

CASE IN POINT

Leading the Care Coordination Team with Knowledge, News and Learning

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10 Healthcare Reform Issues Transforming Case Management

BY ERIC AUSLANDER AND GARRY CARNEAL, JD, MA

The field of case management continues to hold a great deal of promise as policymakers in Washington, D.C., and across the country implement a wide array of changes on the healthcare front. While the vast changes present case managers with opportunities to expand their roles, the new healthcare landscape also brings many new challenges. Many of the most recent and significant legislative changes affecting case management stem from the Patient Protection and Affordable Care Act (PPACA).

This article highlights 10 important issues facing case managers today in the ever-changing healthcare reform environment.

1. Chronic Disease Management. PPACA is requiring that individual and small group plans offer coverage for 10 categories of essential health benefits (EHBs), including ambulatory care and laboratory services.

One category of particular importance to case managers is "preventive and wellness services and chronic disease management." This mandated coverage will provide sorely

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Case Management's Ethical Eight: Preparing for the Next Wave

BY ELLEN FINK-SAMNICK, MSW, ACSW, LCSW, CCM, CRP

Case managers are faced with technology's unparalleled evolution across the healthcare industry. The impact is felt in every environment of practice, whether through a new product, program, process or policy. Conversely, innovation's vast promise is often accompanied by concerns regarding the potential ethical and legal implications for case management practice.

The five ethical tenets of case management are the one constant amid our swift industry change, each supporting the daily practice of professionals.

1. Beneficence: To do good.
2. Nonmaleficence: To do no harm.
3. Autonomy: To respect individuals' rights to make their own decisions.
4. Justice: To treat others fairly.
5. Fidelity: To follow-through and to keep promises. (CMSA, 2012)

However, shifting societal constructs and contexts equally influence how each tenet is adhered to. This is further complicated by the intricacies of each unique situation. While there are an array of resources to ground ethical practice for cases managers, from

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Smarter, Not Larger, Prescription Spending Tied to Better Outcomes

BY STEVEN DASHIELL

The release of hospital payment data earlier this year from the Centers for Medicare and Medicaid Services (CMS) opened a lot of questions about the way our nation's healthcare system operates. The data illustrated a large variance in costs across the U.S., even in regions scarcely miles apart. But does this variance extend to other areas of healthcare, such as prescription drugs?

This is the question that burned in the minds of Jeffrey Munson, MD, MS and his colleagues at the Dartmouth Institutes for Health Policy and Clinical Practice. Prescription drug usage is growing as new drugs find their way into regular treatment routines and more and more baby boomers enter the healthcare system. With prescription drugs accounting for nearly \$60 billion in Medicare spending, the trends and patterns of drug usage among Medicare Part D beneficiaries is a key metric for case managers to understand in the coming years.

Dartmouth's decision to study the patterns of prescription drug use in Part D is among the first. Few pre-existing data are available on the subject, and even with the relatively new hospital payment data from CMS, there was no guarantee that the payment data would have any relevance to the drug usage study.

THE APPROACH

Using the Dartmouth Atlas of Health Care framework, researchers decided to look at three categories of prescription drugs that were commonly used in Medicaid Part D: effective medication use, discretionary medication use and high-risk medication use.

"We were trying to look at the whole spectrum of prescription drug care," says Munson.

Effective medication includes medications that have existing literature and studies that indicate the efficacy and safety of the drug for its intended purpose. Most patients who qualify for these drugs should be receiving them, says Munson, as they are not particularly controversial and it is widely recognized that they work.

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"At the other end of the spectrum, we looked at medication where there was evidence that the side effects generally outweigh the potential benefits," explains Munson.

"Those we call the high-risk medications," Munson says, adding that these high-risk medications are particularly prevalent in patients over the age of 65 – i.e., the Medicare population.

The remaining category, discretionary medication, is largely made up of medications that are effective for some patients but not for others. It is expected that physicians and patients weight the benefits when determining whether to use the medication.

With three medications of such distinct categorization, one would expect spending on each would follow appropriately, with the most helpful and effective medications receiving the most spending and the highest-risk drugs receiving the least. However, this was not the case.

"What we found, surprisingly, was that there's variation in all three of these drug categories," says Munson.

UNPREDICTABLE VARIATION

Researchers found no discernible relationship between the use of effective drugs and the total amount of Part D spending or total drug volume. For the purposes of the study, effective medication was broken down into five measures of care: beta-blockers after a heart attack, statin after a heart attack, statins in patients with diabetes, ACE-I/ARB in patients with diabetes, and osteoporosis drugs after a fragility fracture.

When these measures were summarized and aggregated by region, no difference was found in prescription drug spending between regions that consistently provided effective care and regions that did not.

Discretionary drugs, on the other hand, were associated with higher total drug spending. Proton pump inhibitors, antidepressants, dementia medication and a sedative-hypnotic were all associated with higher prescription drug spending. High-risk medications were also found to positively correlate with Part D spending, a finding that researchers found somewhat unsettling.

"It's interesting; there are a few things that were surprising in this report to us, and that was one of them," says Munson. "One of the things we found was that spending more does not get you better care."

Regions that use a lot of high-risk medications tend on average to spend more on medication in general, says Munson. "That's a little bit concerning because you're spending more and may in fact be getting less. You may be getting higher-risk medications and lower quality care."

LESS FOR MORE

The issue of paying more money for care that does not necessarily result in better outcomes is reflected in the push and pull of generic medications vs. their brand-name counterparts. In examining spending on brand-name medications, researchers at Dartmouth found a great variation in spending across regions, ranging anywhere from 16.5 percent in La Crosse, Wisc., to 36 percent in Manhattan. On the whole, brand-name drug use was positively correlated with total Part D spending.

Though in some cases a brand-name drug may not have a generic equivalent, many medications do, Munson explains. As for why brand-name drugs are so frequently prescribed over generics, the question remains unanswered. In seeking an explanation for this correlation, researchers looked at disease

burden across regions, curious to know if new treatment options for “sicker” patients resulted in less available generic alternatives.

While they found some correlation between these factors when observing each region’s average disease burden, stratifying regions based on their average burden illustrated that these factors could not explain the entirety of the differences in use of brand-name medications. Each quintile of average burden saw a wide variation in the use of brand-name products similar to that observed across all regions. Overlap in the use of brand-name products also occurred in regions with different average measure of burden.

“What I can say from this report is the fact that the variation in how much brand name use there is tells us that there are regions that have found a way to use generic drugs very effectively, whereas there are other regions where physicians are lagging behind,” says Munson. “Whether that’s patient preference or physician preference, we don’t know that yet.”

PART D AND MEDICARE

Data generally showed that regions that had higher spending on Part D prescriptions also had higher spending on Medicare Parts A and B. However, much like generic drug spending vs. brand-name drug spending, disease burden had little to do with the correlation.

When regions were stratified based on their average disease burden, large variation in drug and nondrug spending remained. Similar to generic and brand-name medication spending, large overlaps in spending were found even in regions with wildly different disease burden scores. The correlation of spending on Parts A and B with Part D, large or small, remained, regardless of how much was spent and how great or small the region’s disease burden proved.

TRENDS AND QUESTIONS

As the report indicates, much of the spending taking place in Medicare Part D is not necessarily indicative of the health quality or lack thereof in certain regions. Munson and his colleagues suggest that part of the explanation of this variation in spending stems from regional practice cultures.

“When you look at high-utilization regions, regions where the physicians have

historically used a lot of Medicare resources, we are also seeing that they use the most prescription drug resources,” explains Munson. “That sort of speaks to the possibility that physicians and patients in these communities have become accustomed to a philosophy of aggressive care, where more seems to be thought of as better.”

For regions with lower utilization,

Munson suggests that providers in these areas have found a way to provide effective care at low cost – that efficiency and quality can be achieved.

“Beyond that, we don’t fully understand why there are regional differences or what these regional practice patterns might be,” Munson says.

Researchers also found a few alarming practices occurring in the field of prescription medications. Researchers found several instances of patients who could use effective medications not receiving the prescriptions they need. The sheer amount of spending on high-risk medications is also a concern for the Medicare population, who are made up of beneficiaries who are more likely to suffer ill effects from these drugs.

“I think the most important finding of this study is there’s a quality problem at both ends of the spectrum,” says Munson. “There are patients who need medication that they are not getting, and on the other end, there are patients who should be avoiding the medications that they are getting.”

Why these gaps exist isn’t clear, says Munson. In choosing drugs for the study that the physician community is familiar with, researchers hoped to eliminate any risk of physicians being unaware of the benefits and risks of a particular drug. These gaps remained in spite of this precaution.

“Clearly when you look at a region that is only getting 63 percent of its heart attack survivors on beta blockers, it seems like an easy opportunity to fix. Whether you can do that with a pharmacist or associate pro-

vider or some measurement on how many... patients are getting the drugs they need is an interesting question.”

BRIDGING THE GAP

Though the findings of the Dartmouth report raise many more questions than they may answer, Munson is satisfied with Dartmouth’s findings. “One of the hopes of publishing this

“THE MOMENT OF DISCHARGE FROM THE HOSPITAL IS A REAL OPPORTUNITY TO REVIEW WHETHER PATIENTS ARE GETTING THE DRUGS THEY NEED AND ARE AVOIDING THE DRUGS THAT MIGHT BE HARMFUL TO THEM.”

report was to identify how wide the variation is from region to region in hopes of generating more interest in doing more research in why it happens. All we can really say at this point is there is dramatic variation in the full spectrum of prescription drug care, and that has created real quality gaps between regions.”

Munson hopes that the findings in the report will help physicians understand how they’re performing when it comes to their prescription medications and just how they can improve. By understanding your performance relative to the various regions, you can begin understanding what can be attained, Munson notes.

As for case managers and care coordinators, placing focus on the patient is key. “Patients need information about the medications they’re taking. The moment of discharge from the hospital is a real opportunity to review whether patients are getting the drugs they need and are avoiding the drugs that might be harmful to them,” says Munson.

“Look at each patient and review in a thoughtful way their conditions, the drugs that we know are effective for those conditions...and the potential risks of that drug and whether it should be prescribed.” 

Source: *The Dartmouth Atlas of Medicare Prescription Drug Use*. **Web:** www.dartmouthatlas.org/downloads/reports/Prescription_Drug_Atlas_101513.pdf

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