professionals honestly believe that they are coaching when in fact they are largely doing patient education. Training for transition coaches is highly experiential with a significant emphasis on simulation. Through the training experience, transition coaches come to fully understand the distinction between being a doer and being a coach.

RS: What can case managers contribute to such a program?

EC: We have successfully trained case managers employed in a wide variety of care settings and with different levels of experience. Those case managers that are open-minded to the added value of coaching make outstanding transition coaches.


RS: What is the next step for the Care Transitions Intervention?

EC: With the generous support of the John A. Hartford Foundation, we are further building our capacity to disseminate the model nationwide. This includes developing more efficient and effective training modalities and demonstrating how The Care Transitions Intervention helps health care organizations directly respond to the immediate pressures we face in our evolving health care environment.

RS: Can this be a viable long-term solution to minimize readmissions?

EC: The Care Transitions Intervention in its essence is a self-care model. As such, it recognizes that investing in imparting skills, building confidence, and providing tools pays dividends downstream. The evidence from multiple trials attests to the sustained effect from this model. Of course, building self management skills in our patients in no way obviates the role we health care professionals have in ensuring quality and safety during care handoffs.

RS: Should case managers want to get involved, what can they do?

EC: Case managers are invited to learn more about The Care Transitions Intervention by visiting our website — www.caretransitions.org. Through the website, they can also contact our program office to obtain more information. 

A Performance Measure Quartet

The author shares four enlightening episodes from this year's Summit

BY ANNE JONES, RN, CMCN, CPUM

On March 4, 2009, a group of health care thought leaders came together in San Antonio during the 2nd Collaborative Practice Summit to discuss leading-edge theories on how to best provide care to those most in need. I had the opportunity to be one of them. This forum served as a perfect backdrop for the spirited discussion that took place among the many stakeholders present. Attendees represented providers in private practice and hospital-based providers, as well as hospital administrators, professional case managers, and those involved with health plans and academia. What follows serves as an illustration of the ideas and conversations that permeated the air that day in San Antonio.



The morning discussions set the stage for the prodigious learning and sharing of ideas that would follow, as speakers reviewed models of care from several points of view. Further voices and opinion entered the fray as the presentations sparked much discussion from the audience. In the afternoon the discussion moved to the topic of outcomes as they related to the various settings of health care. During this time, several themes dominated the conversation, chief of which were care models from the academic perspective; health plans; quality; and issues surrounding transitions of care.

PERFORMANCE MEASURES

Del Conyers, the senior program director at National Quality Forum (NQF), kicked off the afternoon session with a presentation titled *Performance Measures in Health Care*, during which he detailed the importance of performance measurement, provided an overview of the NQF, and demonstrated how the NQF evaluates quality measures. He ended with a review of NQF's plan for the future as it relates to performance measures.

The basics for quality, he put it succinctly, are the right care for the right person at the right time. He then expressed the burning need for quality reform, as it impacts patients and providers in totalizing ways — through financial means; increased pain and suffering; an increase in morbidity and mortality due to overutilization or underutilization; an uptick in medical errors; and, overall, a lack of standardization. Performance measures serve as one of the key ways of improving quality and reducing cost. In the measurement of performance we must keep an eye toward enabling quality improvement, assisting consumers in making more informed choices, and looking to change payment structures.

In Conyers' discussion on the NQF, a private, nonprofit organization focused on setting voluntary consensus standards, he explained that it views its role on the quality landscape at a national level, where it sets national goals and priorities for performance improvement, endorses standards for measuring and reporting on performance, and promotes the attainment of goals through education and outreach.

The NQF process is built on consensus building, of which the National Technology and Transfer Advancement Act of 1995 (NTTAA) is core as it defines the key attributes of voluntary consensus settings and obliges the government to adopt and participate in the setting of voluntary consensus standards.

The question arose: How do we know when we have a strong measure? Conyers stated that a good measure incorporates the following — strong clinical evidence; broad

consensus with clinical practice; and an incorporation of standards for determining satisfactory performance. Academia, specific societies, hospital systems, accreditation organizations, quality improvement organizations and government agencies may all submit measures to NQF for consideration of their endorsement once they have passed committee consensus approvals.

Once a measure has been endorsed it must be evaluated and represent the "best in class." It also must meet the standards of feasibility and usability, as well as scientific acceptability for the measurement properties. The number of measures NQF has endorsed from 2005-2008 has risen to more than 200 from less than 20.

The summary of this section focused on the need to expand measures around pay for performance and gaps in care. The results demonstrate that measures that are reported and accepted do have a positive impact, while NQF has national priorities that will focus, align and accelerate the urgent need to drive change in the health care system as costs are skyrocketing and value is questionable.

The chief areas of focus in the coming two years are: care coordination, safety, patient and family engagement, population health, palliative care, overuse in the system, home health and outcomes. A care coordination measure is set to achieve release in the fall of this year.

Following Conyers' stimulating presentation, Dr. Chad Boulton from the Johns Hopkins Bloomberg School of Public Health presented his *Guided Care* model for patients with chronic care. Boulton focused on a case study of an elderly widow with multiple clinical conditions, physicians and medications — along with someone whose children have divergent priorities. The danger presented by a situation as common as this leads to the conclusion that chronic care is often fragmented, discontinuous, inefficient, unsafe, expensive and difficult to assess.

The Guided Care model requires specially trained professionals, technology that merges evidence-based guidelines with individual needs, and a process that coordinates care. The Guided Care nurse follows a process where he or she assesses the patient's needs and preferences to create an action plan. The action plan or care guide is used to monitor the patient's condition and provide support that results in effective self-management. The nurse also provides education and support to the caregivers while facilitating communication among providers and support systems. The nurses support the transition of care process to ensure a smooth transition between sites of care while facilitating access to community resources.

In Dr. Boulton's Guided Care model, the focus is on the patients who embody the top 25 percent of risk. The percentage of risk is determined by review, which looks at 12 months of claims to perform a randomized trial with roughly 1,000 patients split in two groups. Each group was measured on specific outcomes from the point of view of all involved. Patients rated quality of care, use/cost of health services, mortality, functional ability, general health, and satisfaction with care. The informal caregivers assessed strain, quality of care and productivity. Providers looked at satisfaction from the primary care source, the guided care nurse and the office environment. Finally, insurers evaluated the groups on utilization and cost of services. The results revealed that the groups were well-aligned, and the Guided Care group showed improved quality of care in all areas, as well as improved physician satisfaction overall.

The study would not be complete without looking at the costs to provide the program. A Guided Care nurse and all the needed support systems come in at slightly less than \$100,000, and each nurse provides a net savings of nearly \$75,000. The teams undertaking the Guided Care model are able to participate in online classes to prepare them for this function. Conclusions about the

program were that the Guided Care model improves the quality and professional satisfaction of health care for high-risk patients and caregivers while reducing costs to the health care system.

As the next presenter and the director of clinical programs for Medicare at Humana, I focused on the health plan point of view in looking at clinical outcomes. I started off with a review of health care costs, specifically total spending comparing commercial and Medicare lines of business. Medicare spending exceeds commercial spending by \$9 billion and is projected to outpace projected revenue by nearly 50 percent come 2017.

There are many factors causing this rise in spending — a fragmented delivery system that leads to excess cost and poor outcomes; the fact that the majority of costs are for acute care; that the health care system does not reward wellness or chronic condition management; that behavioral health issues often exacerbate medical issues; and that members are not being engaged, supported or motivated to become effective self-managers. There are many advantages in the private Medicare Advantage plans over traditional Medicare due to insurers leveraging their commercial experience and providing focus on improving the health status of the Medicare member. Private Medicare plans not only provide improved benefits; they also lower the out-of-pocket costs for their members.

Multiple surveys conducted by nationally recognized organizations reveal that less than 2 percent of the members in Medicare Advantage plans would return to original Medicare. I believe this is the case in part due to the improved clinical models that exist. The Humana process, for instance, is fully integrated by technology that is member-centric and multidisciplinary across pharmacy, behavioral health and medical areas. The appropriate interventions can engender a change in member behavior, as shown by an improved generic dispensing

rate, a decrease in inpatient admissions and outpatient ER use, and an increase in physician office visits and surgery in the outpatient arena.

Humana has implemented a program much like the Guided Care model that Dr. Boulton presented, which demonstrates that organizations are realizing the value in care coordination for the frailest patients. At Humana there is a home-visit component to the model which offers an opportunity for a face-to-face with the member that gleans information beyond the scope of telephonic management. This home visit serves as the eyes of the telephonic manager who quarterbacks the case.

In summation, it is clear that the system must change to survive, that wellness and chronic condition management create results, that behavior change must occur, and that everyone must collaborate to create the needed change in health care.

The final presentation of the afternoon came from Edward Davidson, PharmD, from Eastern Virginia Medical School. The title of his talk was *Evaluating Improvement in Transitions of Care Processes*. Dr. Davidson took us along a different path in looking more in-depth at how improving and analyzing the transitions of care can impact quality. He also shared the advantages of following an evaluation research methodology.


At the start of his presentation, Dr. Davidson defined the specifics of the particular transition in question — the movement of patients from one health care practitioner or setting to another. This transition can occur within health care settings, between settings, or across health states. For example, it may be a move from curative to palliative care. We were not surprised to learn that ineffective transitions resulted in poor outcomes like errant treatment, delays in diagnosis, severe adverse events, increased complaints and higher costs.

Davidson provided a stark example. “On hospital admission,” he said, “more than 50 percent of patients have at least one medication discrepancy. Forty percent of those have potential to cause harm.” This example, followed by several others, shows the deleterious outcomes due to poor transitions from every setting.

Davidson’s team had set up an evaluation research scenario. More rigorous than the basic QI methodology, it involves developing an evaluable model and includes measurement to identify variables while assessing baseline performance with comparison to a post-intervention period. In the EVMS scenario they looked at the bidirectional transfer of patients from the nursing facility to the hospital.

In going down this path, we saw the rigor of the evaluation process and the results that can be achieved with the tools presented. Through the scenario, Davidson shared the key elements of the framework — structure, process and outcomes. The next step was to look across all organizations and associations for measures to benchmark. In the research scenario, the team was able to demonstrate improvement over time in four key areas showing the success that can be achieved with the evaluation research model.

To summarize, Dr. Davidson stated that by using a well-designed evaluation strategy, institutions can accurately assess their current level of performance, and the information learned from the evaluation can be incorporated into a sound quality improvement plan. Finally, he stated that compliance can be improved through the model.

Following the presentations, the audience and the panel engaged in an interactive session of dialogue, and the back and forth continues, and will continue, well past the publication of this article. 

Congratulations to the Case Management Society of America for positioning itself for the future with the Collaborative Practice Summit!

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QUALITY IS JUST A CLICK AWAY





An Eye to the Future

Technology, Innovation,
Electronic Medical
Records and the Thoughts
of an IT Expert

BY RICHARD SCOTT

What does the future of health care look like? Will the nodes of care and service provision, currently untethered, be drawn together in a comprehensive, connected system? Will technology be utilized in an optimal way? Right now, as you ponder these questions, government agencies, public and private organizations, and individual consumers are busy envisioning the glittering, gilded network of health information, communication and delivery as it stands to exist a handful of years from now — or at least the refulgent hopes they are pinning on it and urging it toward.

With the federal government's \$19 billion allocation toward the implementation and expansion of health information technology (IT) in the recently enacted stimulus bill, the open-ended future of health care appears to be entwined — or be it, more forcibly, driven and undergirded — by the latest and most salient advances in technology. The

emphasis, long talked about, is transforming into practical expression.

At long last, may come utterances from diverse corners of health care. That this creeping movement, though not novel in all places and organizations, has become a focus of national pressure suggests progress, yes, but also the tinges of absurdity, for no irony is lost in the dual-faced system of health care, where outdated battlements and tactics are engaged in fortifying a practice whose ostensible centerpiece — medical care — has relied on prescient entrepreneurship and steady technological innovation to produce scores of clinical breakthroughs and guarantee the most sophisticated care in hospitals and clinics across the nation. It is these battlements, these connective tissues, that are now engaged in a colossal game of catch-up.

Governmental intervention in areas like electronic prescribing and the use of digital medical records signifies the ascribed magni-

tude of widespread health IT advancement, and research shows that consumers too are ready — pining, even — for a modern, systematic network to take root. A recent survey conducted by the Deloitte Center for Health Solutions found that greater than 40 percent of consumers would like the ability to establish an electronic personal health record with their physicians. In addition, 55 percent would like to have the ability to communicate with their doctor on the Internet when seeking health information, according to the report, while nearly three out of five consumers report interest in buying prescriptions and scheduling appointments online.

Likewise, companies around the U.S. have been launching new services to meet the prospect of a reformed model. Wal-Mart recently debuted an electronic medical record (EMR) system produced in collaboration with eClinicalWorks and Dell. Meanwhile, organizational spurs like Google Health and Microsoft Health are aiming to

transform the system through innovative software and adaptable business models. It seems all of these factors make for a landmark moment.

"The ground is very fertile right now," says Dr. Bill Crouse, the senior director of worldwide health at Microsoft, who was interviewed the week before he gave a presentation on technology at the Collaborative Practice Summit in San Antonio. Dr. Crouse points to the "injection of capital" and "properly placed incentives and business models" as two of the key determinants in the successful implementation of technological advancement, namely in the potential for EMRs. Other components, that is, the software and hardware themselves, are ready to go.

"It's not so much about the technology," he says. "We clearly have the technology. In America, one of our biggest hurdles is that we are the worst in the industrialized world in our use of IT in health care."

Though just one portion of what is seen as the coming wave, EMRs are considered pivotal — in their functionality and in the implications they confer to other bellwethers of progress.

"Most folks can agree that aggregating data and giving consumers control over that data and whom they want to share it with gets us close to where we want to be with a national information exchange," says Crouse, who enumerates the benefits of a connected, coordinated system that is accessible to patients and practitioners alike — payer quality, patient safety, a reduction of medical errors, and the recent emphasis on an increase in personal responsibility.

So far, studies agree with those stated benefits. A 2006 review in the *Annals of Internal Medicine* found that health IT can reduce medication errors while increasing the rate of a physician's adherence to applicable guidelines. Authors from a separate study presented in the *New England Journal of Medicine* last year corroborated those findings, noting in addition that physicians reported better communication between themselves and providers and patients. The problem is the paucity of practitioners currently exploiting

the benefits of electronic record-keeping. According to the same *New England Journal of Medicine* study, just 4 percent of physicians practicing in outpatient clinics were using "fully functional" EMRs. Thirteen percent were using EMRs of any kind. (However, a study conducted late last year by the Health Information and Management System Society found that one-third of doctors had "functional components" of an EMR system in place within their organization.)

The issue of personal responsibility, meanwhile, seems to speak for itself. A family physician by history, Dr. Crouse understands the effect such a system can have on a patient. "As physicians, we all know that when patient are engaged about their health, about health information and about treatments, they actually make better patients," he says.

Dr. Crouse compares an ideal EMR with an electronic financial account — both systems put the power of information and a galvanizing sense of control at the user's fingertips. "The personal health record idea has been around for a long time. But people by and large didn't do it because the idea of filling out your own information can only get you so far," he explains. "What you really want is a way to aggregate data from all the hospitals, all the providers your interact with."

The potential in this model is apparent: it is not one that can connect silos; it is one that can demolish the walls of silos' altogether. Of course, discussing health care means discussing dollar signs. And the price to raze these silos — or what can be seen as related but uncommunicative factions of health care (primary vs. specialty care, for instance) — is not cheap, and there is not always buy-in.

It is estimated that the cost to implement EMRs in ambulatory settings, where the overwhelming majority of small practices continue to operate on pen-and-paper systems, would approach anywhere from \$15,000 to \$40,000 per doctor, plus the need for ongoing technical support. On the other hand, government agencies predict that their widespread implementation could save tens of billions of dollars — if not more — every year, as well as thousands of lives due to reduced


medical errors.

Yet despite the financial burden, the fomenting shift toward a more technological-based system does not appear to show signs of stasis, let alone retreat. "The days are coming to a close when you will be able to practice medicine in the U.S. and not use these tools and get paid," Crouse says.

In spite of the Obama administration's pledge to create a nationally relevant computerized record-keeping system within five years, Dr. Crouse foresees a more regional application, where local hospitals, doctor's offices and emergency rooms are connected and able to share information. "I doubt that even in five years we will have reached a point that some define as a national health information network, which is everything connected to everything, bidirectionally, all the time," he says. "Instead I think we will have a blended model. In addition, I think we will have a very robust personal health record data aggregation around consumers."

Microsoft has been busy on this front. Microsoft HealthVault (www.healthvault.com), a Web-services platform for data launched in 2007, recently teamed with Mayo Clinic. The result — the Mayo Clinic Health Manager — is the first broadly available consumer health service built on the HealthVault platform. The Mayo Clinic Health Manager enables people to store their personal health information and receive individualized health guidance and recommendations based on the clinical expertise of the Mayo Clinic's health care professionals. HealthVault also has teamed with New York Presbyterian to launch a similar personal health record portal for their patients.

"Most patients would like to have a way to interact with the health care system in ways other than getting on the telephone, making an appointment, driving somewhere, waiting in a waiting room, getting a slip of paper, and driving to a pharmacy," says Crouse. "In 2009, we ought not to have to do that for any little thing we want from a clinician."

The face of health care is changing, but not because companies, consumers and federal agencies are sitting by watching it transform. 

BEST PRACTICE: CASE STUDY

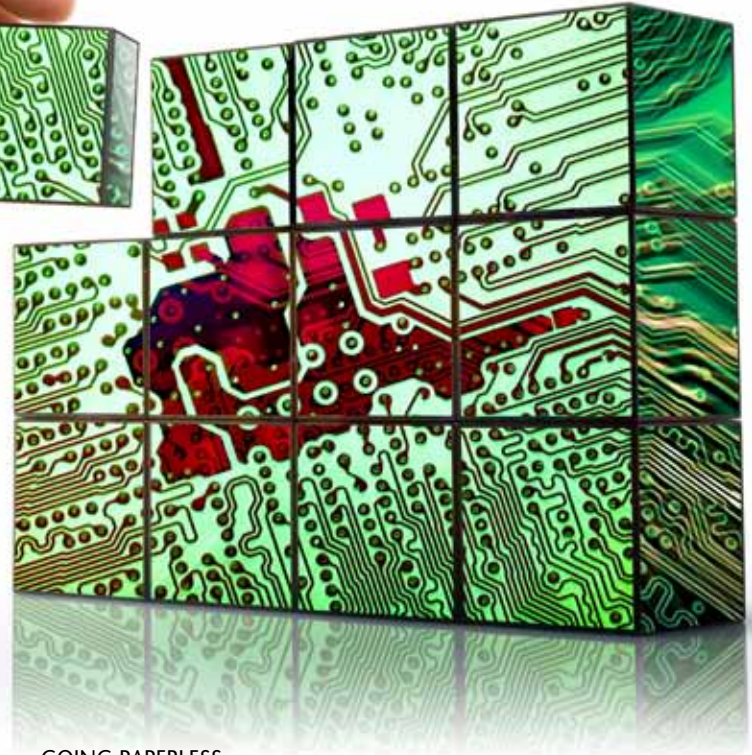
Using New Technology
to Improve Patient Care,
Efficiency and the Bottom Line

LESS PAPER, GREATER RETURNS

BY MARI FINLEY, RN, MBA

Effective case management is at the cornerstone of promoting quality care and achieving cost-effective outcomes at every hospital. The collaborative nature of case management, from admission through discharge and beyond, affects the health of both the patient and the hospital. However, case management can also be a very cumbersome process because there are so many variables at work.

At Harris Methodist Fort Worth Hospital (HMFw), we recently joined the ranks of many prominent hospitals seeking to reinvent our case management process. HMFw is the flagship facility of Harris Methodist Hospitals and a cornerstone of Texas Health Resources (THR), one of the largest faith-based, nonprofit health care delivery systems in northern Texas. HMFw has been a Consumer Choice Award Winner among Fort Worth residents for the past 11 years, and has consistently been named one of the "Top 100 Hospitals in America." It began in 2005 when THR began a systemwide transition to electronic methodologies with the aim of substantially improving data collection and other critical hospital functions. Case management was one of the first areas targeted.



GOING PAPERLESS

In order to get the electronic transformation under way, HMFw selected an automated, easy-to-use case-management tool, the Canopy Care Management Solution by Allscripts. Our old paper-based system consumed time and resources that could be more effectively channeled toward patient care and management. The new Web-based system allows hospital staff to coordinate and communicate reviews, assessments, denials and outcomes across the new care management program. HMFw's new system was also easy to implement and use, requiring little upfront capital, minimal IT infrastructure and low IT staff support. Thankfully, the new system only required a short learning curve, and all of the potential users were on the same page very quickly.

One of HMFw's goals is to use best practices in case management. In order to do this, we must be able to get critical time-sensitive information into the right hands so that the patient can move to the next level of care. The new Canopy system provides dependable, standardized mechanisms for entering and accessing case information and making sure we can deliver it quickly to the appropriate caregivers.

Before, handwritten documentation presented some barriers for staff because each person had a system or method that was unique. We

BEST PRACTICE: CASE STUDY

often had to check and recheck to verify that we had all of the patients' reviews and complete information on the care they received before moving forward. In addition, excessive work was necessary far too often. We found ourselves having to go back and redo reviews in order to get the proper forms out to the insurance company. We could spend up to 45 minutes extra per patient just sorting out the insurance paperwork.

It was also difficult for us to know the exact status of insurance claims and discharge planning without contacting caregivers personally. With the automated system, we can capture key clinical, financial and demographic data on a dynamic, real-time basis and distribute this information to all members of the HMFV care team. The Canopy system facilitates data input and access, streamlines communication within the case management department, provides dependable backup for insurance claims and denial management, and permits higher continuity of care for patients.

It also gives senior-level supervisors, managers and directors easy access to hospitalwide case management information for review and decision-making. Going paperless is increasing our productivity in a noticeable way at the hospital every day.

EVERY LEVEL, EVERY PATIENT

One of the biggest improvements resulting from the new system is in managing patient flow. Our nurses typically have 35 patients to review every day, and we are often at capacity, so managing patient flow is an important aspect of our care management process. On any given day, 40 to 60 patients could be backed up in the emergency department waiting for a room. The automated care management tool lets us know which patients are priorities, so we are able to move patients appropriately and efficiently after their acute-care stay. This aids the decision-making process for physicians, patients and their families in critical, hectic, and what are often emotional times. It also identifies the high-cost, high-risk patients who will benefit from care management.

These patients, who are at the greatest risk for negative clinical outcomes and who pose

the greatest economic risk to the health care provider, can be placed into specific episode tracks for optimal care coordination.

Since going paperless, our staff is entering time-sensitive information much faster. We no longer have the delays associated with a paper-based system, and our nurses can use the system's built-in alerts to notify physicians of key patient data, enabling physicians to quickly prioritize patient care. The tool makes relatively complex information straightforward and simple so that our caregivers can quickly set priorities for the day, look at cases in real time, and determine the appropriate level of care. We can work together to customize a patient-care plan that specifies the goals, tasks and interventions for each patient, one that better coordinates and communicates the services to be provided both with the patients and with their larger health care team.

The technology features colorful, easy-to-read reports that give us snapshots and trends. These new, extensive reporting capabilities allow HMFV's administrators and staff to immediately access productivity and outcomes reports. For instance, it reveals physicians who may be having trouble managing acute care. With this information, we can work with the doctors and show them where they can use more help.


Having an automated care management system is not only improving quality of care and efficiency inside the hospital, it's also extending beyond our doors to improve the continuity of care overall. Having readily available documentation ensures that caregivers and staff have immediate access to complete, up-to-date information, and provides upper-level management with quick ways to determine where improvements can be made. The system lists various health care resources in the community, enabling the health care team to provide connections to the appropriate community resources and ensuring that our patients continue to receive optimal care. It is also improving our discharge management process by ensuring that social workers have full and immediate access to case reviews, physician's notes and other critical patient information in order to provide the most effective and timely guidance possible.

THE BOTTOM LINE

The care-management tool also is improving our hospital administration and bottom line in a number of ways. The system is helping us quantify avoidable days. We can track trends much easier now, drilling down to see where the barriers are, and then following up with physicians, administrators and other providers to improve efficiency. Our length-of-stay (LOS) figures also are going down, translating into significant dollar and bed-capacity gains.

All hospital staff can attest that reimbursement is a complex and time-sensitive process, no matter what system is being used. With the old paper-based system, we often spent a lot of time going back and redoing reviews in order to get the proper forms out to the insurance companies. Now we can transmit information to payers quickly and respond easily if they ask for clinical documentation. Claims are getting approved faster while patients are still at the hospital. Ultimately, this eases the burden on our patients because they are focusing on getting well and getting home, instead of worrying about their hospital bill.

AN INVALUABLE COMPONENT

By automating, our case-management department became the eyes and ears of the hospital and a valuable component to its overall health and success. Through our use of the electronic reports, we hope to discover more innovative methods for managing LOS and optimizing resources. Going paperless made our caregivers more organized and efficient. It improved our case-management workflow across the board. And it is simplifying the complex environment where we work. Because the care management team recognizes that the organization is dynamic and changing rapidly, this new software has become a vital resource for keeping a pulse on our hospital's progress and the well-being of our patients. 

Mari Finley is the Director of Medical Management, Harris Methodist Fort Worth Hospital, a full-service medical center offering specialized capabilities in oncology, trauma, cardiology and women's services.



BOLSTERING LEVELS OF CARE

How Sutter Health Achieved More Consistent and Efficient Clinical Reviews



BY KAREN DUNNING, LPT, MS, HSA

Many hospitals and health plans invest in rigorous, evidence-based criteria for determining medical necessity and standards of care. But there's a big difference when that criteria is applied with an automated utilization review system. Results at Sutter Health confirm that moving the criteria into an electronic workflow drives consistency and was the right choice for our organization.

Sutter Health is a family of not-for profit hospitals and physician organizations serving more than 800,000 people in northern California and a regional leader in pediatric, obstetrical, heart and cancer care.

In 2000, the Sacramento Sierra Region of Sutter Health began using McKesson's InterQual® decision support criteria to assist with its level of care decisions. We made this decision based on the product's national rep-

utation and recognition as the gold standard by many medical groups, hospitals and payer organizations. The goal was to introduce a "universal language" to the Sacramento Sierra Region that would work across the region's five campuses and lend greater consistency to care management decisions.

After using InterQual Criteria in book form for a few years, we began exploring electronic options. We had invested in evidence-based criteria sets and we were happy with the InterQual product, but what we couldn't get from books was assurance that the criteria were being applied consistently and appropriately.

Many experienced case managers, who have grown familiar with criteria books, respect the criteria and have used it for years, tend

to rely on their "nurse gut." By this, I mean a tendency to skip over review steps by deciding intuitively, based on experience, whether a condition meets criteria.

We knew we needed a way to ensure that the criteria before us was interpreted and acted upon consistently and appropriately, and that the best way to do that was with an electronic solution. Our goal was a tool that would require use of the criteria, standardize the way it was used, enforce rigorous processes and ensure accountability. At the time, we weren't fully aware of the difference between using criteria books and using an effective electronic workflow for determining appropriateness of care, but that would all change.

As we considered our options, everyone

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acknowledged the strength of the InterQual clinical criteria and we also had a good working relationship with McKesson as an organization. This positive history led us to evaluate McKesson's CareEnhance® Review Manager software to provide interactive, browser-based access to the InterQual criteria. After appropriate due diligence, we decided Review Manager was the best fit for us.

THE TRANSITION

In 2005, Sutter's Sacramento Sierra Region rolled out Review Manager at all five of the region's campuses, seamlessly integrating it with our MIDAS+ Care Management System. The goal was to bring consistency and compliance to the highest level possible, while providing a communication tool that would support the hospital system's integrated care management model. Review Manager is now used by all case management staff in documenting and validating admission criteria and level of care during utilization review.

We learned quickly that the electronic InterQual tool provides capabilities that could not be achieved by flipping through a criteria book. Some are time-savers, such as electronic decision trees and the ability to attach evidence summaries to a review to justify a decision. Others enhance reviewer knowledge and patient safety, such as one-click access to relevant medical references, warnings and many other resources. Most important, however, was the ability to embed the criteria as an integral part of the review process.

A big "aha" moment came when the reviewing team's knowledge of InterQual was tested during implementation. The testing exercise revealed that reviewers' understanding of the criteria and how they applied it varied. Until then, we hadn't been aware of the potential gap in the difference between using the book and using an electronic review tool in terms of driving consistency. This was clear confirmation that moving to an electronic tool with its ensured consistency was a good choice.

Changing a familiar work process by introducing new technology is always a risk, but careful planning leading up to the implementation helped ease the transition.

The hospital system faced some challenges during this time, such as case managers' unfamiliarity with computers, IT resources that varied from campus to campus, and the need for care managers to continue to do their jobs well in the midst of the change. Review Manager training was a priority, starting well in advance of implementation. We also made it clear that, going forward, people would be expected to use Review Manager exclusively, although we would always have ample mentoring available.

We recognized that any transition pains were outweighed by the need to standardize the way care decisions are made. Since we implemented Review Manager, I've been asked many times how we convinced case managers to give up their criteria books. The answer is simple: we took the books away and put them under lock and key. And our reviewing team adapted — our reviews are now 100 percent electronic. What's more, they've embraced the automation and would never go back to the old process.

The implementation itself went very smoothly, which reinforced that this was the right move for us. Within the first day of software implementation, the Sacramento Sierra Region was up and running with automated reviews at four of our five hospitals, with the fifth implementation completed at the end of three months. Key success factors included a strategic implementation team that spanned all five facilities and a system coordinator who was part of the case management team serving as an IT resource and liaison. McKesson also offered an enormous amount of support, including training and education to guide us through the transition and optimize our use of the technology.

THE RESULTS

Case managers now have an easy-to-use tool to aid in determining medical necessity and level of care. All 100-plus case managers have access to the best clinical evidence as part of an electronic review workflow, helping optimize care management while improving quality and efficiency. We now perform electronic utilization reviews via InterQual and Review Manager for all inpatient admissions and also use the electronic

criteria to review observation admissions for appropriateness. Using InterQual Criteria and automated reviews, we have also expanded our emergency department case management program to redirect cases that do not meet admission criteria prior to hospitalization.

Since going live, we have learned there is a significant gap between use of the criteria book and use of the electronic tool, even though the content is identical. The difference comes down to the fact that the electronic tool requires reviewers to follow the decision tree, rather than leap from disease process to disease process or take for granted whether a condition meets criteria. There are no shortcuts or assumptions — a value or condition must be met in order to move forward, leading to more accurate and consistent results.

The automated reviews and workflows enabled by Review Manager have yielded measureable improvements in several key areas:

Reduced accounts receivable (AR) days. By using the electronic solution, we're able to capture and easily report on data. Through this functionality, we've learned that the ability to streamline and automate the way we communicate utilization reviews to our health plans has resulted in a significant and sustained reduction in accounts receivable days. Utilization reviews are performed using Review Manager and flow into our MIDAS+ Care Management System for communication to the appropriate payer organization. We believe this reduction in AR days is directly attributable to the electronic communication of utilization review, avoiding inefficient telephone processes. As a result of this automated workflow, in 2008 we were able to eliminate review calls — and endless rounds of telephone tag — between our hospitals and health care payers.

Easier, more thorough audits. Electronic reviews greatly simplify our ability to fulfill audit requirements, including helping us prepare for possible Recovery Audit Contractor (RAC) audits. We have programmed a report that identifies cases for second level oversight. The second level reviewer uses Review

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Manager to re-review cases, audit them for accuracy, and document the finding of the second level review.


Improved relationship with payers. The Sacramento Sierra Region's relationship with health plans has also benefited, as payers know that a single standard is being used to guide decisions. With a single set of expectations, we now have fewer disputes over claims. Our payer partners know that we are adhering to InterQual guidelines, we have the data to support our decisions, and we can demonstrate how our cases meet criteria for care.

LOOKING AHEAD

Encouraged by our success, electronic reviews are taking hold across all of our facilities. We're adding two new hospitals in our Sacramento Sierra region, both of which will go live with Review Manager by May 2009. Late in 2008, Sutter Health made the decision to utilize CareEnhance Review Manager as the official standard across the Sutter organization. This year we're expanding access to all 26 hospitals in the Sutter system, bringing InterQual criteria and the option of electronic reviews to all reviewers and care providers in the Sutter system by the end of 2009.

We're continuing to identify new opportunities to integrate review data with other care delivery processes to improve our workflow, improve performance and monitor progress. For example, utilization review and discharge planning have become a single integrated process that increases overall efficiency. We're also able to standardize and manage timing expectations for actions such as admissions reviews and the escalation of cases that did not meet criteria. And with ongoing enhancements to our electronic workflows, we're able to expedite communication among staff and between health plans and providers in ways that paper processes never could.

Going forward, we intend to pilot expanding our InterQual criteria and electronic capabilities by implementing McKesson's new diagnostic benefits management solution in which we will be able to carry out automated authorizations on new molecular diagnostics criteria. We're also implementing a Medicare one-day stay audit that will help us reduce risk in the event of a RAC audit by ensuring that we have processes in place to guarantee admissions are appropriate. Using the InterQual criteria and professional services provided by McKesson, we're working very hard to reduce the number of inappropriate Medicare admissions.

In conclusion, we have learned that consistent reviews, documented electronically, create accountability and a level of workflow efficiency that cannot be achieved by paper-driven processes. Using integrated processes, all of our staff members are drivers for appropriate levels of care and appropriate length of stay for our patients. 

Karen Dunning is the Regional Director of Continuum Case Management for Sutter Health Sacramento Sierra Region. Her areas of focus include medical management, case management reporting and analysis, and utilization management/regulatory compliance. She holds a Master of Science degree in Health Services Administration from Saint Mary's College of California and is a certified Six Sigma Black Belt.



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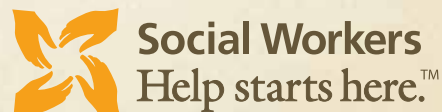
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