Inside: Silver Crown Award Winners

CASEINPOINT

March 2011

Coordinating Care, Changing Lives

Transitions of Care

Best Practices of Transitions Across Settings

Medication Reconciliation

Complex Care Settings

HITECH and Health Reform: What's Coming

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for 2009
(Health Care: Medical Facilities)
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TRANSITIONS OF CARE

As it stands, gaps in care often mark the junctures of our healthcare system. But at these transitions exist opportunities for cohesion. Starting on page 18, a set of articles explores these connections and offers examples of best practice for quality care and cost containment.

IN EVERY ISSUE

DEPARTMENTS

EDITOR'S LETTER

Tackling Transitions

Welcome to the 2011 March issue of ***Case In Point***. This year, we plan to focus each issue on a specific theme. This issue spotlights transitions of care.

With a focus today on patient-centered care and the emergence of unavoidable questions like how to decrease readmissions and contain escalating costs, each sector of the industry is working to secure innovative and efficient plans. One thing is certain: to accomplish these challenges, all providers need to work together in a coordinated manner.

To illustrate models of best practice, we look at care transitions from various segments of the industry, from managed care and critical care to skilled care and pharmacy management. As we move forward with the integration of health reform, the area of transitions of care becomes increasingly important due to its impact on cost, quality and access. A superb resource for hospitals and payers are quality improvement organizations (QIOs).

As Dr. Jane Brock, chief medical officer of the Care Transitions Theme Support Center at the Colorado Foundation for Medical Care, warns: "The United States has a 19.6 percent rate of hospital readmissions within 30 days of discharge. The process by which patients move from hospitals to other care settings is increasingly problematic as hospitals shorten lengths of stay and as care becomes more fragmented."

Brock continues: "The Medicare Payment Advisory Commission estimates that up to 76 percent of readmissions within 30 days of discharge may be preventable. The QIOs have data and are willing to assist each hospital [to] better understand where their readmissions are coming so that projects can be developed to improve processes." As you can see, solid transitions can do a great deal to improve quality and reduce costs.

Also presented in this issue are the winners and honorable mentions of the first annual Dorland Health Silver Crown Awards, a program that recognizes the best in senior care. If you would like to reach any of the organizations or people mentioned to learn more about their program, please feel free to email me. I look forward to your comments and suggestions for future issues of ***Case In Point***. CIP

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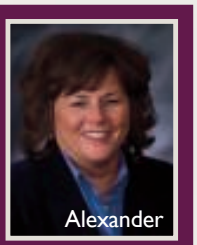

All webinars in the series will be presented by **Dr. Amy D'Aprix**, Executive Director of the DAI Foundation, and moderated by **Mary Alexander**, Business Relationships Director with Home Instead Senior Care.

Each webinar is an hour in length and provides one continuing education unit of credit.

Mark your calendar so you don't miss these great webinars:

May 11, 2011:
Long Distance Caregiving
10:00 AM Pacific / 11:00 AM Mountain / 12:00 PM Central / 1:00 PM Eastern

August 17, 2011:
In-Home Care during a Recession
10:00 AM Pacific / 11:00 AM Mountain / 12:00 PM Central / 1:00 PM Eastern

November 16, 2011:
Patient/Doctor Communication
10:00 AM Pacific / 11:00 AM Mountain / 12:00 PM Central / 1:00 PM Eastern

Each of the webinars will be recorded and available for viewing for up to 60 days after the live presentation. Pre-registration is required to attend the live webinars.

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asaging.org

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NEWS IN BRIEF

Sunlight, Vitamin D Tied to MS Risk

An Australian study found that regular sun exposure may ward off the development of multiple sclerosis, the autoimmune disease previously shown to affect populations living in weaker-sun areas farther from the equator. Yet this is the first study to examine the affect of sunlight on individuals showing early (pre-diagnosis) signs of MS, and the results corroborate past findings. Studying over 600 patients, researchers found that the more sun exposure one gets, the less risk there is for developing early symptoms. What's more, high vitamin D levels (which increase with sun exposure) were linked independently to a lower risk of MS.

Hospitals Neglect to Follow Up on Tests

New research shows an alarming gap in care: Hospitals fail to follow up on up to 75 percent of tests, which can lead to delayed or missed diagnoses in patients. Analyzing 12 major studies, researchers found that hospitals failed to follow up on inpatient test results up to 61 percent of the time, with neglect on up to 75 percent of tests on emergency care patients. Published in *BMJ Quality and Safety*, the study shows that transitional areas – when patients move from one setting to another – were a major follow-up pitfall.

Hearing Loss? Watch for Dementia

Tracking 600+ patients for more than a decade, researchers discovered a link between hearing impairment and the development of dementia, including Alzheimer's. While mild hearing loss correlated to a small risk, the risk increased with moderate and severe forms of impairment. For every 10-decibel loss, the risk of Alzheimer's shot up by 20 percent, according to the findings. While scientists haven't established a causal relationship, the link could lead to other research, including prevention strategies.

For Irregular Heartbeat, New Blood Thinner OK

Updated guidelines from several national associations recommend that the anti-clotting drug Pradaxa can be used in place of warfarin for patients with atrial fibrillation, or irregular heartbeat, a condition that affects 2 million Americans. Issued by the American College of Cardiology, American Heart Association and the Heart Rhythm Society, the guidelines rubber stamped Pradaxa for those with both recurrent and ongoing atrial fibrillation.

Despite Warning, OTC Meds Given to Kids

A recent poll shows that many parents are giving their children under 2 over-the-counter cough and cold medicines, despite warnings from the FDA, which has linked these medicines to hundreds of cases of poisoning or death. Sixty-one percent of parents gave their children such OTC medicines, and more than half reported that the child's doctor said they were safe. In addition to being dangerous, according to the FDA, these medicines have a negligible benefit in controlling symptoms.

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Medication Reconciliation: Securing Proper Drug Treatment

The Clinical Pharmacist's Role in Transitions of Care

BY MICHAEL GIUSANI, RPH, AND GARY DALY, MA

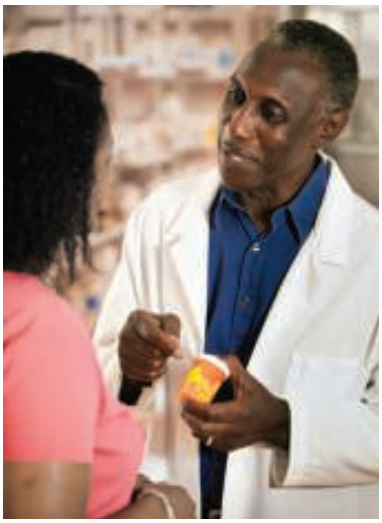
Since 2000, the Food and Drug Administration (FDA) has received thousands of reports of medication errors. According to The Joint Commission's ***Journal on Quality and Patient Safety***, "more than 40 percent of medication errors are believed to result from inadequate reconciliation in handoffs during admission, transfer and discharge of patients."

Meanwhile, transitions of care refers to the movement of patients between healthcare locations, providers or levels of care. It occurs within settings (e.g., primary to specialty or intensive care), between settings (e.g., hospital acute to ambulatory clinic), across health states (e.g., curative to home care) and between providers (e.g., acute to palliative care).

AVOIDING COSTLY ERRORS

According to The Joint Commission, medication reconciliation "is the process of comparing a patient's medication orders to all of the medications that the patient has been taking," which is done to avoid errors like drug-to-drug interactions.

When patients are transferred from one setting or provider to another, who is responsible for medication reconciliation and what specific steps are required when? The Agency for Healthcare Research and Quality says: "It should be done at



every transition of care in which new medications are ordered or existing orders are rewritten."

The National Center for Biotech Information published a chapter on medication reconciliation, authored by Jane H. Barnsteiner, which describes the steps in medication reconciliation as "seemingly straightforward. For a newly hospitalized patient, the steps include obtaining and verifying the patient's medication history, documenting the patient's medication history, writing orders for the hospital medication regimen, and creating a medication administration record. At discharge, the steps include determining the post-discharge medication regimen, developing discharge instructions for the patient for home medications, educating the patient, and transmitting the medication list to the follow-up physician. For patients in ambulatory settings, the main steps include documenting a complete list of the current medications and then updating the list whenever medications are added or changed."

Barnsteiner adds: "However, the process of gathering, organizing and communicating medication information across the continuum of care is not straightforward. First, there is tremendous variation in the process for gathering a patient's medication history. Second, there are at least three disciplines generally involved in the process – medicine, pharmacy and nursing – with little agreement on each profession's role...Third, there is often duplication of data gathering with both nurses and physicians...rarely comparing and resolving any discrepancies between the two histories."

INVESTING IN ERROR AVOIDANCE

Through the Recovery Act, the federal government and selected state government grants are funding health information exchanges (HIE) and are committing to tax refunds for hospitals and physicians who invest in electronic medical records. Although these medium- to long-term investments hold promise for medication reconciliation in transitions, it will take time to establish universal patient

A Bad Medicare Program Producing Bad Results.

After the January 1st implementation of Medicare's controversial "competitive" bidding program in nine regions across the U.S., hundreds of Medicare patients are reporting problems receiving home medical equipment & services that were prescribed by their physicians.

The program has been implemented in Charlotte, Cincinnati, Cleveland, Dallas-Ft. Worth, Kansas City, Miami, Orlando, Pittsburgh, and Riverside, CA.

The program is scheduled to start up in another 91 regions later this year. The bidding program affects millions of Medicare beneficiaries who require oxygen therapy, enteral nutrients (tube feeding), continuous positive air pressure (CPAP) and respiratory assistive devices, power wheelchairs, walkers, hospital beds and support surfaces, and mail-order diabetic supplies.

Please report feedback and problems from this program at www.biddingfeedback.com or call 1-888-990-0499.

For more information about this program, visit www.aahomecare.org/competitivebidding.

American Association for Homecare

Caring that Feels Right at Home

records that will address this problem.

Private industry contributes to medication reconciliation when patients are covered by group health or workers' compensation insurers. "Pharmacy benefit management service providers work on behalf of insurance carriers, third-party administrators and self-insured organizations to make it easier for injured workers or for patients covered by group health insurance to get the right medication at the right time," says Gary Daly, vice president of sales with ScripNet. "We have established formularies that are administered at the point of sale through our network of pharmacies that have access to patient-specific prescription histories, safeguards and alerts to detect therapeutic duplications and potential drug interactions."

In addition to concurrent drug utilization reviews that are implemented in real time when an injured worker fills a prescription, ScripNet's programs conduct retrospective drug utilization reviews to identify health risks as well as possible abuse or diversion.

"Education and collaboration are key," says clinical pharmacist Michael Giusani. "Prescribers, pharmacists, nurse case managers, claims adjusters and patients need to work together as a team to determine the best course at each stage of treatment to improve the patient's outcome.

"The pharmacist's role is unique in understanding the medication and how it works with the treatment, making sure that the medication the patient is receiving is appropriate for the condition being treated. A clinical pharmacist can add significant value if involved early, such as at the point-of-sale, and often, throughout the transitions of care process."

Because clinical nurses and case managers have the closest contact with patients throughout their treatment, they play a central role in both education, i.e., making sure that the patient understands what, why and when to take their medication, as well as collaboration with prescribing physicians, dispensing and clinical pharmacists, and pharmacy benefits managers, to help facilitate medication reconciliation at each stage in the transition of care. CIP

Gary T. Daly is VP of sales for ScripNet, a workers' compensation pharmacy benefit management company. (gdaly@scripnet.com) **Michael W. Giusani** is the VP of pharmacy services, workers' compensation division for RJ Health Systems. (mgiusani@rjhealthsystems.com)

New Drug Approvals: A Case Manager's Guide

MAKENA (HYDROXYPROGESTERONE CAPROATE)

Company: Hologic Inc.
Date of Approval: February 3, 2011
Indication: Premature Labor
The FDA approved Makena (hydroxyprogesterone caproate) injection to reduce the risk of preterm delivery before 37 weeks of pregnancy, in pregnant women with a history of at least one spontaneous preterm birth. The drug is not intended for use in women with a multiple pregnancy, such as a twin pregnancy, or other risk factors for preterm birth.

VIIBRYD (VILAZODONE)

Company: Trovis Pharmaceuticals LLC
Date of Approval: January 21, 2011
Indication: Depression
The FDA approved Viibryd tablets (vilazodone hydrochloride) to treat major depressive disorder in adults. The drug will be available in 10, 20 and 40 milligram tablets.

ABSTRAL (FENTANYL)

Company: Orexa AB
Date of Approval: January 7, 2011
Indication: Pain
The FDA approved Abstral, a medication licensed for the treatment of breakthrough pain in cancer patients, 18 years of age and older, who are already receiving, and are tolerant to, opioid analgesics for their underlying persistent cancer pain.

AMTURNIDE (ALISKIREN, AMLODIPINE AND HYDROCHLOROTHIAZIDE)

Company: Novartis Pharmaceuticals
Date of Approval: December 21, 2010
Indication: Hypertension
The FDA approved Amturnide (aliskiren, amlodipine and hydrochlorothiazide) tablets for the treatment of hypertension. Amturnide combines the only approved direct renin inhibitor worldwide, Tekturna (aliskiren), with the widely used calcium channel blocker amlodipine and the diuretic hydrochlorothiazide.

GABLOFEN (BACLOFEN)

Company: CNS Therapeutics
Date of Approval: November 19, 2010
Indication: Spasticity – Cerebral and Chronic
The FDA approved Gablofen (baclofen injection) for use in the management of severe spasticity. The new drug is billed as an easy-to-administer and cost-effective intrathecal baclofen treatment option.

Severe spasticity is a movement disorder affecting more than 500,000 patients in the U.S. alone and is often brought on by multiple sclerosis, cerebral palsy, spinal cord injury, brain trauma and stroke.

Further drug information, including safety information, warnings, contraindications and other facts about general use, is available online at ***www.fda.gov/drugs****.*

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Home and Community Services: What You Need To Know

BY CHRISTINE MACDONELL AND AL WHITEHURST

Home and community services assist persons with a special need to remain in their homes as an alternative to being institutionalized. This assistance can also be used by individuals in other community living arrangements, such as group homes and assisted living facilities.

As a case manager, your guidance is essential to preparing an individual plan to identify and design the delivery of the services and supports that allow a person to stay in his or her home or community.

WHAT DO HOME AND COMMUNITY SERVICES COVER?

The U.S. Department of Health and Human Services (HHS) classifies several types of home and community services:

- Personal care and assistance might be provided by personal care attendants or home health aides. They can help individuals perform activities of daily living (ADL), such as eating, bathing, dressing and toileting, and instrumental activities of daily living (IADL), such as light housework, laundry, transportation and money management.
- Long-term health and health-related services include a wide range of skilled and unskilled nursing services for chronic conditions. Examples are tube feedings, catheterizations and range-of-motion exercises.

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- Specialty services aim to improve the individual's functioning and are related to the specific nature of an individual's impairment. For example, psychiatric rehabilitation services address the needs of individuals who have a mental illness. Habilitation services enable persons with mental retardation to acquire or improve skills to help them become more independent. Assistive technology, such as communication devices and motorized wheelchairs, can help persons with many different types of disabilities become more self-sufficient.
- Adaptive services cover home and vehicle modifications for individuals with physical impairments. Home modifications might include installing wheelchair ramps; widening doorways; and retrofitting bathrooms and kitchens. This may also include vehicle modifications.
- Family and caregiver supports are designed to help the family and friends who are the primary caregivers to individuals with disabilities. Respite services, for example, provide relief to the individual's primary caregiver. Training and education can improve the caregiver's ability to meet the needs of the patient.
- Social supports help individuals take an active part in activities and avoid social isolation. Companion services, for example, provide assistance so that individuals can participate in community activities.

WHO USES HOME AND COMMUNITY SERVICES?

The demand for home and community services is mushrooming, in part because baby boomers are seeking services for their aging parents or are entering their retirement years themselves. Yet adults with age-related disabilities or illnesses are not the only persons who benefit from home and community services. People of all ages increasingly rely on support services in their homes and communities, including those who are temporarily disabled after a surgery, hospitalization or illness; a new mother needing in-home support; or an aging couple needing assistance with transportation.

"More and more people are saying, 'I want to stay at home,'" observes Sue VanderBent, executive director of Ontario Home Care Association (OHCA), whose member service providers deliver home health and social care. "They prefer to maintain their independence in their own home rather than live in a nursing home."

Persons with disabilities, such as cerebral palsy or mental illness, also increasingly use home and community services. HHS acknowledges, "People with disabilities are now recognized as being able to live in their own homes and other community settings and to lead satisfying and productive lives when provided the range of services and supports they need to do so."

Thanks to advances in medicine and assistive technology, persons with developmental disabilities are living more productive and longer lives today. "In 1930, the average age of a person with a developmental disability was 10. Now it is 61," says Tony LoDuca, president and CEO of St. Coletta of Wisconsin, Inc., an accredited provider of support services.

Moreover, the need for home and community services might arise earlier in the life of a person with a developmental disability. "Individuals with Down syndrome typically experience secondary disabilities, such as vision loss or mobility impairments, at a much earlier age than the general public – sometimes as early as age 40," says LoDuca, whose organization has responded to this need by assembling an array of supports for people who want to live in their own homes or in group homes.

IS ACCREDITATION IMPORTANT?

Your role as a case manager not only includes screening and selecting home and community services for your clients, it also includes monitoring the quality and effectiveness of the services. Choosing accredited services can make you confident of your choices.

CARF International introduced standards for home and community services in 2010. The standards can be applied in a variety of settings and in a continuum of services – aging services, behavioral health, child and youth services, employment and community services, and medical rehabilitation.

Persons who require home and community services can feel vulnerable with strangers coming into their homes and engaging them in personal activities. Consumers told CARF they want a review of organizations that send persons to assist them – whether it is a home care aide or a driver transporting them to appointments. They said they feel more secure if they know an accreditor is watching out for their interests, and they look favorably on service providers that have earned the CARF accreditation seal.

THE ROLE OF COLLABORATION

Sustaining relationships and resources is a key to successful case management – and essential for the growing home and community services field. "OHCA's biggest breakthrough is our collaborative work with other public health organizations. Collectively, we are achieving impressive outcomes in home and community services," says VanderBent. "The field of home and community services has been emerging for some time, and now I believe it is maturing." CIP

Christine MacDonell is managing director of CARF International's Medical Rehabilitation customer service unit. (cmacdonell@carf.org) **Al Whitehurst** coordinates the accreditor's corporate communications. For more information, visit carf.org.

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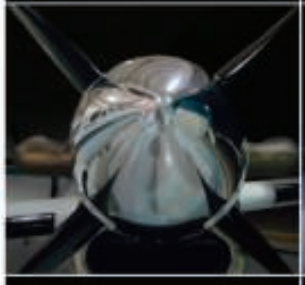

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ASK THE EXPERT

In this session, Dennis Robbins, PhD, MPH, takes on the challenging area of healthcare leadership – those troubling areas that keep the expert up at night, and how we, as stewards, can navigate the interface between knowledge and uncertainty and integrate the results into a more comfortable, and practical, realm to better healthcare delivery.

Q: In short, what makes the expert an expert?

A: In my case it has been a combination and culmination of captured opportunities. For many years I have been acknowledged as a healthcare visionary, which in essence translates as being way (or even a little) ahead of the curve in terms of what was likely to come down the pike. It also assumes one can approach an issue from multiple perspectives and greater depth than the nonexpert.

I had the good fortune to become well connected and work closely with and benefit from the cross-fertilization of diverse thought leaders and movers and shakers in healthcare and with diverse trade associations, prominent medical societies, research, IT, and academic and government entities.

Three decades as a speaker helped develop a presence across disciplines and healthcare sectors, which afforded a cross-disciplinary perspective, granting both a broad bird's eye view and from-the-trenches worm's eye view.

I have worked closely with key players and innovators in the payer community, policy, legal and clinical communities and traversed diverse disciplines across the healthcare field.

I have consulted or advised both our national and foreign governments on healthcare policy and am an Adjunct Professor of Health Policy at Pepperdine and a former National Fund for Medical Education Fellow at Harvard.

All of this may seem impressive. But I have found it not to be enough.

HAS SOMETHING FUNDAMENTALLY CHANGED IN OUR HEALTHCARE DISCOURSE?

The access to good information, picking the brains of influential colleagues and keeping up with the literature used to be enough. That's no longer adequate. But we must not get discouraged and overwhelmed by atrophy, delay and politics.

For a short time, it seemed futile to get good reliable information and I was disappointed with the absence of integrity in the healthcare policy debate. The distasteful political climate infused with banter was just intolerable. But to let the banter prevail over informed expertise is also intolerable. So after temporarily backing off until the dust began to settle and shutting down from political antics overload, I determined it was time to move forward. I suggest we all move forward to help this healthcare delivery system become what it indeed can become. This is an unprecedented time for science, data and quality to prevail over ignorance and myopia.

Healthcare delivery reform is aimed at improvement through change, and many of us are in the position to help make that happen. In essence, each of us can do our part and lend our expertise to help the system become what it has the potential to become. This translates into new opportunities to transform and redefine care as well as offer better coverage and more security. Primary care that is patient-centered, coordinated and seamless can help create a foundation upon which a high-performing system prospers, one that delivers health not just care.

HOW CAN YOU RECAPTURE SOME ELEMENT OF CONTROL AND DIRECTION?

First, while change and uncertainty can be painful, one should never

become a victim when you can remain a vanguard. It just means that I really have to work hard to bend the knowledge curve to supersede all the chaos and political bantering, as well as not be dissuaded by the prophets of doom, gloom and false hope. Some additional tips include:

1. Make what you want to know something you need to know.
2. Ensure that we move from political football back to science and quality and fill in the gaps with very good data and information.
3. Stay on track and avoid offering great answers to the wrong questions.
4. Align and harmonize goals and strategies.
5. Share rather than ration good information.

WHAT DOES THIS ULTIMATELY MEAN FOR THE AVERAGE CONSUMER?

I can only begin to imagine that if it's that hard for me or other thought leaders, how about the average healthcare consumer? As we navigate upstream against the turbulence of uncertainty, one can only imagine that the non-health professional who is not adept at understanding this chaos and confusion will get inundated and swept away.

We must advocate for getting the right thing done for the right reason and doing it well. We must help the consumer understand what truly is in his or her best interest and both advocate for and help empower him or her to make good decisions We must mitigate misunderstanding with the promise of improvement and positive change.

WHAT CAN WE DO SO AS NOT TO BE OVERWHELMED AND DISCOURAGED BY UNCERTAINTY?

This is an unprecedented time for uncertainty and promise in healthcare, but we must be vigilant to prevent hope and change to become overshadowed by fear and trembling in the face of proactive change. We must maintain homeostasis to stand firm and challenge adversity, misunderstanding and confusion.

We cannot permit overreaction, political positioning and special interests to undermine our ability to navigate the chaos and dysfuntionality that surrounds us. We must keep our eyes focused at the light at the end of the tunnel and be careful not to allow our confidence in helping to create and employ better mousetraps to deteriorate.

We must maintain solid footing and a high degree of professionalism, advocacy and ethics. We must realize that complicated times and times of transition require stewardship and advocacy on behalf of those who rely on us and whom we serve. We must reduce uncertainty to a manageable realm. We must supersede the propensity of being victims and reassuming a status of a vanguard and advocate. We must keep on truckin' and don't let the naysayers grind us down.

ARE YOU HOPEFUL?

Yes. We have immense talent and visionaries in the policy-making area. I am looking forward to what comparative effectiveness and patient-centered outcomes will contribute to shaping our thinking and policy. I look forward to the insights and stewardship of Don Berwick at the helm of CMS and the promise of what can be accomplished by the Center for Health Care Innovation under the tutelage of Richard Gilfillan (www.innovations.cms.gov).

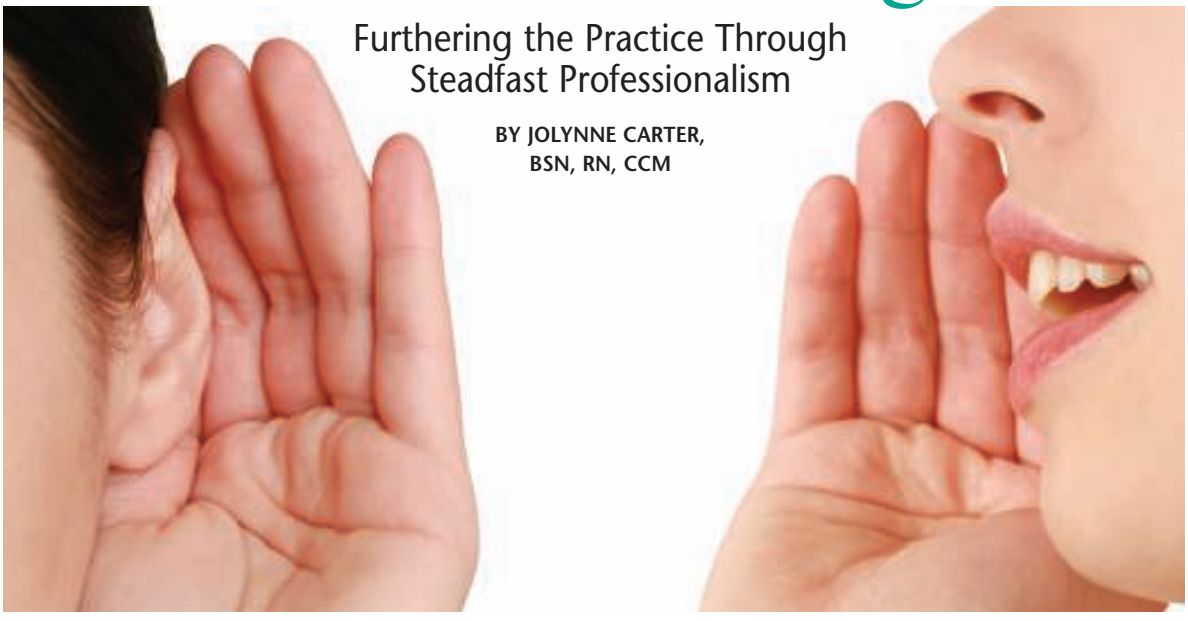
The sense of commitment and demonstrated integrity, quality and thoughtfulness is unprecedented. In essence we have a healthcare policy dream team. Synergy is before us. I anxiously await the fruits of their vision and integrity as science, data and quality prevail over the politics of smoke and mirrors.

And finally, this process has made me realize that expertise does not stop with the acquisition and retention of knowledge. It involves that next step of seeing how the pieces fit together and understanding the implications and promise of options before us. CIP

Reavealing the Best-Kept 'Secret' of Case Management

Furthering the Practice Through Steadfast Professionalism

BY JOLYNNE CARTER, BSN, RN, CCM



Amidst all the talk about how to improve quality, efficiency and efficacy in healthcare these days, case management sometimes feels like the best kept secret. Those of us in the field know without question the difference that case management makes to those for whom we advocate, in particular patients with complex cases or multiple co-morbidities. Yet at times case management seems to occupy an understated position while newer and sometimes nearly synonymous terms such as care coordination take the spotlight.

To understand why, we need not look beyond ourselves.

CLARITY IN DEFINITION

Across the spectrum of health and human services, case management is made up of professionals who, by their nature and vocation, are nurturers and caregivers. We expend so much emotional energy giving to others that self-promotion seems both unnatural and too much work. Few of us have the extra energy it takes even to contemplate the difference we make to our patients, employers, profession and community. That, however, is precisely what we need to do.

As case managers we need to "toot our own horn" individually and collectively to promote our practice to our patients/clients, our employers, the healthcare teams with which we collaborate, and within the broader community of healthcare practitioners.

Case managers from every discipline and background must capitalize on the ongoing healthcare reform discussion and become informed and empowered participants in the debate. Unless we make our voices heard, we run the risk of getting lost in the ever-widening chorus of job titles and roles, such as care managers, care coordinators, patient navigators, guided care nurses and the like. We need to draw attention to the important roles that case managers fulfill as patient advocates and stewards of scarce and costly care and treatment resources.

The 2009 Case Manager Role and Functions Study conducted by the Commission for Case Manager Certification (CCMC) revealed the essential activities and knowledge areas that define the practice of case management. Essential activities are identified as case management process and services, resource utilization and management, psychosocial and economic support, rehabilitation, outcomes, and ethical and legal practices. Knowledge domains determined by the study are case management concepts, healthcare management and delivery, principles of practice, psychosocial aspects, healthcare reimbursement, and rehabilitation.

As the role and function study findings reveal, case managers contribute

their knowledge and expertise in meaningful ways in the pursuit of desired clinical, financial and patient-satisfaction outcomes. Moreover, those who are certified case managers go the extra step to attest to their professionalism, commitment to continuing education, and adherence to a strict ethical code. These are the qualities that case managers should showcase in order to differentiate the practice against an increasingly confusing backdrop in which nonclinical people in largely administrative roles are sometimes called "case managers."

RESPECT THROUGH PROFESSIONALISM

At the same time, case managers need to take a close look at their professionalism to ensure that we hold ourselves accountable to the highest degree of professional and ethical behavior. Because of our roles as advocates and our natural inclination to take care of others we may be tempted to "cross the line" when it comes to human relationships. Even with the best of intentions, it is very easy to blur professional boundaries, such as giving a patient/client a ride in one's own car, inviting that person to a worship service at our church, or adding the person's name to the prayer list.

In order to command the respect of others, particularly members of the healthcare team, we need to present ourselves in a professional manner in how we dress, interact with patients, and explain the scope of case management services and our role as the case manager. Furthermore, we are not just clinicians, we are also businesspeople who must be accountable for the full scope of our responsibilities, including submitting complete and accurate reports, communicating in a timely fashion and even billing on time.

Beyond individual accountability, there are other ways for case managers to become involved for the good of the practice. Through professional organizations case managers can attend professional conferences to keep abreast of the latest developments in the field. For certified case managers, for example, CCMC offers opportunities to volunteer one's time and talent in a variety of capacities, such as item-writing workshops to support the certification examination.

Receiving the credibility that case management deserves will not happen if we fail to recognize and communicate our value. In the midst of critical debate around healthcare delivery, case managers cannot afford to stay silent. We must speak up and let our voices be heard. CIP

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Improving Transitions via Synchronized Patient Management

BY THOMAS R. FERRY

When it comes to case management and discharge planning, the status quo has got to go.

The world has changed and so have the demands on these departments. Increasing regulations, mandatory adherence to more onerous compliance policies, tighter financial controls (e.g., LOS and readmissions) and a shrinking workforce necessitate the need for new approaches and strategies.

Take discharge planning for example. It generally takes at least eight healthcare professionals to complete one patient placement. This includes individuals within your facility as well as third-party organizations, all with different agendas and goals. The friction between these relationships is often compounded by the communication gap that exists within the department and outside of the department, with payers and providers.

This communication gap is like a black hole that swallows up all the valuable information required to drive quality in clinical outcomes and profitability in financial results. Therefore it is imperative to fill this gap by capturing data, the data necessary to drive best practices that in turn will lead to a better discharge process. Closing the gap requires a brand-new approach: synchronized patient management.

Synchronized patient management is a fully integrated solution that connects healthcare providers and payers with a user-centric view of patient-centric records, results and reviews. It is both a workflow tool that helps automate manual processes as well as a communication tool that connects users and departments with their external partners. This approach enables everyone involved to make informed decisions in real time based on a standardized set of data that is meaningful to each function. Only with that integrated, holistic approach will we be able to build better discharges and achieve better results.

THE NEED FOR SYNCHRONIZED PATIENT MANAGEMENT

Just as utilization management (UM) evolved as an adjunct to case management to fill a new need, synchronized

patient management will take root to satisfy still more distinct, yet related, needs. It will include and align every discrete discipline governing all aspects of patient care. Case management and care management. Utilization management and transition management. Payer approvals and denials. And the challenging requirements of evolving models of care.

The big difference, however, is that while UM was a reactive development designed to ensure maximum payments and minimal denials, synchronized patient management will be a deliberate, proactive effort that anticipates and satisfies a broader set of needs of all participants. By anticipating who needs what, there will be an integrated approach of connectivity and meaningful, accessible data and tools that spur utilization, which drives better outcomes.

While some may think that this approach to reconfiguring and synchronizing the people, processes and technology of patient care is revolutionary, it's really evolutionary. It is a natural response to complex changes in healthcare, including:

Throughput pressure underscores need for synchronization. Efforts to control spiraling costs have the downstream effect of squeezing patient flow to increase capacity and optimize reimbursement. Now, to carefully choreograph the well-timed movement of patients from one level of care to another, connectivity and quick communication are required. Long gone are the days of dropping a referral packet in the mail to a SNF.

Volume of administrative work detracts from patient care. With dozens of pages of paper required in just one typical referral packet and dozens of data points required by third parties to document everything from need and eligibility to an estimated vs. actual discharge date, administrative work threatens to dwarf the clinical. There is an increasingly acute need to capture once and share detailed, updated, need-to-know information.

Evolving models need management tools. No matter how well-thought out the idea – ACO, medical home, HIE, RHIO – most concepts for improving care and lowering costs are largely just that: concepts. Making them reality means anchoring them on a technology platform that captures the data necessary to drive the creation and use of best practices and protocols for positive results.

THE RIGHT PLATFORM FOR THE RIGHT RESULTS

Building this new, integrated solution of the future requires new thinking. In the past, it used to be enough to capture data but not capture the specific task involved or the user or even the department. Some data, after all, was better than no data at all. But that amorphous approach is why utilization and adoption of some case management or discharge planning technology is poor. With a narrow approach, organizations are hamstrung. Incapacitated? No, but they're definitely not being sufficiently supported to achieve the outcomes they're after.

The following questions will be addressed as we enter the next significant phase of healthcare technology, which will be characterized by connectivity, collaboration and consequences.

- How do departments work? And with whom?
- What do they need for better performance? And what's the best way measure that?
- What's needed for a shared, transparent view of the same information to generate good outcomes?

PREPARING FOR SYNCHRONIZED PATIENT MANAGEMENT

As the focus shifts from software to outcomes, forward-thinking clinicians today can start to embrace pieces of the multifaceted mosaic of a fully integrated approach to patient management. They are working, for example, to:

- **Require an estimated discharge date (EDD).** Establishing a target date and sharing it with the patient, as well as other healthcare professionals on his case, is a basic requirement for synchronization. An EDD in a referral packet helps align providers and identify potential post-acute care needs and appropriate settings for care. It can also help ensure care is available when needed, like home care starting on a weekend.
- **Communicate clearly and consistently to provide choice.** Involving the patient and his family immediately after admission in anticipation of discharge contributes to a more successful transition with an optimal outcome. By determining patient needs and preferences, staff better sets expectations with both the patient and post-acute providers being considered. Detailed information should flow in both directions – such as medication doses and schedules for providers; facility features; and services for patients.
- **Depend on documented best practices.** Reviewing and responding to data to refine activities enhances the management of patient care with continuous improvement. To cut preventable readmissions, for example, conduct a root-cause analysis by tracking readmissions by diagnosis, placement and physician. Doing that regularly, a typical hospital can cut readmissions by about 0.5 percent and save $1.3 million annually.

Building a better discharge means not settling for the status quo. It means building on what we have to achieve a fully integrated patient management process. CIP

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Transitioning Complex Patients From the ICU

Tools, Tips and Strategies for the Team

BY FLORENCE SIMMONS, RN, MSN, CCRN

More patients are surviving acute, severe illness or injury because of increased technology and improvements in overall patient management. The clinical management of the critically ill is the priority, but the primary objective of care is to stabilize the patient and transition from the intensive care unit (ICU) to the next level of care, which may include a direct transfer to a post-acute provider or transfer to multiple units in the hospital.

The fragmentation affiliated with the movement of the critically ill through the continuum, the risk of complications, and complex care needs make transition management an extremely important part of the patient's treatment plan. Proactive discharge planning is often overlooked in the ICU, but is a major component of transition management. Discharge planning improves outcomes for patients, reduces costs, and decreases the length of stay. This article focuses on steps for effective discharge planning that moves the patient to the next level safely and efficiently.

BENEFITS OF CLEAN TRANSITIONS

Discharge planning for critical care patients is challenging because their hospital course is unpredictable, post-acute care requires complex and expensive resources, and in many cases the clinical outcome, discharge date, and needs are not determined until later in the admission. Proactive discharge planning is essential for decreasing length of stay through early identification of post-hospital needs, for better resource utilization, for improving family and patient satisfaction, and for providing appropriate continuity of care. The best practice for successfully moving a critically ill patient throughout the continuum of care is management by a consis-

tent multidisciplinary team led by a nurse case manager and social worker that develops and monitors effective transitional care strategies that meet the patient's complex needs. Compromised transitions may lead to complications, adverse events, readmission to ICU, increased mortality rates, and increased costs.

Many post-acute care providers, such as long-term acute care units (LTACs), ventilator-weaning units and specialty rehabilitation units, can provide the necessary complex care once the patient is stable enough to leave ICU and are able to accept patients without a transfer to the floor. The discharge planning process is usually the same regardless or whether or not the patient leaves the hospital upon transfer from the ICU or after an extended stay on an inpatient unit. If the patient leaves early in the stay, the plan is implemented sooner. Early discharge may decrease fragmentation, because the ICU team who is familiar with the patient and has managed the care completes the discharge plan, rather than a secondary post-ICU team assuming the implementation of the discharge plan.

There are several barriers to discharge planning for the ICU patient, especially when early, direct transfer to a post-acute provider is the plan, because of family stressors, physician beliefs, patient acuity, financial constraints, and lack of appropriate post-acute care providers. Family members are often overwhelmed by the stress of an ICU admission and the unpredictable hospital course that may include multiple readmissions to the ICU. They may not be familiar with early discharges to post-acute care facilities and may be reluctant for the patient to leave the security of the hospital. Physicians may not agree with early transfers because they want to continue to manage the patient, they may fear not being appropriately notified of changes in patient status post-discharge, or because of negative experiences with a specific provider, concerns about readmissions or even fear of financial losses.

Funding resources may provide limited benefits, may be lost after a prolonged inpatient stay, or the patient may lack medical insurance. The number of post-acute care providers that provide services to complex patients may be limited, located a distance from the patient's home, or may require expensive transportation due to distant location. Most ICU patients will require post-hospitalization placement or homecare services, thus proactive discharge planning that begins in the critical care unit will need to be implemented for a smooth transition to the next level of care.

Rorden and Taff's (1990) definition of discharge planning begins with early assessment of anticipated patient needs; includes concerns for the patient's total well-being; involves patient, family and caregivers in dynamic, interactive communication; places a priority on collaboration and coordination among healthcare professionals; results in mutually agreed upon decisions about the economic and clinical options for continuing care; and is based on thorough, up-to-date knowledge of available continuing care resources. It is a dynamic process that involves a variety of specific skills and requires all members of the healthcare team to work together in a coordinated method to achieve mutually agreed upon goals, and ultimately, continuity of care.

DEFINING THE PROCESS

The discharge planning process (see below) for ICU patients is the same as for any other patient, but takes into account that needs are generally more complex. Typically, once the patient finally stabilizes, the time for planning and implementation of the discharge is limited. The discharge plan may require relocation to a facility in another city or state, which will further increase the planning time.

Discharge planning process. An interdisciplinary team that is usually led by a nurse case manager and social worker is essential for development and implementation of a discharge plan for critical care patients. Key components of the process include 1) early and ongoing clinical status assessment; 2) early and ongoing financial assessment and payer interaction; 3) early and ongoing family and patient (if alert) meetings; 4) identification of appropriate placement options and referrals; 5) transportation arrangements; and 6) actual discharge to a post-acute care facility.

The interdisciplinary team. The interdisciplinary team is responsible for planning care throughout the entire episode of illness. Unfortunately, the team may cause barriers to discharge due to fragmentation, lack of consensus for the plan, and poor communication, including lack of handoffs as the patient moves from one area to the next. Many times there is a different clinical team for the patient when in ICU compared to the floor team. There may be conflicts between consult services and the primary team. It is highly beneficial when the case management team is service-based and remains consistent throughout the entire admission. A consistent team follows the patient throughout the entire hospitalization, is familiar with care needs, develops and updates the plan, and communicates the plan to patient, family and team members who are working with the patient.

Early and ongoing clinical assessment. Ongoing assessment of clinical status through rounds and direct patient observation is essential for the discharge planner to identify the patient's clinical status and to formulate a plan for post-acute care. Rounds also provide the discharge planner with an opportunity to communicate interventions that are needed to meet facility admission criteria, including permanent feeding tube placement, tuberculosis skin testing, therapy consults, etc. Early mobilization is a key component of patient manage-

ment. Starting therapy in the critical care unit, even if it is passive, to prevent loss of function and complications, and to strengthen muscles, which could assist with ventilator weaning, is essential.

Early and ongoing financial assessment and interaction with payer. Funding dictates the resources that are available, so it is an important component of discharge planning. A detailed financial screen is essential and is usually completed by the admission's department and the social worker. This is necessary regardless of source of medical coverage, because the patient may need additional funding applications completed for long-term care or because of limited benefits. Funding resources for uninsured patients should be initiated early in the hospital stay due to the time that it takes to complete applications and also because a family member may need to obtain power of attorney to file the application if the patient is not able to make decisions for himself. It also provides time for the appeal process if there are denials. In cases that involve liability, extent of coverage needs to be explored and claims need to be filed.

Early and ongoing family meetings. Early and ongoing family conferences are necessary to educate family about the need for proactive discharge planning, to identify a plan, and to provide emotional support and resources. The patient may be involved if alert and oriented. However, an ICU stay can be frightening and intimidating. Discharge planning itself can be threatening and sometimes offensive to family members, who are focused on the patient's clinical status. Many interpret discharge planning as "kicking the patient out of the hospital." It is important to keep family updated on a patient's clinical status and that the discharge disposition will meet the patient's specific clinical needs.

Identification of appropriate placement options and referrals. There are several discharge dispositions for critical care patients, including LTAC, specialty rehabilitation, acute care hospital, skilled care facility, or out-of-state placement. It is important to be clear about the patient's clinical status, as well as providers that are in network and if there are out-of-network benefits provided. It is usually easier to negotiate care for a complex patient, but some providers do not have benefits for LTACs and sometimes appropriate providers will not accept the patient directly from the ICU. The referral process may involve multiple calls to the facility's admissions team to clarify their admission criteria and to send chart

data to them for extensive review. The referral process needs to be started early because it can be timely and may need to be revised. The patient and family have the right to make the decision for a provider, but they need to be made aware of the appropriate provider for the specific patient care needs. Ongoing education is essential.

TRANSPORTATION CONCERNS

Ambulance transportation for a critical care patient is expensive due to advanced care needs and the travel destination. Family members should understand that most payers rarely pay for transfers of convenience to move a patient to a facility that is closer to home. Benefits review is essential, and every attempt should be made to have transportation costs covered. Liability monies are an excellent resource for paying for transportation. Conversations with discharge planners at the accepting facility may identify more cost-effective rates for ambulance services.

BARRIERS TO DISCHARGE

If a patient remains in ICU for months and lacks a secondary payer, the patient may lose benefits and may have to remain in the hospital until stable for a lower level of care that is covered. Sometimes no facility will accept the patient, or family may refuse an early transfer. Early transfer may not be the option if the transportation cannot be paid for by the provider or the family. The patient may need to wait until he is more stable and can travel by plane or private car. The patient may lack funding resources and may need to remain in the hospital until ready for transfer to home. Transfer may also be delayed due to lack of bed availability, pre-certification, or changes in the patient's acuity level.

ICU patients are leaving hospitals "sicker and quicker" due to the need to decrease length of stay and improve resource utilization. Also, post-acute care providers can meet the complex needs of the critically ill. A smooth and timely transition from hospital to next level of care can be accomplished, but discharge planning needs to begin while the patient is still in the ICU. A consistent, multidisciplinary team is needed to plan and implement this process. CIP

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Transitions in Long-Term Care

A New Program Eases the Way

BY WILLIAM MARTIN AND CHRISTINA O'LEARY

We all work hard to attain a comfortable place in which to live. It is one of the basic needs of our lives. And invariably as we settle into these places, create memories and watch our families grow, it becomes more than a dwelling. It becomes a home.

Many senior citizens, as they grow older and are forced to assess their living situations, struggle with the idea of leaving their homes when unexpected events require a change in residence.

As part of a generation that has lived through the Great Depression, survived several wars and worked much of their lives to provide for their families in securing a place to live, it is no surprise that many seniors would prefer to stay in their homes for the duration of their lives. As these people

unfortunately survive their friends, siblings and sometimes even their children, they are often left with a home they can no longer afford to manage or maintain. Sometimes a serious health condition arises during which it is determined that it's no longer safe to live alone. The idea of transitioning to a new residence can be extremely difficult for seniors. It can also prove more stressful for those already experiencing difficulty from other unavoidable life events.

DEVELOPING A BEST PRACTICE SOLUTION

At Spring Hills Senior Communities, we recognize and understand the life-changing nature of this situation and how it can be taxing on both seniors and their families. In addressing this issue, we have developed a simple solution: the Resident Concierge.

Beginning with the community relations counselor, the first person to meet and interact with seniors and their families, the entire transition of care is designed to provide a one-on-one approach in learning of the resident's needs and appropriately addressing them. The community relations counselor works to make the best decisions for a resident's transition, with consideration to both the individual as well as their surrounding family. The very next person the senior and their family will meet is the resident concierge.

Once the decision to join the community is finalized, the resident concierge strives to provide a familiar face, ensuring a smooth transition into the new community. A recognizable concierge can often make all the difference for a senior accomplishing the daunting task of relocating into a new home and can help them navigate this sometimes frightening experience.

A pre-care conference attended by all management staff at the community is next held in order to provide the "wow moment" that Spring Hills believes each resident is entitled to. The resident concierge position dramatically increases the opportunity for a resident to be pleased with their new home.

James Tavormina, resident concierge at Spring Hills' Morristown, N.J., location since August 2010, outlines the importance of the wow noment when welcoming seniors to the Spring Hills family.

"It is something we acquire or create as a welcome gift that incorporates a resident's life before they came to the community, or even a current liking," he says. "Many days I get to create a unique wow moment for members of our community."

Tavormina adds that the position allows him to become intimately aware of each of the resident's personal needs in terms of their transition – down to the time of day they like to take a bath or shower, whether or not they prefer bar or liquid soap or how a resident may like his or her hair styled. It all culminates into what Spring Hills refers to as an individualized service plan.

"All of these details are extremely important to maintaining the resident's dignity," he says. "And it also stresses to the residents and their families that our staff will go above and beyond in order to satisfy their needs."

The position also allows him to keep residents abreast of all the services available to them, such as the new "Signature Living" program, which provides a unique, resident-specific approach to total well-being by encouraging health, wellness and peace of mind. All this and more is included in the 30-day follow up for each new resident, performed by the concierge, he says.

AN UPTICK IN CARE – AND RESIDENTS

The introduction of the resident concierge position has proven successful for addressing resident needs, increasing overall service satisfaction by 10 percent at the Somerset, N.J., location. Similar to a customer service professional in other settings, the position takes into account both the new resident, their family and everything in between. The concierge works to keep open lines of communication between all parties so a resident can address concerns as well as realize their personal assisted living goals.

With the attention to detail and the enhancement of overall community care, the new resident concierge position truly adds something to the Spring Hills experience rarely found elsewhere. Many other communities may require management staff to attend workshops or engage in more extensive training, but the dedicated position at Spring Hills ensures a low-stress relocation for new residents and their supporting families. Scott Weiss, director of program management for Spring Hills Senior Communities comments on the importance of the initial transition for seniors moving into a new home.

"Residents are wowed from the moment they walk in the community and see the attention to detail that was put into the transition to their new home," says Weiss.

Change is difficult at any age. The resident concierge at Spring Hills provides something new and genuine in an undoubtedly difficult time for many senior citizens.

"Being the person to help them through heir first 30 days and to acquaint them with other residents and services offered is always special," Tavormina says. "When you become that person for them to rely on, it becomes easier and eventually the resident will bloom into an active, happy and independent person." CIP

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Patient-Centered Model Elevates MCO's Success

BY DAWN PROCTER, BA, CSW, MBA, CCM

When I think about the nature of discharge planning and the complexity that is involved, it is no wonder that at the end of the day it is so easy to overlook the most crucial of details. What the most recent shift in healthcare is teaching us is that the most easily overlooked detail is the patient themselves. The idea of changing discharge planning to "transitioning" has merit to it. It seems to force us to focus on the patient's needs rather than the "to-do" list in order to safely discharge the patient. The process of how each of us transitions our patients is unique based on resources and job descriptions; however the mission at the core is the same. We all want to provide safe and effective transitions of care throughout the care continuum.

A TURN TO PATIENT-CENTERED CARE

At Group Health Cooperative of South Central Wisconsin (GHC-SCW), a

managed care organization, we have shifted our focus to patient-centered care and have reorganized ourselves to support this mission. Where doctors and nurses used to work in silos with the patient, they now form care teams, allowing them to more intimately know their patients. This has also provided patients the reassurance that they will have more than one person who understands their healthcare needs if their primary physician is unavailable. If they need to make any appointment with their primary care physician and are unable, the care team coordinator will try to provide them an appointment with another provider on their care team. When a patient is admitted to the hospital, the primary physician is notified of the admission and diagnosis. In turn, they are also notified of the discharge and discharge orders and are then able to have the care team nurse coordinator follow up with the patient to assist with follow-up appointments and needs.

In addition to the care team design, the care management department has realigned themselves to be an active and present part of the care team. A case manager is assigned to each clinic to be the primary contact for patients requiring complex coordination of care and is present in the clinic at least three days a week. The case managers are able to meet with patients and assist the care teams with complex care needs. The department is diverse, employing both social work and nurse case managers to provide case management services. The disciplines complement each other well, and they are able to collaborate with each other to meet the complex healthcare and psychosocial needs of the patient.

The case manager is aware of every admission for patients at their designated clinic and can talk with the primary care physician about the patient's care needs. If the patient has complex needs, the case manager will contact the patient and discuss the complex case management program. In collaboration with the patient and care team, the case manager develops a care plan that directly reflects the goals of the patient and the measurable interventions to achieve those goals. The program has been developed to assist the patient for up to 90 days, with an extension when appropriate in order to continue working on unmet goals.

DECREASING FRAGMENTATION

Patients with complex co-morbidities are often the bulk of the patient caseload, however patients new to the HMO or those requiring assistance navigating the healthcare system are also brought into case management. The goal of each case is to assist the patient with identifying and accessing the resources required to maintain their health, empowering them to be accountable for their own healthcare, and reconnect them with their primary physician and care team to reestablish care. An acuity tool is used to determine the anticipatory needs of the patient and establish a caseload size.

The case managers utilize every resource available to them, including maximizing home healthcare nurses to be their eyes and ears in the field, social service contacts, community financial resources, and internal and external expertise. The complex case manager can assist and oversee the patient's transitions between acute care facilities, long-term care or rehabilitation, and long-term acute hospitals. Having one case manager follow the patient throughout the care continuum decreases the fragmentation of care throughout the transitions and increases patient and provider satisfaction. It is a model that is working well and we continue to expand our role and redefine how healthcare is delivered to our patients.

CENTERING ON THE PATIENT

When transitioning a patient from one delivery system to the next, it is easy to focus on the immediate and overlook who the patient is as a whole. After all, there are assessments to be done, paperwork to complete, and financial issues to address. Who has time to ask the patient what they want? So how do we truly provide "patient-centered care" and successfully transition patients across the care continuum? What I learned early in my career is that the only person that can make a plan of care a success are patients themselves.

All the care planning in the world will not diminish readmission rates for high-risk patients or ensure the success of patients with co-morbidities if the planning is done *for* the patient instead of *with* the patient. There is one ideal that we are coming to accept and that's that the patient is in control. This is the easy part to forget. We spend such an extensive amount of time planning around the patient's needs that we forget to involve them in the process, except to inform and educate them about the plan that we have developed for them. It's seemingly hard to take a step back and ask the patient what they want, where they want to discharge to, or what they feel they need to be successful.

We have lived and worked within a medical model that anticipates that the patient needs to be educated about what's best for them and the patient should blindly follow the recommendations of the physician and clinical staff. No longer is this the case, as depicted in the newest changes in healthcare reform and pay-for-performance initiatives. The most successful transitions of patient care will be the ones that place the patient at the center of the planning process and take into account the

entire range of patients needs. This goes beyond their immediate healthcare needs, including socioeconomic and psychosocial needs as well.

A wise friend and co-worker once pointed out to me that we can arrange for a patient's home care needs post-discharge, but it won't make much of an impact if he doesn't have a home to discharge to. The same can be said regarding durable medical equipment, follow-up appointments and medications. If the patient doesn't have the resources, transportation, finances or motivation required to follow up with these arrangements, then we have wasted a good part of our day making sure that we have met the requirements for safe discharge – but done very little for our patient or our readmission rates.

DETERMINING THE BEST MODEL

At Group Health Cooperative of SCW we have come to accept that patient-centered care is the medical model that has the most positive outcomes and patient success, and we continue to acclimate ourselves to this model. Like most organizations, we have begun to take the steps necessary to reorganize ourselves to implement patient-centered care, but we still have work to do. Implementing a new medical model requires a transformation of how we deliver healthcare and a fresh look at how we view the patient. No longer is the patient the helpless victim of their own extremes, but an active participant in their care, treatment and eventual outcome. Gone are the days of directing the patient on what they need without patient input.

To have successful outcomes in transitions of care we will have to resist directing the patient as to what they must do, and listen first to what the patient is willing to do. This includes what the patient's identified goals are, what they are willing to do for themselves, and where they lack the necessary resources to be successful. This is going to take some time to get used to, but Rome wasn't built in a day and neither is healthcare reform. The more that we can do in our everyday interactions to support patient-centered care, the more likely we will be to have successful outcomes and smooth transitions throughout the care continuum. CIP

Dawn Procter, BA, CSW, MBA, CCM, is employed as a Complex Case Manager at Group Health Cooperative of South Central Wisconsin and has extensive experience in case management and patient advocacy. (dprocter@ghcscw.com)

DORLAND HEALTH

Leadership SUMMIT

Where the Best Minds in Care Management Meet

WEDNESDAY, MAY 11, 2011 · 8:00 A.M. - 5:15 P.M.

The National Press Club, Washington, D.C.

Presented by DORLAND HEALTH a division of Access Intelligence · CASE IN POINT

www.dorlandhealth.com/leadership-summit

As case management leaders know, staying at the cutting-edge of new models, effective initiatives and professional development programs can pay off with huge dividends – for the trajectory of your organization and the health of your personal career arc.

Care management leadership goes beyond a good management program. It involves strategic thinking, calculated foresight, strong communication, balanced goals and the commitment to achieve success. The Leadership Summit is the first of its kind to bring case/care management professionals who are working at the point of care together to learn, network and share new ideas that attendees can use to add value to their organizations – and value to themselves.

The Dorland Health Leadership Summit covers these areas in tandem. With a day of high-powered sessions, the Leadership Summit is the place for the change agents and thought leaders in care management.

CE credits available.
Refer to www.dorlandhealth.com/leadership-summit for details and contact hours.

TO REGISTER

CALL: 301-354-1769
VISIT: www.dorlandhealth.com/leadership-summit

AGENDA

8:00-8:30 a.m.	Registration and Continental Breakfast
8:30-8:35 a.m.	Welcome and Introduction
8:35-9:15 a.m.	Keynote Presentation: Accelerating Results through the Power of Collaboration: Lessons from High-Performing Healthcare Systems
9:15-10:00 a.m.	Moving Toward Patient-Centered Care: Using Evidence-Based Medicine to Improve Outcomes
10:00-10:15 a.m.	Networking Break
10:15-10:45 a.m.	Speed Learning: Leadership Roundtables
10:45 a.m.-11:30 p.m.	Accountable, Definable, Successful: Enabling an ACO via Care Management and Collaboration
11:30-1:00 p.m.	Luncheon and Keynote Presentation: Opportunities for Nursing Leadership and Influence: A Personal Perspective
1:00-2:00 p.m.	Legal and Ethical Challenges for Today's Case Managers
2:00-2:45p.m.	Show Me the Evidence: Demonstrating the Value of Your Program to Key Stakeholders
2:45-3:00 p.m.	Networking Break
3:00- 3:45 p.m.	Leadership for Consumer Engagement and Empowerment through Coaching and Health Information Technologies
3:45-4:45 p.m.	You Can't Be a Leader If You Don't Know Where You Are Going
4:45-5: 15 p.m.	Networking Reception

VENUE INFORMATION

The National Press Club · 529 14th Street, NW 13th Floor · Washington, DC 20045

HOTEL INFO

JW Marriott · 1331 Pennsylvania Ave NW, Washington, DC 20004 · 888.236.2427 · Conference Room Rate $329/night (Regular Rate $509/night) · code: dhgdhga

To maximize your time while in DC, attend both the Case In Point Platinum Awards Luncheon and the Leadership Summit: Where the Best Minds in Care Management Meet. Take advantage of the two-day event discount pricing for both events. Visit www.dorlandhealth.com/leadership-summit or www.dorlandhealth.com/case-in-point-platinum-awards for more information.

The Future of HITECH and the ACA

BY AVRUM GOLUB, MD, JD

Two wide-ranging pieces of legislation have significantly changed the way we deliver healthcare, from how we handle patient information and how we protect and safeguard this information from misuse to how we communicate amongst each other and with those we serve.

Both the American Recovery and Reinvestment Act of 2009 and the Patient Protection and Affordable Care Act (PPACA) will continue to shape the future of our delivery systems. Let's take a closer look at what each has to offer.

THE HITECH ACT

An acronym for the Health Information Technology for Economic and Clinical Health Act, the HITECH Act comprises nearly one-quarter of ARRA 2009's text and is composed of two titles. Title XIII, "Health Information Technology," is part of the appropriations division of ARRA 2009; Title IV, "Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions," is part of the division that deals with tax, assistance to workers and families, COBRA benefits, Medicare and Medicaid, broadband technology, and executive compensation.

Title XIII has four subtitles:

Subtitle A: Promotion of Health Information Technology:

- Establishes Office of the National Coordinator (ONC) for Health Information Technology (HIT).
- Establishes the Chief Privacy Officer of the ONC.
    - Establishes HIT Policy Committee.
    - Establishes the HIT Standards Committee.
- Requires application and use of adopted HIT standards.
- Requires various federal reports, e.g., effectiveness, lessons learned, actions to facilitate adoption of a nationwide system for the electronic use and exchange of health information.

Subtitle B: Testing of Health Information Technology requires the National Institute of Standards and Technology (NIST) to:

- Test standards and implementation specifications to ensure efficient implementation and use.
- Support establishment of a testing infrastructure – may include program to accredit nonfederal laboratories to perform testing.
- Establish assistance program to listitutions of higher education to establish multidisciplinary centers for healthcare Information enterprise integration.
- Directs the National High-Performance Computing Program to include federal R&D HIT programs.

Subtitle C: Grants and Loans Funding:

- Requires investing in infrastructure necessary to allow and promote electronic exchange and use of health information for each individual in the U.S.
- Ensures funds are expended for acquisition of HIT that meets standards.
- Creates HIT research center and regional support centers.
- Authorizes grants to states and Indian tribes for loan programs to healthcare

providers to support certified EHR technology.
- Authorizes matching grants for projects developing academic curricula.
- Authorizes assistance to institutions of higher education to establish/expand medical health informatics programs.

Subtitle D: Improves Privacy and Security Protections of Electronic Protected Health Information (PHI) by:
- Adding to, amending or extending the protections contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Social Security Act (SSA).
- Defining one's personal health record (PHR).
- Enabling HHS, its Office of Civil Rights (OCR) and the Federal Trade Commission (FTC) to promulgate rules to extend safeguards protecting PHI to business associates (BA) of covered entities (CE) and to penalize BAs for failure to comply with PHI requirements.
- Having HHS issue yearly guidance as to the most effective and appropriate technical safeguards and security standards for use in protecting PHI.
- Requiring CEs and BAs handling unsecured PHI to notify each individual of any security breach of PHI and notifying HHS of breaches, including immediate notice of breaches involving 500 or more persons.
- Allowing an individual to restrict the disclosure of PHI if: 1) the disclosure is to a health plan for payment or healthcare operations; and 2) the PHI pertains solely to healthcare for which the provider has been paid out of pocket in full.
- Limiting the use, disclosure or request of PHI to the data set or minimum necessary to accomplish the task at hand.
- Giving individuals a right to an accounting of the disclosures of their PHI and prohibiting the sale of an individual's PHI without the individual's authorization with exceptions for public health activities, research, treatment of the individual or healthcare operations.
- Allowing individuals to obtain their electronic medical records in an electronic format.
- Setting forth condition for the marketing of PHI and allowing persons to opt out.
- Imposing financial and criminal penalties for HIPAA violations.
- Allowing enforcement by state attorneys general through civil actions

Title IV has three subtitles:
Subtitle A: Medicare Incentives:
- Creates incentive payments for certain eligible physicians (EP) in 2011 and eligible hospitals (EH) in federal fiscal year 2011 who adopt and use certified EHRs meaningfully.
- Reduces Medicare payments for EPs who do not meaningfully use EHRs and reduces the market basket update for EHs that have not adopted a certified EHR by 2015 except for a significant hardship.

Subtitle B: Medicaid Incentives:
- Amends SSA Title XIX ("Medicaid"), which is administered by the Centers for Medicare and Medicaid Services (CMS), creating incentive payments for Medicaid providers to adopt and use certified EHRs with state spending for payments to providers being fully and 90 percent of state administrative costs reimbursable by the federal government.

Subtitle C: Miscellaneous Medicare Provisions:
- Sets forth budgetary matters related to Medicare hospices, medical education, Medicare, Medicaid, SCHIP and long-term care (LTC) hospitals.

REGULATIONS PROMULGATED UNDER THE HITECH ACT

An organic statute, also called an enabling act, is a law enacted by Congress that creates an administrative agency such as HHS, defines its authorities and responsibilities, and allows the agency to promulgate regulations. Most commonly, rulemaking is accomplished by "notice and comment," by which a rule is proposed and published in the federal register, after which comments from the public are solicited.

Several rules have been issued which are final, an interim final or in the proposed state. Additionally, HHS has issued guidance to render PHI unusable, unreadable or indecipherable to unauthorized individuals.

Interestingly, HHS had planned to finalize its interim final rule regarding breach notification for unsecured protected health information that was published on August 24, 2009, and became effective on September 23, 2009. The final rule was submitted to the Office of Management and Budget (OMB) for review but was withdrawn at the end of July 2010.

THE ONCHIT

The HITECH Act established the ONC to develop a nationwide health IT infrastructure allowing for the electronic use and exchange of health information. A major and current goal of ONC is the "meaningful use" of EHRs.

CMS published a final rule to provide incentive payments to eligible professionals and eligible hospitals and critical access hospitals (CAHs) participating in Medicare and Medicaid programs that adopt and successfully demonstrate the meaningful use of certified EHRs. The rule specifies initial criteria EPs, EHs and CAHs must meet in order to qualify for the incentive; the calculation of payment amounts; adjustments for covered professional services and inpatient hospital services not demonstrating meaningful use of EHRs; and other requirements.

Simultaneously, ONC published a closely related final rule adopting an initial set of standards, implementation specifications, and certification criteria for the achievement of Stage

1 of the meaningful use of EHRs by EPs, EHs and CAHs. EHRs are required to be tested and certified according to published criteria to ensure proper implementation and compliance with the certification criteria.

Section 1561 of PPACA requires HHS in consultation with the ONCHIT Policy Committee and the HIT Standards Committee to develop interoperable and secure standards and protocols that facilitate electronic enrollment of individuals in federal and state health and human services programs.

On September 17, 2010, HHS adopted these recommendations that include initial standards and protocols to encourage adoption of electronic systems and processes. These systems and processes will allow consumers to obtain seamlessly and maintain a full range of available health coverage and other human services benefits.

CMS EHR INCENTIVE PROGRAM

The Medicare EHR Incentive Program provides incentive payments to eligible professionals, hospitals and CAHs that demonstrate meaningful use of certified EHR technology. A few notes:

- Participation can begin as early as 2011.
- Eligible professionals can receive up to $44,000 over five years under the Medicare EHR Incentive Program. There's an additional incentive for eligible professionals who provide services in a Health Professional Shortage Areas (HPSA).
- To get the maximum incentive payment, Medicare-eligible professionals must begin participation by 2012.
- Incentive payments for EHs and CAHs may begin as early as 2011 and are based on a number of factors, beginning with a $2 million base payment.
- For 2015 and later, Medicare EPs, EHs and CAHs that do not successfully demonstrate meaningful use will have a payment adjustment in their Medicare reimbursement. The Medicaid EHR Incentive Program will provide incentive payments to EPs, EHs and CAHs as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years.

The Medicaid EHR Incentive Program is voluntarily offered by individual states and may begin as early as 2011, depending on the state. A few notes:

- EPs can receive up to $63,750 over the six years that they choose to participate in the program.
- EH's incentive payments may begin as early as 2011, depending on when the state begins its program. The last year a Medicaid EH may begin the program is 2016. Hospital payments are based on a number of factors, beginning with a $2 million base payment.
- There are no payment adjustments under the Medicaid EHR Incentive Program.

The Medicare Advantage EHR Incentive Program will provide incentive payments for certain Medicare Advantage Organizations (MAOs) whose affiliated EPs and EHs are meaningful users of certified EHR technology.

Timeline For the Medicare and Medicaid EHR Incentive Program:

Oct. 1, 2010: Reporting year begins for EHs and CAHs.
Jan. 1, 2011: Reporting year begins for EPs.
Jan. 3, 2011: Registration for the Medicare EHR Incentive Program begins.
Jan. 3, 2011: For Medicaid providers, states may launch their programs if they so choose.
April 2011: Attestation for the Medicare EHR Incentive Program begins.
May 2011: EHR Incentive Payments expected to begin.
July 3, 2011: Last day for EHs to begin their 90-day reporting period to demonstrate meaningful use for the Medicare EHR Incentive Program.
Sept. 30, 2011: Last day of the federal fiscal year (FY). Reporting year ends for EHs and CAHs.
Oct. 1, 2011: Last day for EPs to begin their 90-day reporting period for calendar year 2011 for the Medicare EHR Incentive Program.
Nov. 30, 2011: Last day for EHs and CAHs to register and attest to receive an Incentive Payment for federal FY 2011.
Dec. 31, 2011: Reporting year ends for EPs.
Feb. 29, 2012: Last day for EPs to register and attest to receive an Incentive Payment for calendar year 2011.

The successful transition to EHR usage involves collaborative interaction among a panoply of federal and state agencies, elected officials, manufacturers and care providers. It is crucially vital that, as providers, we participate in the evolution of EHRs by expressing our views.

We have the opportunity to participate in and comment on the laws, rules and guidances that the regulatory arena will develop. These documents will serve as the framework for our service to patients and the public. CIP

Avrum H. Golub, MD, JD, is a consultant for accreditation, regulatory affairs and compliance for institutions, group and individual practitioners, and lawyers, and is former medical director of a multi-centered healthcare system. (agolub@optonline.net)

Transitioning Patients from Hospital to Home

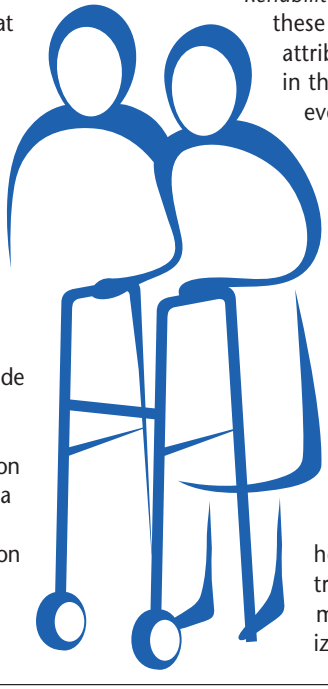
Why We Must Focus on Activity Limitations, Not Just Disease

BY ERIC C. RACKOW, MD

An alarming rate of one in five seniors is rehospitalized within 30 days of being discharged from a hospital. Only half recall receiving self-care instructions or seeing a doctor the month after they leave the hospital, suggesting that a substantial number of hospitalizations could be prevented with adequate discharge planning, education and follow up.

Considering the prevalence of chronic conditions and functional limitations among our elderly, it's no surprise that Medicare beneficiaries 65 years and older account for 12 percent of the U.S. population but more than one-third of hospitalizations and almost half of total hospital costs.

Emergency room visits and hospital admissions are failures of the healthcare system to provide timely, effective care. The problem stems from our healthcare system's focus on disease management and a lack of attention to the reality that activity limitation is an independent risk factor for increased healthcare costs.



In fact, according to a LewinGroup analysis of Medical Expenditures published in 2010, seniors with multiple chronic conditions who received help with instrumental activities of daily living (IADL) and activities of daily living (ADL) were seven times more likely to be among the top 5 percent of patients most expensive to treat - more than twice the rate of those with multiple chronic conditions alone.

Chan et al. reported in the *Archives of Physical Medicine and Rehabilitation* in 2002 that these increases in cost are attributed to an increase in the frequency of all events (e.g., hospital admissions, outpatient visits) rather than an increase in the intensity or cost of those events.

It is now recognized that when patients with complicated medical, functional and cognitive conditions receive care coordination in the home by specially trained geriatric care managers, hospitalizations and emergency room admissions are substantially reduced. In fact, SeniorBridge's data show 90 percent fewer emergency room admissions, 80 percent fewer hospitalizations and 70 percent fewer rehospitalizations within 30 days in older adults receiving care management in the home.

As an industry we must identify patients with these functional limitations as at risk of a rehospitalization and ensure they have the proper support system that goes beyond medical needs to address physical and cognitive function that puts them at risk for adverse events. Does the patient have food in the refrigerator to ensure adequate nutrition and hydration? Is the patient taking medications or vitamins you don't know about? Are their support limitations preventing them from complying with a discharge plan?

Disease management is only part of the problem. Until we address these functional needs, we cannot provide these patients the care they deserve. CIP

Dr. Eric C. Rackow is President and CEO of SeniorBridge, a national health management company that provides care management and direct care in the home, and is a Professor of Medicine at NYU School of Medicine.

DORLAND HEALTH

Save the Date!

Important Fall Events

2nd Annual Dorland Health People Awards Luncheon

Thursday, October 20, 2011 • 12:00 p.m. – 2:00 p.m. National Press Club, Washington, D.C.

"The power of a moment can change our lives. The gathering at the National Press Club during last year's Dorland People Award Ceremony helped me to realize the power of healing when healers are gathered. I had an overwhelming desire to talk with and listen to each person that approached the podium. I knew that our talents and dedications complimented each other as partners of a new approach to health care". Ann Mody Lewis, Ph.D.

The 2nd Annual Dorland Health People Awards gives you the opportunity to showcase the innovative and creative work you have accomplished as a leader, an individual practitioner, or vital in-the-trench healthcare professional. The Awards program recognizes individual healthcare professionals who are making important contributions to improve the quality, safety, efficiencies and patient care experience in 30+ categories that span the continuum of care.

A testimonial from a 2010 People Award attendee after experiencing the Awards Luncheon:

"Thank you for the experience of being a part of the Dorland Health People Awards celebration. I was honored to be in the company of such stellar professionals across the health care industry. Highlighting the great work done everyday helps to remind each of us about the profound impact we can have on the people we serve."

Rose Marie Antonucci, MS, CRC, CCM, LPC
Vocational Rehabilitation Counselor
CIGNA Group Insurance
2010 People Awards Participant

www.dorlandhealth.com/peopleawards

Care Coordination Summit

Advancing the Delivery of Care

Friday, October 21, 2011 • 8:00 a.m. – 5:15 p.m. National Press Club, Washington, D.C.

For forward-thinking practitioners, the Care Coordination Summit delivers the latest trends, new models, innovations in healthcare, public policy initiatives, best practices and networking opportunities that will help you advance your cause of improving quality and bettering outcomes. Canvassing the emerging opportunities and strategies across a range of topics—from ACOs, medical home, and patient-centered care programs to care transitions, quality improvement initiatives, and health IT mandates—this unique Summit equips you with the knowledge and resources you need to provide the newest, safest and most cost-effective care to your patients.

Learn, network, share ideas, and arm yourself with the latest trends in care coordination and improvement strategies to enhance your case/care management practice.

www.dorlandhealth.com/Care-Summit

Testimonials from 2010 Care Coordination Summit attendees:

"Presentations were fantastic. Learned a lot and found validation for my current practice."

-Bobbi Jo King, RN, CCM, BSN, Case Manager II,
Health Net Federal Services

"Packed with information. Really learned a lot. Got my money's worth." -Chris Delich, Officer of Business Development, The ALARIS Group

"Well-presented Summit. Timely and relevant topics."

-Jan Robison, RN, MSN, CCM, Case Manager II,
Children's National Medical Center

"Great conference. All very relevant."

-Anita Schambach, RN, MS, Director, Community Care
Partners of Greater Mecklenburg, Carolinas Healthcare

Celebrating the Top Professionals in Senior Care

In one of the truly varied and complex areas of healthcare - the world of senior services - practitioners are silently making discernible differences in people's lives. As a culmination of the 2011 **Dorland Health Silver Crown Awards** program, we would like to celebrate the winners and the honorable mentions - that is, the leading practices, programs and practitioners who profoundly ease the burdens of our aging population.

SILVER CROWN AWARDS

AGING IN PLACE PROGRAM

BROADSPIRE CARE MANAGEMENT – BROADSPIRE

Broadspire Care Management utilizes two types of assessment services in its leading-edge aging in place program that others would be wise to model after: an on-site visit and telephonic consultation. Through the on-site assessment, Broadspire's dedicated care management professionals determine possible hazards in the home and perform a comprehensive evaluation. The subsequent round of telephonic consultation provides superlative advice and aging and disability efforts that the patient and family can easily adapt into their lives.

Providing its clients with distinguished personnel, including RNs, master-level social workers and certified rehabilitation counselors, Broadspire delivers high quality care and consistent services, whether the client remains at home or faces an unexpected transition to a long-term care facility.

FUNCTION FOCUSED CARE – UNIVERSITY OF MARYLAND

An innovative approach to keeping seniors aging in a respectful and healthy place, the University of Maryland's Function Focused Care program optimizes function and physical activity, helping residents remain in their settings of choice over an extended period of time. Function Focused Care overturns the traditional philosophy of care within assisted living communities by paying special attention to advancing the functional capabilities of seniors.

At the core of its success, direct care workers operating in the Function Focused Care paradigm help residents engage in all of their care-related activities vs. simply performing the tasks for the resident. Through this powerful shift in focus, the program has borne witness to tremendous outcomes, including improvements in walking and balance, increased social support, more physical activity and, what's most telling, a reduced chance of moving to another care setting. Now that's a plan focused on function.

HONORABLE MENTIONS

CERTIFIED ENVIRONMENTAL ACCESS CONSULTANT (C.E.A.C.) CREDENTIAL – ACCESSIBLE HOME IMPROVEMENT OF AMERICA (AHIA)

Accessible Home Improvement of America is recognized for administering a national certification program, ensuring a level of confidence for the consumer as well as the payer when home modifications are required due to an injury, chronic illness or mobility issue due to aging.

SILVER OAK COUNTRY ESTATES - RESIDENTIAL CARE FACILITY

Silver Oak has one driving mission: deliver the kind of care to seniors at the end of life that we would want for ourselves. Defined by its compassionate care, individualized for each resident, Silver Oak excels at achieving its noble mission.

SUSAN BACHNER – SUSAN BACHNER CONSULTING, LLC

Recognized for her ability to communicate effectively with the healthcare team and translate the client's needs and wants into recommendations for products and structural modifications that improve safety, comfort and promote independence to the disabled.

ALZHEIMER'S CARE

ST. LEONARD'S BEHAVIOR-BASED ERGONOMICS APPROACH TO ALZHEIMER/DEMENTIA CARE

A boon to the health and well-being of senior patients, the innovative Behavior-Based Ergonomics approach pioneered within the Alzheimer unit at the St. Leonard senior living community in Dayton, Ohio, has produced wonderfully effective outcomes with the population it faces. Built on the principle that residents with Alzheimer's or dementia experience challenging behaviors when levels of cognitive stress increase, the BBE approach provides customized

tools in an always-open resource center that residents can access.

At the crux of the BBE approach is the ability for caregivers to provide emotional support through the customized tools, which range from a music library to a cognitive-stimulating collection of games and puzzles. The unique approach has resulted in increased socialization among residents, high engagement and bolstered family satisfaction.

HONORABLE MENTIONS

NATIONAL COUNCIL OF CERTIFIED DEMENTIA PRACTITIONERS

Recognized as a leading organization for their work in developing standards, guidelines and educational programs for professionals and caregivers who strive to meet the diverse needs of those who suffer from dementia.

RIGHT AT HOME

Recognized for developing a model of caring and safety that allows patients with Alzheimer's disease to remain in their home. They assist the family in understanding the disease, how best to cope with difficult behaviors, and provide enhanced quality of life for the patient.

CASE/CARE MANAGEMENT PROGRAM

EVERCARE SOLUTIONS FOR CAREGIVERS – UNITEDHEALTHCARE

A case management program designed to help caregivers provide optimal care to their loved ones – whether their loved one lives with them in their home, across town, or across the country. Making this possible is the unique breadth of Evercare's network, a contracted group of case managers who can provide services throughout all 50 states, helping be a caregiver's "eyes and ears" when that caregiver lives far away.

The comprehensive program has achieved outstanding success rates. Not only are clients satisfied with the program, but utilization rates in some cases have increased 100 percent – a sure sign of a well-run and committed mission. As employers continue to understand the stress that can occur when an employee finds himself or herself in a position of being a caregiver for a loved one, Evercare will continue to provide the answer – with a personal touch that goes beyond simple care.

THE GUIDED CARE PROGRAM AT JOHNS HOPKINS HEALTHCARE, LLC – JOHNS HOPKINS HEALTHCARE, LLC

With its target one of the most difficult class of patients, the Johns Hopkins-developed Guided Care program shows that effective planning and steadfast carry-through can produce dividends in even the toughest populations. This interdisciplinary model of case management targets elderly patients with multiple chronic conditions, with a specific focus on the 25 percent of top-using Medicare beneficiaries.

At the center of the model is the Guided Care Nurse, who handles 50-60 patients and interfaces with the treating team. Among the best-practice interventions are an assessment of the patient at home; a comprehensive care guide and action plan; regular monitoring; and a complete coordination of all treatment efforts. The plan, it turns out, is wildly successful. Caregiver strain and costs are down, while physician satisfaction rates are up – as are job satisfaction rates of case managers.

HONORABLE MENTIONS

CAREPLUS – INSPIRIS, INC.

Dedicated to improving lives and lowering costs, Inspiris continues to set the bar in care management. Its CarePlus program, providing services to its most frail member population, is supported by a cutting-edge care management call center and technology-supporting electronic health records. The program is clearly working, with costs of at-risk Medicare patients roughly one-quarter of the norm.

OUTREACH IMPROVEMENT PROGRAM WITH A MEDICAID SSI (ABD) POPULATION – NURSE RESPONSE

In its attempt to bolster the rate of successful health risk assessments for its Medicaid SSI population, NurseResponse established a smart and thorough work plan that focused on diligent outreach, research and follow through, as well as a dedi-

cated contact line for potential sign-ups. The program achieved its stated goal of 60 percent contact rate for members, and other metrics are also on the rise.

SENIOR SOURCE – SENIOR SOURCE

Senior Source is recognized for their innovative care management program. Their remote sensor and telehealth technologies enable their patients to live safely and independently in their home.

CLINICAL NURSE

LESA SCOTT, RN, BS, CALA

Lesa Scott, RN, BS, CALA, is the director of Compliance and Clinical Services for Spring Hills Senior Communities. Scott developed the Somerset Safety Committee in 2006, which focused on minimizing incidents, and increasing resident safety and developed an Acuity Documentation Program that focused on increasing the operational excellence of the nursing team by facilitating the ability of nurses to evaluate, plan and monitor patient needs. Scott was also involved in creating the company's Signature Living Program that focused on holistic approaches to senior living. Scott has proven her leadership abilities and is a highly respected and proficient manager. She has assisted in the creation of a company manual to help train and acclimate new Directors of Resident Care into the company culture.

MELISSA TROWNSELL

Melissa Trownsell is director of medical management for senior business at WellPoint. Known for her analytic skills and her ability to determine and prove the value of programs benefiting seniors, Trownsell exemplifies WellPoint's "One Company, One Team" philosophy through her tireless efforts to implement new procedures and provide programs and services to seniors that make a meaningful impact. Trownsell has previously served as director of utilization management for Medicare Advantage programs and worked to establish the Chronic Kidney and End-Stage Renal Disease Management programs employed by the company. Personable and friendly, Trownsell is able to easily relate to patients and is seen as understanding and empathetic to their unique and specific needs. A natural problem solver, she is also able to diffuse difficult situations and facilitate resolutions with ease.

HONORABLE MENTIONS

ANGELA ESTRADA, RN, BSN

Angela Estrada, RN, BSN, owns and operates The Sweet Bye N Bye Inc. Estrada has established five adult foster care homes, one 16-bed RCF and a non-medical in-home care agency.

CYNTHIA CROUSE, RN, BSN, CCM, COHN-S

Cynthia Crouse, RN, BSN, CCM, COHN-S, is a senior nurse case manager for WellPoint who specializes in caring for seniors. Crouse works to offer seniors an optimal level of health.

FACILITY DIRECTOR, ASSISTED LIVING/NURSING HOME

JENNIFER JASPER – THE MANORS AT HOBE SOUND (NURSING HOME)

For Jennifer Jasper, the mission is personal. As the administrator of The Manors at Hobe Sound, a skilled nursing facility in southern Florida, Jasper manages her patients and her staff with a categorical eye toward quality, customized care that focuses on an element often gone missing in healthcare – the power of family-style care.

The family-oriented philosophy that permeates the rooms and hallways of The Manors at Hobe Sound comes from the top. And its dedicated doyenne understands what can result from such focused care – the constant ranking as a five-star facility and the steady number of residents living within the facility.

SUE BROWN – VINTAGE PARK AT BALDWIN CITY, AN ASSISTED LIVING COMMUNITY

Leadership comes naturally to Sue Brown, the 10-year-long director of Vintage Park at Baldwin City, an assisted living community in Baldwin City, Kan. In her leadership role, Brown has initiated programs for her residents and staff alike, from awards programs for her employees to get-well wishes for her residents that are admitted to the hospital.

Known for her creativity, critical thinking and financial management, Brown draws praise for her multitalented approach to her job. "She is loved by her staff, residents and family members and is a prime example of a true professional," remarks Brown's supervisor, Denise German. It's no surprise Vintage Park is thriving. Sue Brown is at the helm.

HONORABLE MENTIONS

JEANNE JONES – CLASSIC RESIDENCE BY HYATT IN RENO (ASSISTED LIVING)

Jeanne Jones is recognized for her leadership, caring manner and attention to detail by her staff, medical team, residents and the families.

TMOTHY GRAFTON – PARK PLACE ASSISTED LIVING

Timothy Grafton is recognized for creating a culture in Park Place that preserves the independence of each resident while ensuring a safety net that promotes a safe, healthy and active environment for each resident.

FALL PREVENTION PROGRAM

MYHALO ADVANCED PERSONAL MONITORING AND ALERT SYSTEM – HALO MONITORING

The myHalo Advanced Personal Monitoring and Alert System is the creation of Halo Monitoring company. CEO Chris Otto drew upon family experience when spearheading the company's creation of a fall-monitoring system for the elderly that did not require the push of a panic button. Most seniors, after a fall, are either too injured or stunned to be cognizant enough to push the panic button on traditional medical alarms to notify professionals of their accident. The myHalo monitor, strapped to the patient's chest, utilizes accelerometer sensors and other proprietary technology to recognize when a senior falls. Because there is no call button, aid services are notified through a wireless message sent through a base station in the home.

OCEANVIEW NURSING & REHABILITATION CENTER, LLC

The Oceanview Nursing and Rehabilitation Center, LLC, has established a fall prevention program serving a diverse population of elders in Far Rockaway, N.Y. Gait disorders make the elderly population more prone to falling, but young-elders, mostly in their 50s, are still active, and their fall concerns relate to rushing to or from activities, steadfast beliefs in maintaining independence, not checking where they step and psychomotor problems. The interdisciplinary team at Oceanview worked thoroughly to create a comprehensive, compassionate, safe and sanitary home environment for those at risk of falling injuries. Pre-admission, plans for prevention, injury causality education and identification and monitoring outcomes are the main components of the Oceanview program. In addition, the company's Safety Committee reviews trends for benchmarks, analyzes patterns of behavior and presents education on fall prevention's best practices for the greater community.

HONORABLE MENTIONS

SILVER OAK COUNTRY ESTATES – RESIDENTIAL CARE FACILITY

Silver Oak Country Estates' fall prevention services in Vista, Calif., are led by founder Lorena Eckert, RN, whose education program identifies health optimization by identifying key risk factors for the elderly.

SILVER CROWN AWARDS

SAFE STRIDES – GENTIVA HEALTH SERVICES

This outstanding service is recognized for developing an innovative home balance therapy program that has been shown to decrease the risk of dangerous falls to those who suffer from balance disorders.

GERIATRIC CARE MANAGER

COLLEEN VAN HORN, RN

Colleen Van Horn, RN, a former adult intensive care and cardiac nurse, is the vice president of the Western Geriatric Care Manager Association and founder and CEO of Innovative Healthcare Consultants, which specializes in assisting individuals and their families with geriatric case management. Her company strives to maintain the independence and dignity of the elderly community. As a member of the National Association of Professional Geriatric Care Managers, Van Horn is committed to maintaining the highest ethical standards within her company and only works with experienced RNs educated in the needs of an aging patient. She also volunteers by educating the public through community classes that outline concerns, medication and disease, dementia care education and home safety.

LINDA FODRINI-JOHNSON, MA, MFT, CMC

Linda Fodrini-Johnson, MA, MFT, CMC, is the founder of Eldercare Services, a geriatric care management agency, and president of National Association of Professional Geriatric Care Managers, working diligently at the individual, family, local, state and national levels for the overall improvement of patient welfare. Johnson counsels new professionals in the field, helps families navigate their various options and is proactive in education and outreach nationally for families who would benefit from the services of a geriatric management worker. After 26 years in the field, Fodrini-Johnson remains inspired for helping assist the elderly population in need of medical service.

HONORABLE MENTIONS

VICTORIA COX

Victoria Cox of Victoria's Compassionate Nursing Care Management provides comprehensive home assessment, medication management and advises lawyers entrusted with patients' power of attorney rights in New Jersey.

TERRI BROWN

Terri Brown is a senior nurse care manager at WellPoint with a "can-do" attitude. Brown works directly with elderly patients with planned, recent or current hospitalizations.

BECKY BIGIO – SELFHELP COMMUNITY SERVICES

Recognized for her leadership as a geriatric care manager for SelfHelp Community Services, a company dedicated to improving resources and assisting the elderly and other at-risk populations to live in their own homes, independently and with dignity.

GERIATRICIAN

CHARLES A. CEFALU, MD – LSUHSC, NEW ORLEANS, LA.

Dedication is the name of the game for Dr. Charles Cefalu, a clinical professor within Louisiana State University's Department of Medicine, where he serves as chief of the section of geriatric medicine. In addition to his distinguished post at LSU, Dr. Cefalu serves as the executive director of the Louisiana Geriatrics Society, where he champions the needs of the elderly.

Through his diligent efforts in training and unsurpassed passion for elderly care, Cefalu has created a program through which senior caretakers will be well advised and ready to tackle the

pressing issues of the geriatric population. Through his devout stewardship at LSU, the training program has grown and through its growth the region – and the healthcare system – will be blessed with ardent Cefalu protégés.

HONORABLE MENTIONS

KAREN AMSTUTZ, MD – WELLPOINT

Vice president medical director with WellPoint and overseer of the company's Senior and State Sponsored Business, Dr. Karen Amstutz is known as an astute, driven and innovative leader whose personal touch "has benefited the lives of millions of senior members," in the words of a colleague. Crystallizing her success, another colleague calls her something more simple: a role model.

TOREY B. CLARK, MD – HARBOR GRACE HOSPICE

Known as a compassionate practitioner, Dr. Torey Clark, the medical director of Harbor Grace Hospice in Fayetteville, Ga., gives every patient the same personal touch and expert insight when they reach their final stages of life. Focusing on more than just physical concerns, Dr. Clark's compassion touches the whole well-being of all of her patients.

HOME HEALTH AGENCY (MEDICAL)

BAYADA NURSES

Bayada Nurses is a private full-service home health company committed to providing the highest quality home health care services. The company was founded in 1975 and employs over 13,000 nurses, home health aides and therapists working from more than 170 offices in 18 states. The company is led by its founder, Mark Baiada. Recently, Baiada led a company initiative to clarify the company's mission so that all employees would have a guide to follow as they cared for patients throughout the country. This mission has enabled the company to maintain its core mission and values as it grew. The endeavor coined the phrase "the Bayada Way." The statement is viewed from the top down as the foundational compass for the company. It states the beliefs and the fundamental values that guide each member of the company: compassion, excellence and reliability.

SENIOR INDEPENDENCE

Senior Independence is a subsidiary of Ohio Presbyterian Retirement Services providing premier home and community based services in Columbus, Ohio. Senior Independence operates in seven Ohio communities, offering patients and their families with financial limitations the utmost in quality care. Senior Independence is working industriously to enhance the independence and well-being of the elderly while building the capacity of families, communities and organization to care for seniors in their own homes. The company is also working to develop a manual to aid older adults and their caregivers while making critical medical and financial decisions.

HONORABLE MENTIONS

AMEDISYS, INC.

Amedisys, Inc., is recognized as a leading home health agency, recognized for the use of innovative technology to ensure a safe and effective transition of care.

CHARLES COLE HOSPITAL HOME HEALTH

Recognizing Bonnie Kratzer, RN, for her passion and leadership as a director of nursing and for living her goal of being able to teach other nurses the compassion she felt for every patient/family.

CORAM SPECIALTY INFUSION SERVICES

Recognized for proving a specialized service that enables patients in need of complex medications to transition to home and receive a high level of personalized and safe care in the privacy of their home.

HOME HEALTH AGENCY (NON-MEDICAL)

HOMEWATCH CAREGIVERS OF CHARLOTTE

The past year has been a year of milestones for Homewatch Caregivers of Charlotte, an industry-leading provider of nonmedical and personal care services. Perhaps their best practices outline it best. Four exciting and cutting-edge initiatives display Homewatch's diverse outreach – and its wide breadth of services that make it a number-one provider.

First among its initiatives is the Resident Care Program, developed with a local senior housing facility, which presents affordable home care services so that seniors can age in place. The After Care Specialists program gives guidance during recovery. The Client Care Coordination is a comprehensive geriatric care management service. And Pathways to Memory customizes the way forward with techniques to bolster individual perseverance.

SHERIDAN IN-HOME HEALTH CARE

The Los Angeles-based Sheridan In-Home Health Care is a paramount leader in the senior caregiving community. Focusing on such difficult disease states like Alzheimer's, Parkinson's and other neurological disorders, Sheridan provides a network for not only at-risk individuals but for the caregivers that administer to patients with such disorders.

The quality of caregivers stands as a central element to the success of Sheridan. As a client puts it: "My relationship with Sheridan Care goes beyond that of receiving daily care. I think of you as friend and value your services to me." As leaders of the pack, Sheridan is deserving of all the hard-won praise that it reaps day after day.

HONORABLE MENTIONS

COMFORCARE HOME CARE

A leading in-home care agency based in Charlotte, N.C., ComForcare Home Care prides itself on the quality of its employees and the positive outcomes they produce in the lives of their patients. As part of its quality programs, ComForcare established the first joint support group for Alzheimer's and Parkinson's in South Carolina.

INNOVATIVE HEALTHCARE CONSULTANTS

As part of its unique model of care, Innovative Healthcare Consultants in San Diego, Calif., solely employs RN case managers in in providing care plans and continual advocacy for its senior patients, often in the complex areas of dementia, behavioral problems and multiple medical diseases. Its focus on quality makes Innovative Healthcare a leader in the field.

VISITING ANGELS

Saluted for its expertise as a non-medical home care provider that gives those unable to perform activities of daily living an alternative to assisted living facilities and nursing homes.

HOME HEALTH AIDE (MEDICAL OR NON-MEDICAL)

FLORENDA VINSON – COMFORCARE HOME CARE

Florenda Vinson is a certified nursing assistant for ComForcare Home Care in Charlotte, N.C. A certified nursing assistant since 1989, Vinson has spent over 20 years dedicated to helping others. Vinson juggles being an advocate for the health of her Alzheimer-affected father and for her various clients with a rare type of commitment. Vinson's caring personality, dedicated nature and unsurpassed skills

are obvious to her company, clients and their families. Her dedication is repaid with a fierce loyalty as many clients outright claim that if they cannot receive care from Flo, they would not want any at all.

HONORABLE MENTIONS

BEATRIZ OSPINA – INDEPENDENT HOME CARE AIDE

This inspiring home care aid is recognized for her caring attitude and her abilty to go the extra mile to bring a smile to her patients.

HOSPICE/PALLIATIVE CARE COMPANY

INSPIRIS, INC.

Recognizing that individuals with life-limiting conditions need information, support and resources much earlier in their disease trajectory, Inspiris developed an innovative advanced illness/EOL program called Inspired Living, which provides counseling and educational support to seriously ill Medicare Advantage members and their families.

An expert at bridging the gaps in care for patients in need of critical services, Inspiris developed the Inspired Living program to help patients become owners of their end-of-life care, to help them navigate the system, to help them understand their options and to promote the use of requested care for those at the end of life.

VITAS INNOVATIVE HOSPICE CARE

For one of the nation's leading providers of end-of-life care, Vitas Innovative Hospice Care had a banner year in 2010, especially in the area of care for military veterans. With more than 10,000 veteran patients in its programs, Vitas' outreach efforts have the ability to touch special populations across the U.S. In addition to the heralded quality of its end-of-life services that care for 13,000 patients daily, its initiatives for veterans created a poignant moment for a special class of American seniors.

Two national programs for veterans over the past year mark the special Vitas touch. "Keep the Spirit of '45 Alive" recognized the 65th anniversary of the end of World War II, while The Honor Flight Network continued its state of excellence by flying war veterans to our nation's capitol to experience the memorials to their service. We salute you, Vitas.

HONORABLE MENTIONS

HEALTH CARE OPTIONS, INC.

As the CEO and director of nursing for Health Care Options Inc., Annette Austin, RN, BSN, MBA, stands as an outstanding representative of personal character and noble devotion in caring for seniors. Known for her great vision, Austin has expanded her home health and hospice services to rural areas and high-risk areas alike. As a colleague sums it up: "She is truly an ambassador for the elderly."

HOSPICE OF PALM BEACH COUNTY

Located in West Palm Beach, Fla., Hospice of Palm Beach County stands at the forefront of innovative hospice programs. It utilizes a large variety of integrative therapies, including music therapy, massage, aromatherapy and guided imagery, and it also presents the choice of Open Access, a philosophy of care giving patients who face life-limiting illness the opportunity for aggressive but noncurative therapies.

ST. CATHERINE HOSPICE

On top if its extraordinary care, St. Catherine Hospice in Garden City, Kan., offers a bounty of additional services, from quarterly newsletters and counseling to annual bereavement retreats and card mailings. All of its passionate services help St. Catherine accomplish its stated mission of providing every patient with reverence, integrity, compassion and excellence.

SILVER CROWN AWARDS

MEDICARE ADVANTAGE PROGRAM

30-DAY READMISSION REDUCTION – WELLPOINT

The 30-Day Readmission Reduction program at WellPoint was created to help assist seniors recently hospitalized from being readmitted by addressing high-risk issues discovered upon first admittance. Post-discharge management is key to prevent readmission, so seniors are enrolled in telephonic case or disease management programs to help maintain progress. The main pillars of care include helping seniors understand why they were hospitalized in order to make symptoms clear, educating patients about the importance of follow-up appointments with primary care physicians, performing a medication reconciliation that makes seniors aware of the possible side effects of use and who to contact and a personal health record where the senior records all medication, dosages and reason for taking in order to make all information streamlined.

PPS SENIOR CARE COORDINATION – KAISER PERMANENTE COLORADO

The collective senior care coordinators at Kaiser Permanente-Colorado are being acknowledged for their innovative and cutting edge care for the elderly in the state. At Kaiser Permanente-Colorado there are over 62,000 Medicare members, and senior care coordinators service these individuals through secondary prevention, future planning, risk behavior analysis, health screenings and community resource identification. U.S. News and World Report and the National Committee for Quality Assurance recognized these coordinators nationally in 2009 in their "Best Health Plan" rankings. The Kaiser Permanente-Colorado is unequivocally on the frontlines working to improve overall care and quality of life for seniors nationally.

HONORABLE MENTIONS

CANCER CARE SUPPORT PROGRAM – WELLPOINT

The Cancer Care Support program established by WellPoint centers on supporting healthcare needs with effective interventions, reducing hospital readmissions and reducing cancer-related healthcare costs.

HUMANA – HUMANA CARES

Recognized for an innovative on-the-ground care management approach for working with the complex chronic Medicare Advantage patients.

PATIENT ADVOCATE

LORENA ECKERT – SILVER OAK COUNTRY ESTATES

As the founder and owner of Silver Oak Country Estates, Lorena Eckert operates her assisted living facility in Vista, Calif., with a singular focus on advocacy and patient empowerment. With Eckert at the helm, Silver Oak realizes its mission of fostering independence, promoting self-dependent routes of care, protecting privacy and, above all else, treating all residents with dignity and respect.

Members of the care team, from social workers to pastors, doctors to caregivers, find the dedicated community efforts of great assistance. This includes educational materials available on the Silver Oak website that help guide seniors and their providing team with the information they need to make the best choice for their particular care needs. The spirit of the mission stands at the heart of all operations.

HONORABLE MENTIONS

CELESTE R. RILEY, MD – DOC CONSULT, INC.
Dr. Celeste Riley works with the patient, the family and physicians to investigate multiple treatment options and to develop a comprehensive cancer treatment plan.

DOUG HALL – PULSE OF FLORIDA
A recognized leader in patient advocacy and safety community who has developed tools and resources that empower each consumer to ensure a safe healthcare experience.

KEN FARBSTEIN – PATIENT ADVOCARE
With over 20 years experience in healthcare, Ken Farbstein has advised clinical and administrative leaders in hospitals, medical groups, HMOs and state governments on ways to improve medication safety and reduce costs. He is author of Patient Safety Blog, a forum to share healthcare stories.

RECREATION PROGRAM

PATITAS CALIENTES – MMM HEALTHCARE INC.
In the local language, "patitas calientes," which translates literally to "hot feet," means being active and engaged. As a community program for seniors over 60, MMM Healthcare's Patitas Calientes initiative provides benefits for members that include physical training, health education and social, charity and entertainment events. MMM Healthcare is Puerto Rico's leading Medicare Advantage plan.

With nearly 1,000 involved seniors across 18 local chapters, Patitas Calientes has delivered terrific results in the health of its members, leading to improvements in cardiovascular wellness and a reduction in age-related diseases. Through its community-focused meetings and events, the program has resulted in a steadfast commitment to engagement. As proof of its power, 10 members of Patitas Calientes hold national records in their age groups in races such as the Boston and New York marathons.

HONORABLE MENTIONS

CITY OF LAS VEGAS DEPARTMENT OF LEISURE SERVICES – CENTENNIAL HILLS ACTIVE ADULT CENTER
Recognized for providing an accessible community resource designed to meet its seniors with a host of choices for their leisure-time activities.

MEMBERS CLUB – MMM HEALTHCARE INC.
In another of its innovative, industry-leading programs, MMM Healthcare in Puerto Rico established a collection of Members Clubs that serves as exclusive community centers for its 130,000 members. The Members Clubs provide education, health and wellness programs, recreation programs and community areas – all in a dedicated, cutting-edge setting for seniors.

REHABILITATION PROGRAM

GLEN COVE CENTER FOR NURSING & REHABILITATION
By listening to and observing staff and residents, Glen Cover Center for Nursing & Rehabilitation took innovative steps to reinvigorate their traditional therapy and restorative program to a state-of-the-art program that promotes wellness instead of illness and improved function instead of disability. Examples include the construction of a putting green for active residents recovering from hip and knee replacement surgery. The course provides a fun environment and has been shown to improve balance, range of motion and coordination. To create a similar experience for less mobile residents with chronic conditions, the Nintendo Wii video gaming system was incorporated into many of the

residentss plan of care. To assist staff in understanding what the resident goes through before they come to the center, all levels of the staff were able to view an actual hip surgery at a local hospital. This newfound empathy has resulted in more attentive care and a stronger bond between caregivers and patients.

HONORABLE MENTIONS

WHITEHALL OF BOCA

Recognized for their patient-centered, interdisciplinary team approach that brings together skilled medical professionals who combine their talents to ensure each aspect of the patients rehabilitation program is addressed in order to ensure a safe return to home and maximum level of functional status.

PALM VILLAGE REHABILITATION

Saluted for thier rehabilitation program that provides a "continuum of care" approach that meet the unique needs of the residents of this continuing care center.

GENTIVA – REHAB WITHOUT WALLS

Recognized for a unique and reproducible model of neurological rehabilitation delivered where patients need it most, that is, in their own surroundings. The program has improved outcomes, allowing patients to participate in practical daily activities at home, work or in the community.

SENIOR COMMUNITY PROGRAM

SENIOR PROMISE – FRANCISCAN ST. FRANCIS HEALTH

St. Francis Senior Promise

The Senior Promise membership program at St. Francis Hospital & Health Centers in Indiana provides a suite of benefits to those 50 or older, encouraging a healthy lifestyle and keeping seniors engaged with their care. From free insurance counseling and discounts on wellness programs to free screening and reduced rates on services like TV and telephone, Senior Promise delivers on its exceptional pledge of providing the best care to its members.

One of program's flagship events is the annual Fall Health Festival, a free event that provides seniors with health information and health screenings like cholesterol or balance screenings. Flu shots are available, often covered 100 percent through insurance. By bringing the community together and engaging its members with cutting-edge programs and services, Senior Promise fulfills the need of honest, quality care.

SENSITIVITY PROGRAM – MMM HEALTHCARE INC.

MMM

The Sensitivity Program at MMM Healthcare, Puerto Rico's leading Medicare Advantage Plan, operates on a simple premise – that seniors should be respected and honored, not least in the area of receiving consistently excellent healthcare. Founded in 2008, the Sensitivity Program has excelled at educating the greater population about the complex health needs of seniors.

In Puerto Rico, nearly half a million seniors – one-eighth of the population – are affected by common ailments like hearing loss or mobility limitations. Through advertisements, case studies, media outreach, educational materials and other initiatives, the Sensitivity Program has seen terrific results in its quest to create a societal commitment to senior well-being. Along with effective cultural penetration, the monthly enrollments in MMM's Medicare Advantage have increased 11 percent, furthering both access and education.

HONORABLE MENTIONS

DOOLITTLE SENIOR CENTER

Saluted as a venue for active seniors to improve health, gain information on benefits they might not be aware of, and learn of financial advice that allows them to conserve their limited resources.

EAST LAS VEGAS COMMUNITY CENTER

Honored as a senior community center designed to reflect the cultural preferences of the Latino community. The Center provides resources, entertainment and events that allow seniors to reconnect with their heritage and traditions.

SHELTER/CRISIS FACILITY

NEW ENGLAND CENTER FOR HOMELESS VETERANS

Working in what can be a difficult environment, the nonprofit New England Center for Homeless Veterans has achieved phenomenal success in its stated goal of moving homeless veterans into independent living through a two-year transitional residency program. Through a team approach where a case manager, housing manager, rehabilitation specialist, medication administration nurse and two VA staff collaborate on care, the Center regularly surpasses its annual goal of placing 50 percent of seniors over 65 in permanent housing.

One of the most creative approaches is the Stay-In Program, designed to keep seniors active and engaged during their shelter stay. Stay-In focuses on physical, mental and social engagement through community groups like vet-to-vet conversations or movie discussions. The unique approach continues to prove the power of creative thinking to strengthen our delivery of care.

HONORABLE MENTIONS

MARTIN LUTHER KING CENTER

Recognized as a critical resource for seniors in distress and in need of care. The Center provides a caring staff and necessary resources to meet the needs of the elder community

PANTRY OF BROWARD

Saluted for a unique program to meets the needs of grandparents caring for their grandchildren. The Pantry provides food and other necessities that seniors on a fixed income can use as full-time caregivers.

SKILLED NURSING FACILITY

PONCE PLAZA NURSING AND REHAB CENTER

Ponce Plaza Nursing and Rehabilitation Center is part of the larger not-for-profit organization The Plaza Health Network and maintains a dedicated core of nursing professionals working in the heart of Miami, Fla. Since opening its doors in 2000, the 127-bed facility has provided skilled nursing care and specialized therapy to the local community. Fully functioning as a bilingual operation, Ponce Plaza offers 24-hour service to the diverse, mostly Hispanic patients it serves in need of nursing, hospice or sub-acute care. The facility also maintains an advanced therapy program, including professionals equipped to handle wound care, internal nutrition, diabetic management and speech, physical and occupational therapy.

TIERRA PINES CENTER

The Tierra Pines Center is a mission-driven organization dedicated to the highest standard of patient care in Florida. It was awarded a gold seal award from the Governor's Office for excellence in the state. In 2010, the American Health Care Association and National Center Assisted Living also recognized the center with a Commitment to Quality National Quality Award. Tierra Pines promotes a

culture of safety through its extensive training and interdisciplinary involvement in inspections and recognition. The management team demonstrates its commitment to helping patients through creative and innovative programs and community involvement.

HONORABLE MENTIONS

THE MANORS AT HOBE SOUND DBA EDGEWATER MANOR
Edgewater Manor is a family-owned company established in 1965 by Mr. and Mrs. Donald J. Bortz, who continue to operate this and 12 other facilities across Michigan, leading the way with top-quality patient care.

ST. MARY'S HEALTH SYSTEM
The Rehab Center at St. Mary's d'Youville Pavilion has spent the last 27 years creating a comfortable, private healing environment for patients during their time of need between hospital stays and home care.

VILLA MARIA NURSING & REHABILITATION COMMUNITY
The Villa Maria Nursing and Rehabilitation Community is a family-owned center established 30 years ago by the Disco family where patients have exemplary access to both long and short-term care.

SOCIAL WORKER

CORINNE KENNEDY – WELLPOINT

Corrine Kennedy, LISW-S, CASWCM, joined the care management team of WellPoint as a geriatric social worker with a great passion for improving the quality of life of senior citizens. Kennedy is known to be tenacious and quick to problem solve, using unique and creative methods. Local home care agencies rely on her extensive knowledge and psychosocial training to offer seniors the best possible health and financial options, especially in these difficult fiscal times. Co-workers say Kennedy's clear and direct manner, leadership skills and extensive knowledge of available community resources helps strengthen the holistic focus of the care management program. Projecting an air of confidence and competence, Kennedy is able to empower members of the community to navigate the system.

LOUISE KENNY – AVOW HOSPICE, INC.

Louise Kenny, MSW, LCSW, is a bereavement coordinator for Avow Hospice and has worked diligently over the past decade to facilitate grief counseling through the nationally recognized Opening the Health TM workshop that teaches scientifically proven mind, body and spirit healing techniques to people who have experienced loss, and "care and comfort" sessions for the unique needs of inpatient and facility-based clinical teams. Continually building new business opportunities for Avow, Kenny was able to raise $10 million over the last three years alone for operations, campus enhancement and endowments, and she has introduced new support programs for patients, their families and the community at large.

BRENDA F. OAKLEY, MSW, CCM, LSCW – PARK RIDGE HOME HEALTH
Recognized for her resourcefulness in a difficult environment and her keen ability to meet the needs of her clients.

LINDA GROBMAN, ACSW, LSW, CMP – THE NEW SOCIAL WORK MAGAZINE
Recognized for her leadership and creativity and finding new ways to bring information, networking and education to social worker professionals online and in print.

Congratulations to all finalists.
We salute your passion and applaud your dedication.

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The Professional Patient Advocate Institute is a community aligned around the common cause of providing advocacy for patients as they attempt to navigate the complex healthcare system. The Institute offers training, business resources, and connections for patient advocates to discuss challenges and share best practices with the ultimate goal of improving the patient experience.

MEMBER SERVICES:

- Certificate Program
- Content Center providing the latest protocols, news and information for advocates
- Toolkit with clinical and professional resources for care coordinators and private practice advocates
- Quarterly Reports
- Patient Advocate Training & Events
- Voting rights
- Member Listing in Public Directory
- Committee Participation
- Members-Only Social Network

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