

Ask the Experts

In this and future issues of *MPM*, we ask a panel of experts to comment on a pressing issue of the day. Watch for these panel discussions, and let us know if you have any suggestions regarding experts you would like to hear from or questions you would like to see addressed.

As fitting the start of a new year, we asked our experts:

“What is the single most significant change or focus you are implementing for 2007 to be successful in caring for Medicare beneficiaries? What do you consider the greatest barrier?”



Cheryl L. Phillips, MD, AGSF, CMD
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Much has been described regarding the opportunities to improve care and reduce hospitalizations through care coordination for seniors with complex care needs and multiple chronic conditions. Sutter Health is a not-for-profit integrated healthcare delivery system in Northern California, comprised of 26 acute-care hospitals, 7 aligned Foundation-model multispecialty groups, and a number of affiliated independent practice association (IPA) medical groups divided into geographical service areas or regions. Our successful Sutter Chronic Care Program (SCCP) in the greater Sacramento region primarily serves Medicare Advantage members, cared for by highly integrated practices of our Sutter-aligned physicians. In 2007, we plan to expand this model of care coordination into other regions within the Sutter network, and to include other payors (for example, Medicare fee-for-services).

High patient and family satisfaction, sustained reductions in hospital and emergency department (ED) use, and reduced total cost of care has been seen for the SCCP population in comparison to a risk-matched, utilization-matched group. Our primary care physicians (PCPs) rely on the support provided by an in-office case manager and the ability to coordinate and link services with the community-based program. As we strive to identify local “best practices” and export them to other regions, we face a number of challenges. The first challenge is the diversity of physician-hospital relationships and significant variation in physician-physician integration (eg, loosely structured IPAs, Sutter-aligned physician groups without Sutter hospitals in their service area, and Sutter hospitals without clearly aligned Sutter physicians). Difficulties in accessing information from different care and provider sites, an essential element to effective care coordination, is also a barrier. Perhaps our single greatest challenge is the current lack of reimbursement through fee-for-service Medicare, outside of the limited demonstration programs, to support such care coordination efforts. Furthermore, the fee-for-service Medicare payment model creates disincentives by potentially decreasing Medicare hospital admissions and increasing the demands on the PCPs for services that are already delivered below costs.

It is hoped that Congress will take another look at the Chronic Care Act and create expanded structures to reimburse for such critical care coordination. Meanwhile we will seek to expand our program to other regions to improve overall care, reduce unwarranted variation in care, improve capacity, and reduce the length of stay for patients with chronic conditions.



Kyle R. Allen, DO
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Chief, Division of Geriatric Medicine
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I recently heard one of the regional Medical Directors for the Centers for Medicare and Medicaid (CMS) state, “All health care is local.” To that end our healthcare system and community continue to work on healthcare delivery at the local level.

We are conducting a randomized controlled Af-

After Discharge Care Management of Low Income Frail Elderly (AD-LIFE) Trial

Principle Investigator: Kyle R. Allen, DO

AHRQ Grant # R01 HS014539

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The AD-LIFE trial will test the effectiveness of improved clinical practice through comprehensive care management in elderly patients with chronic illness and functional impairment who are discharged from an acute care hospital. For the intervention group (n=265), an advanced practice nurse (APN) will coordinate care among medical and psychosocial caregivers. The APN and an RN care manager provide an initial in-home comprehensive geriatric assessment within 1 week after discharge. The RN care manager will provide patient education and self-management support. These two healthcare

providers will work with an integrated team (IT) to develop and implement a plan of care in collaboration with the patient, the PCP, the local AAA, and other community social agencies. The care manager will provide frequent patient follow-up across all providers to ensure integration of medical and social issues. Control patients (n=265) will be referred to the local AAA with no IT follow-up. The absence of a care manager and IT will, we expect, result in functional decline, lower quality of life, and higher healthcare costs for control patients in this 1-year study.

ter Discharge Care Management of Low Income Frail Elderly (AD-LIFE) trial, funded by the Agency for Healthcare Research Quality (AHRQ), which is a comprehensive 12-month care-management intervention for 500 low-income older adults discharged from acute hospital (see box). This trial's interdisciplinary team is integrated with a local Area Agency on Aging (AAA) to support RN care managers working with frail low-income older adults, their caregivers, and PCPs.

Over the past 10 years, our Division of Geriatric Medicine has developed a successful partnership between our health system and the local AAA to better serve the most vulnerable population in our community. This strategic partnership, called SAGE: Summa Health System, Area Agency on Aging, partnership for Geriatric Excellence, aims to collaboratively improve care for vulnerable older adults. The partnership has spawned improved referral and communication processes, established an inpatient AAA RN assessor who works with our interdisciplinary teams and discharge planning staff, integrated care-plan development between case managers and our system-owned health plan for Medicare Choice enrollees, and developed a geriatrician-led interdisciplinary team that meets weekly with AAA case managers to discuss high-risk clients. In 2007 we will strengthen our partnership with AAA to establish a health system-sponsored physician house calls program that will serve homebound elders who are also enrolled in Medicaid community-based long-term-care programs.

The Medicare enrollees who are served by these initiatives are the same populations identified by CMS in

the Special Needs Plans and Chronic Illness Care demonstrations. Excepting the AHRQ-funded AD-LIFE trial, our programs have been developed without direct support, grants, or payment sources. The biggest barrier to effective care for these vulnerable Medicare populations is lack of clinical and process integration, resulting from healthcare policy and financing. One of the broad objectives of the AD-LIFE trial is to provide randomized controlled data and evidence demonstrating the benefits of care coordination for frail populations and to establish a policy for financing the care management of persons with chronic illness and frailty.



Eric G. Tangalos, MD

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As we look to 2007, we should not neglect the impact of the December 18, 2006, effective date for the State Operations Manual on nursing home practice. We are strengthening the role of consultant pharmacists on the care team. Our approach to Medicare and Medicaid drug therapy will start with the new requirements outlined in CMS's F Tag 329, Unnecessary Drugs.

The Beers drug list has been replaced with an expanded "unnecessary medications" list. In fact, drugs are considered unnecessary in the absence of a clear, documented

indication for their use. Consultant pharmacists will have the added requirement to review potential drug events and advise on a regular basis regarding gradual drug reductions. Gradual dose reduction will apply to all medications with psychopharmacologic properties used for managing behavioral symptoms and any psychiatric diagnoses, including antidepressants, anticonvulsants, anxiolytics, antipsychotics, sedative hypnotics, and cognitive enhancers. This review of drugs will require increased communication between pharmacist and prescriber.

F Tag 428, Medication Regimen Review, states that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used¹:

- (i) In excessive dose (including duplicate drug therapy); or
- (ii) For excessive duration; or
- (iii) Without adequate monitoring; or
- (iv) Without adequate indications for its use; or
- (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- (vi) Any combinations of the reasons above.

The survey process comes ever closer this year to encouraging good clinical practice. How this ultimately plays out state-by-state and survey-by-survey remains to be determined. Nonetheless, a goal of the regulations is to teach closer monitoring of residents for potential adverse consequences. Physicians, pharmacists, and facilities have shared responsibility for ensuring appropriate drug use in our residents. Levels of compliance will require a tighter clinical team better able to communicate and efficiently respond to almost daily changes in patient conditions.



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ECRI's primary relationship with Medicare, spanning several decades, is to provide objective assessments of screening, diagnostic, therapeutic, and assistive technology to support coverage decision making. The nature of the technology and the way it is assessed are changing and will continue to do so in 2007. Two technology assessments commissioned by CMS illustrate significant changes in the way technology is evaluated and used.

First in 2007, ECRI will evaluate remote cardiac monitoring systems for outpatients. At one time, Medicare was focused almost exclusively on technologies used in hospitals. But increasingly, as technology advances and attitudes shift about what are the best sites of care, Medicare pays for out-of-hospital care. What remains is the obligation to be reasonably certain that what they are paying for, and what beneficiaries receive, can work effectively outside of the controlled setting that institutional care provides. This obligation increases the complexity of the technology evaluation itself. We normally associate complex care with in-hospital care, but from a technology evaluation standpoint, much depends on use, not just the intrinsic integrity of a device. Second, Medicare now has the authority to look at comparative effectiveness—that is, a variety of technologies aimed at yielding similar information for specific conditions. ECRI has been evaluating the comparative effectiveness of modalities for breast cancer imaging for CMS, including positron emission technology (PET), magnetic resonance imaging (MRI), scintigraphy, and ultrasound. By evaluating these modalities from clinician, patient, and purchaser perspectives, ECRI provides the data from which decisions about the best imaging technology for breast cancer can be made.

ECRI's reputation, encapsulated by its designation by AHRQ as an Evidence-based Practice Center (EPC), is a trusted source of technology information, uncompromised by personal or institutional investments, gifts, grants, or consulting for the medical device or pharmaceutical industries. The issue of conflict of interest is a growing concern. Medicare's use of ECRI, with our singularly strong rules, signals a commitment to objectivity that we believe will be a hallmark of the coverage program in 2007 and well beyond.



Steven L. Phillips, MD, CMD
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During 2006 I made several changes in my practice and professional life. These changes were driven by personal decisions regarding my own quality of life and realization of the value of my time and how it was being spent professionally. The result was termination of several contracts that had provided significant income to the

corporation, even though they were creating a burden on me and my family. I also ended my relationship with the state-operated medical school and geriatric programs. These decisions were a prelude to my long-term plan for simplification and reduction of ongoing costs related to the practice of geriatric medicine.

In 2007 many physicians and extenders caring for a Medicare population will face reduced overall reimbursement at a time when medical liability, office expenses, and staffing needs are increasing. In response to what we see for 2007, my practice of 3 geriatricians and 3 extenders (physician assistant/advanced practice nurse) have elected to create an office without walls. We will close our ambulatory office-based practice, which cared for 3000 independent seniors, and instead focus exclusively on the 1000 to 1200 home-bound, assisted living, and nursing facility elderly patients whom we have served for the past 10 to 12 years. Years of data collection and analysis supports the ongoing need for a specialty group that serves only this frail and vulnerable senior population. Our reduction in office space and support staff and use of available practitioners in the LTC setting makes this transition financially sound. At the same time it allows the practice to truly serve the most appropriate and deserving patient population, given our level of expertise, compassion, and understanding of chronic illness management. In return, we know that this population has demonstrated over time the greatest appreciation for our services and expertise.

The most limiting factor for 2007 is the uncertainty of Medicare now and in the future. I am not certain just how many more practice changes can be made that will retain the ongoing viability of physicians and extenders who truly want to serve a Medicare-funded healthcare delivery model.



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The biggest challenge regarding Medicare Part D in 2007, for both patients and pharmacists, is the potential for formulary changes to occur without successful notification of the beneficiary. This will be particularly problematic for dually eligible nursing home residents who may face changes in Medicare Part D plans and

formulary changes in their current plans. Communications of a plan or formulary change typically are mailed to the responsible party who may or may not forward the information to the long-term-care (LTC) facility.

The result could be a significant number of medication changes that will need to be made in the first quarter of 2007. Therefore, the focus for early 2007 will be to try to identify patients who will, possibly unknowingly, be changing Medicare Part D plans and needing assistance to identify covered medications.

A related and continuing challenge for 2007 will be the limitations placed on healthcare providers to assist patients with choosing plans. CMS marketing guidelines do not permit pharmacies, facilities, and medical directors—even when working together—to advise residents about the best available plan to cover their medications. As a result, LTC facilities will again be financially responsible for medications after the transition period ends, and it seems that nothing can be done to change this barrier.

Overall, 2007 will definitely be an improvement over 2006 for Part D Medicare recipients, but no one should expect completely smooth sailing.



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For 2007, Independence Blue Cross is focused on offering comprehensive health plans for Medicare beneficiaries—both health maintenance organizations (HMOs) and preferred providers organizations (PPOs)—that will provide medical services combined with Medicare Part D drug coverage in a one-card healthcare solution. These all-encompassing plans lower out-of-pocket costs, improve access to care, and provide wellness and disease management services. Also provided are services not covered by original Medicare, but proven to improve important clinical and behavioral outcomes, such as regular mammograms, chronic illness treatment regimens, and fitness programs.

While we focus on providing these Medicare plans that offer both medical and drug coverage, we also offer excellent stand-alone prescription drug plans that provide access to thousands of medications from a very broad network of pharmacies.

All Independence Blue Cross Medicare health plans

carry the highest available accreditation rating from the National Committee for Quality Assurance. In addition, a recent report in a national news magazine gave Keystone 65 HMO the highest Medicare health-plan quality rating in our market.

Independence Blue Cross was the first health insurance company in the nation to launch a Special Needs Plan (SNP), which provides coverage to disabled and chronically ill beneficiaries who require specialized case management and disease management services. Our Keystone 65 Complete plan is one of the largest SNPs in the country. For 2007, we will continue to explore innovative home- and community-based services to improve SNP members' access to care, to ease the burden of caregiving on family members, to increase the use of preventive interventions, and to reduce the need for urgent and emergency care. Meeting the needs of this highly vulnerable group is a key priority.

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Changes are on the horizon in 2007 for hospice providers, prompting programs to collect and use meaningful patient and program data to monitor and improve hospice care and outcomes. The Medicare Hospice Benefit was authorized in 1982 and, with just a few modifications over the past 24 years, has changed little in overall scope and content of regulation. In May, 2005, however, the proposed revision to the Medicare Hospice Benefit was published in the *Federal Register*,¹ ushering in a new era in provider accountability for quality indicators and associated outcomes. The proposed revision introduced Quality Assessment and Performance Improvement (QAPI) as one of four major sections. While new to the nation's 4100 hospice providers,² QAPI standards, quality indicators, and online public reporting (via "Compare" Web sites) was already in place for hospitals, nursing homes, and home healthcare agencies. Publication of the final rule is anticipated in 2007.

In the proposed revision, *quality* assessment refers to measuring and tracking indicators of quality across all functions and services within the organization to determine both strengths and areas where improvement is needed. *Performance improvement* refers to the ongoing evaluation of findings from quality assessment activities, followed by application of insights gleaned through data collection to improve patient

care. The new requirements will apply across all functions and services within the hospice organization, including those services, such as medications or home health aides, that are provided through contract. The proposed revision clearly states that QAPI must be hospice-wide and data-driven. What have not been specified are the specific quality indicators, only that the hospice must select and apply quality metrics.

The anticipated final rule with its new QAPI provisions represents an unprecedented opportunity for the hospice industry to define a set of quality standards that are meaningful, measurable, and comprehensive—before specific metrics are imposed. There are numerous barriers to data gathering in the hospice setting, particularly with regard to clinical measures with hospice patients and families. The median length of stay in hospice (defined as the number of days from admission to discharge or death) is 26 days,² which indicates that patients' conditions are often changing rapidly, and their ability to self-report important indicators such as pain and quality of life diminishes rapidly. Further, the location of care for most hospice patients is the home, where a clinician is present only episodically to record symptom outcomes or other clinical indicators. Finally, the average hospice is relatively small with a correspondingly small operating budget, making dedicated staff for QAPI and electronic data recording difficult if not impossible.

The challenges are many but hospices need not be overwhelmed by the looming QAPI requirement. Experts recommend that hospices take time to clarify what quality means within the organization, build on what is already in place, formalize quality monitoring, add quality measures over time, and carry out performance improvement projects.³ In addition, accessing available resources such as the National Hospice and Palliative Care Organization's "Quality Partners" initiative, planning, starting with a manageable project, taking incremental steps, and learning from the process are key factors that will contribute to a successful and smooth transition.

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