

MANAGED CARE

OUTLOOK

The Insider's Business Briefing on Managed Healthcare

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At Presstime

Report Shows Who Gets What in Federal Funding

Trust for America's Health and the Robert Wood Johnson Foundation have released a report that found Midwestern and Southern states received less funding from the federal government than Northeastern and Western states did in fiscal year 2008 for disease prevention programs, which can amount to millions of dollars in differences. *Shortchanging America's Health: A State-By-State Look at How Federal Public Health Dollars are Spent* also examines how the economic downturn could lead to serious cuts to disease prevention and emergency preparedness programs at the state level.

The report found that states receive \$17.60 per person on average from the U.S. Centers for Disease Control and Prevention (CDC) to spend on public health. Midwestern states received an average of \$15.40 per person and Southern states received \$17.89 per person, while Northeastern states received \$18.99 and Western states received \$18.15 per person from the CDC. Alaska received the most funding of any state at \$52.78 per person, while Indiana received the least at \$12.74.

The full report is available at www.healthyamericans.org. ■

Universal Coverage Remains a Hot Issue, But What About Universal Access to Care?

The term "universal coverage" is getting a lot of attention these days on Capitol Hill and in health care circles, with policymakers discussing not only the pros and cons of universal coverage but also how to approach such a massive endeavor. What seems to be getting less attention, however, is who will take care of the 45 million (or more) newly insured Americans if universal coverage ever takes hold?

It is no secret that the United States is already facing a serious shortage of nurses, primary care physicians, and various other health care professionals. That shortage, combined with the current economic crisis, could make implementation of universal coverage overwhelming, at best, explains Adam Singer, MD, one of

(See *Universal Coverage ... page 3*)

A Pay-for-Performance Case Study: How Nonprofit Clinics Can Make it Work

Gloria Mayer

Pay-for-performance (P4P) is being widely promoted as a mechanism for encouraging providers to improve the quality and efficiency of their patient care by offering financial rewards to individuals or organizations who provide care that meets certain standards of quality or cost effectiveness. The perception of consumers and payers, however, is that P4P programs add to current costs since payers assume they already receive optimal care when their patients visit a physician's office. This dilemma leaves many of us wondering whether P4P is the best way to make use of limited resources.

(See *A Pay-for-Performance ... page 5*)

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National Briefs

Health Net Program Seeks to Help Chronically Ill Medicare Members: Health Net Pharmaceutical Services has released the results of a study showing that in 2008 its Medication Therapy Management (MTM) Program reached 90 percent of Health Net's eligible Medicare Part D members. As a result of the program's success, the Centers for Medicare & Medicaid Services (CMS) recently selected Health Net as one of only 10 Medicare Part D sponsors to participate in a pilot program to perform in-depth analysis on MTM outcomes. Health Net's program seeks to help its Medicare Part D members who have multiple chronic diseases and multiple chronic medication prescriptions to improve how they take their drugs and potentially decrease their pharmacy expenses.

HSC Releases Study Results: Introduction of the outpatient Medicare drug benefit in 2006 did little to close longstanding prescription drug access gaps between white and African-American seniors, healthier and sicker beneficiaries, and lower-income and higher-income beneficiaries, according to a study released by the Center for Studying Health System Change. In 2007, almost three times as many elderly African-American beneficiaries (17.6 percent) skipped filling a prescription as white beneficiaries (6.2 percent) while nearly four times as many seniors in fair or poor health (16.6 percent) went without a prescribed drug as those in good to excellent health (4.4 percent). Likewise, almost 16 percent of beneficiaries with incomes below 150 percent of the federal poverty level reported unmet prescription drug needs in 2007, compared with 2.7 percent of beneficiaries with incomes at or above 300 percent of poverty.

CIGNA Teams with NutriSystem, Linkwell, and GlobalFit: More options for health and wellness are now available to people covered by a CIGNA plan as the company expands its Healthy Rewards® discount program. CIGNA has added new discounts with NutriSystem® to its weight management and nutrition offerings, added an additional credit on its existing discounts for gym memberships with GlobalFit, and now offers online money-saving coupons for foods and health and wellness products through Linkwell Communications, Inc. Anyone enrolled in a CIGNA medical, dental, behavioral, pharmacy, life, accident, or disability plan can take advantage of the discounts.

Kaiser Permanente Teams with IBM: IBM and Kaiser Permanente have entered into a strategic agreement. As part of the agreement, IBM will leverage its global technology capabilities to manage Kaiser Permanente's data center operations, including computer systems, storage systems, and associated software. Kaiser Permanente will continue to manage applications, including the organization's electronic health record, Kaiser Permanente HealthConnect™. ■

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the organizers of the Phoenix Group, a “think tank” of physicians and hospital medicine experts that has been meeting for two years to find answers to these types of problems. That does not mean the task is impossible; it just may require a little extra work.

Before delving into a discussion on what needs to be done to address the challenges associated with shortages and limitations in the health care sector, perhaps the first step is to make a distinction between universal coverage and universal access. The idea of making sure every American has insurance is a noble goal, says Singer, but having insurance and having access are two very distinctly different concepts.

“The problem is that universal coverage does not necessarily mean universal access,” notes Singer. “As I listen to all the different policy discussions about universal coverage, the assumption seems to be that everyone will have access to good health care if they have insurance. The problem is that there aren’t enough providers to take care of all these people, and I don’t hear anything being mentioned about the expansion of the provider pool, which is necessary under any scenario — even if we don’t have universal coverage.”

There are currently 28,000 or so practicing hospitalists in the United States out of roughly 110,000 internists. Nearly 25 percent of the primary care doctors have left outpatient medicine to become hospitalists. There is arguably a need for as many as 12,000 more hospitalists, says Singer, which will further reduce the number of available primary care doctors.

Combine the coming millions of baby boomers about to hit the Medicare ranks with roughly 45 million newly insured patients and it is easy to see that the current health care delivery system is in trouble, notes Singer. Simply offering coverage, therefore, will not solve the problem. There must be access to care, which means someone involved in the

discussion should be addressing the need to expand the provider pool.

Expanding the Provider Pool

“I see a couple of options for expanding the provider pool,” says Singer. “The first, and perhaps the most significant, option is to employ more physician assistants and nurse practitioners who have taken on more physician-like responsibilities. It is a basic supply and demand issue right now, and you are going to see rapid escalation in this area as people growingly understand the income potential in these fields created by the overwhelming demand.”

The second solution to expanding the provider pool involves H1B visas and J1 visas. At any given time, 25 percent of the residency slots in the United States are filled by physicians with foreign visas, explains Singer. Restrictions implemented after 9/11 have made it more difficult for physicians with H1B visas and J1 visas to work in this country. Prior to a year or so ago, these restrictions were the primary obstacle involving these physicians. Given the current economic status of the country, however, it has become a two-pronged problem. As economies in other countries improve (and the U.S. economy struggles), some of these physicians are opting to go elsewhere, compounding the problem.

“Not only is this channel not helping us with the shortage, but it is actually making the problem worse,” notes Singer. “We need our policymakers to reduce visa cap restrictions on these physicians and make it more attractive for them to stay here.”

The third solution probably will not happen, admits Singer, but there needs to be an increase in medical school enrollment. This would require a long-term initiative, and it would take as much as 10 years before the first round of doctors would even be available. Therefore, it is an option that would have to be considered in conjunction with something more immediate, like the first two solutions mentioned.

(See Universal Coverage ... page 5)

Northeast

Discounted Options Available to NJ Social Service Workers:

More than 10,000 social service workers across New Jersey now have access to lower-cost health insurance.

UnitedHealthcare and the Social Services Purchasing Alliance are offering alliance members' employees a 5 percent discount on New Jersey Small Employer health plans offered by UnitedHealthcare. Available options include traditional plans, health savings accounts, health reimbursement accounts, out-of-network options, preventive care, and wellness programs. Organizations eligible for the discounted health plans include more than 1,000 New Jersey facilities providing therapeutic, residential, educational, and other services to the disadvantaged and to people with physical, mental, and behavioral challenges and disabilities.

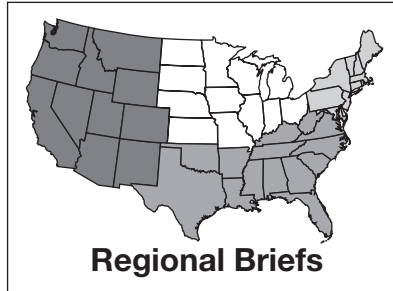
Midwest

Enjoy "Wellness on Us," Aetna Tells Illinois

Employers: Employees of small Illinois businesses can now obtain preventive health care services without being charged a copayment under a new suite of plans being offered by Aetna called "Wellness on Us" plans. Aetna is offering 29 different plan designs for small-group customers in Illinois, including point of service, preferred provider organization (PPO), and health maintenance organization (HMO) options. Many of the plans also can accommodate a health savings account (HSA) or health reimbursement account (HRA). The plans include coverage for prescription drugs. In all of the plans, members are not charged a copayment when they visit the doctor for routine vision exams, physicals, well-child visits, immunizations, gynecological exams, and mammograms.

Blue Cross Launches Online Shopping Tool:

Consumers can now find health care cost and quality information through Care Comparison,[®] a new online tool introduced by Blue Cross



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and Blue Shield of Minnesota. Care Comparison allows nearly two million Blue Cross members in Minnesota to evaluate total treatment costs as well as quality, safety, and accessibility information for dozens of common elective procedures at facilities throughout the country.

Blue Cross members can search online for the most costly and common procedures and make informed health care decisions for themselves and family members. Five Blue Cross companies have collaborated to make this tool available to 22 million members throughout the country. Members can use Care Comparison at members.bluecrossmn.com.

South

Tampa Bay Seeks to Jump Start E-Health

Revolution: A new public/private partnership called PaperFree Tampa Bay has launched a plan to jump start America's electronic health revolution. PaperFree Tampa Bay will deploy more than 100 "electronic health care ambassadors" with a goal to convert 100 percent of physicians in the Tampa Bay area from paper prescriptions to electronic prescribing. The effort is a first step toward the implementation of connected electronic health records (EHRs) to improve patient safety and reduce costs and intends to leverage funding from the American Recovery and Reinvestment Act. PaperFree Tampa Bay anticipates that the program will create new jobs that include trainers and support staff.

West

Idaho School Nurses Get Help Enrolling Kids

in State's Health Plan: The Regence Foundation has announced a \$10,000 grant to Mountain States Group to fund its Cover Idaho Kids Project. The program will help school nurses in 15 rural Idaho school districts enroll uninsured children in the Idaho Health Plan Coverage for Children and Teens program (formerly called the CHIP/Medicaid Program). The Cover

Idaho Kids Project is operated by Mountain States Group. The Boise-based group is committed to increasing the number of Idaho children covered by health insurance and works with hospitals and clinics, schools and youth groups, community-based organizations, and the media to encourage participation in Idaho's health coverage programs for children.

AlohaCare Seeks Statewide Recipients for 2009 Grants: AlohaCare is seeking

nonprofits statewide to award a total of \$40,000 in grants as part of its annual AlohaCare Community Conscience Award program. AlohaCare will award grants to organizations that focus on the prevention and/or treatment of childhood obesity, asthma, or diabetes as well as nonprofits that provide access to care for children and adolescents. Eight selected organizations will receive \$5,000 each. The deadline to submit a completed application is April 30, at 4 pm. ■

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Another piece of the puzzle is to find a way to improve the efficiency and productivity of the existing workforce, stresses Singer. An efficient, skilled physician can handle a full-time schedule, but that is not always the message being communicated. For example, one common shift model for hospitalists is to work seven days on and seven days off or roughly the equivalent of 0.7 of a full-time physician. Many of these doctors, however, are paid full-time wages — sometimes even premium wages — for this schedule.

This creates two problems, explains Singer. If a doctor is working at 70 percent, then two employees are needed instead of just one to

cover the workload. That contributes to the physician shortage problem, and it creates an economic problem for hospitals that must pay two physicians to cover the workload.

One way to address this is to change the staffing model and to implement education and training programs to help physicians better manage their schedules. Increasing the efficiency and productivity of the physicians currently available in the system is like adding more physicians to the workforce, says Singer. It's not easy, but it can be done. The bottom line, "There is no solution to universal coverage without addressing universal access, and that may be an even more daunting challenge than the current rush to insure every American," says Singer. ■

A Pay-for-Performance ...

(from p. 1)

Currently, there are many P4P programs that have been implemented and are functioning across the United States. While much has been written about the broad structure of P4P programs, very little can be found on the specific details of P4P program implementation in ambulatory care centers.

Friends of Children Health Center (FOC) is a licensed pediatric community health center serving a broad spectrum of patients, including the vulnerable and underserved in La Habra, Calif., an area in northeast Orange County that is considered medically underserved. FOC is open

six days a week, two evenings until 8 p.m., and other days from 8-5 p.m. FOC has nine examination rooms and three full-time providers.

FOC uses a fully implemented electronic medical record that includes all laboratory work, x-rays, and prescriptions, so there is essentially no paper at the center. FOC sees 20,000 visitors a year, but this number is increasing since the third provider was added early this year.

FOC always gave raises and bonuses to its staff. Typically, the raise was a cost of living increase ranging from 2 to 5 percent. Bonuses were given with no particular formula, and it was the supervisor's prerogative to suggest the bonus for the staff. The staff and providers

seemed to appreciate the raises and bonuses, but it was becoming routine and an entitlement rather than a reward for doing outstanding service or something above and beyond the routine job description.

Introducing P4P

Top management at FOC decided to implement a P4P program to add more structure to its bonus program and to establish very substantial criteria for the P4P program with the addition of new money to fund this program. The rationale for doing this was to increase quality of care, generate better organizational systems, generate new revenue sources, collect all of the P4P bonuses given by our payers, and make the P4P system generous enough that the staff would all want to participate and strive for optimal performance.

In most of the literature, providers are the recipients of P4P payments. Sometimes it is the organization that receives the bonuses, but it is assumed that the payments will get into the provider's hands. Many P4P programs are designed by and for providers while the office staff typically is not included.

At FOC, the office staff has significant roles. For example, a referral coordinator handles all the referrals and follow-ups. We have a person that just enrolls families in insurance plans, a critical job function that assists the entire center since we convert nonpaying patients into patients for whom we can collect insurance reimbursement. Our receptionists must call patients to remind them of their appointments and double-book appointments as needed.

The medical assistants perform a variety of tasks that are critical for keeping the patient flow going and providing before and after care. It is the medical assistant that actually gives the immunizations and performs many other tasks that allow the providers to be more efficient.

Therefore, after long discussions, it was decided to include all the staff at FOC in the P4P system. This included all the providers, front and back office staff, and special project staff. Everyone who worked at FOC was

included in the program. Part-time staff's P4P was prorated based on the hours they worked.

Defining P4P

The next step was to establish the criteria for the P4P program. We established some ground rules that included the following:

- The criteria had to be quantitative.
- The data established had to be easy to collect.
- The criteria had to be something beyond the basic job description.
- The criteria were for individuals, not groups of staff.
- Staff could receive partial P4P bonuses.
- Generating revenue was a primary goal.

FOC contracts with seven different health plans, and each one of them has quality measures that provide some type of bonus structure. We reviewed all of the quality measures that the health plans required and included them in our internal criteria. One of our annual goals as an organization was to receive 100 percent of the health plan's P4P bonus, so it was natural to include these indicators.

We then set out to establish specific criteria for our providers, receptionists, medical assistants, and referral coordinators based on their unique job responsibilities and roles in the organization. Each of the criteria was related to patient-oriented activities. These criteria defined specific components of the activities in more detail — in terms of the staff contributions — and made them quantifiable.

Program Costs

The program cost FOC about \$45,000 more than the previous year. When we completed an analysis of the program, however, we generated far more than that in savings, improved access, and the new revenue generated.

For example, in 2007 our providers were seeing 2.7 patients per hour with the medical assistants merely taking vital signs and doing minimum patient care. Currently, these same providers are seeing 3.5 patients per hour, which is a change of a positive 0.8 patients per hour or

1,600 patients per year per provider. If we multiply that across three providers, our center can see 4,800 additional visits without adding staff.

We also provided additional training to our medical assistants so they can perform all functions that their status permits them to do under the law. Our goal for 2009 is that our providers see four patients per hour, which will further increase access.

The increase in provider productivity is an example of how the entire group has to work together to achieve results. If the no-show rate is high and the receptionists turn away same-day appointments, the providers cannot achieve their patient visit goals. If the medical assistants are slow to greet and treat the patients, again the provider is slowed down. It is a team effort; consequently, we decided to include everyone in the program.

Lessons Learned

There were many mistakes made and lessons learned during the first year of this program. One major lesson is that we are not going to do the annual evaluation and pay increase at the same time we complete the P4P bonus assessment. Since the P4P program should encourage staff members to go above and beyond their basic job description, it gets confusing to combine the two evaluative systems.

For example, an employee may get his or her entire pay increase but only half of the P4P bonus. A staff member may be doing his or her job very well but did not get 100 percent on the P4P

criteria. We now are doing the annual evaluations in July and the P4P assessment in December.

Another lesson learned from our prior P4P experience is that not all criteria for the P4P evaluation are the same. Some criteria are more important than others. Therefore, we are going to assign a weight value to the criteria and assign them a grade based upon how well they did on that criteria; for example, if someone got 80 percent of a criterion weighted at 40 percent, he or she would have achieved 32 percent overall of his or her P4P goal in this area. Some staff may receive 60 percent of their P4P, and others may only receive 30 percent. The system will be quantitative to reduce subjective scoring bias.

The Results: P4P Can Work

FOC implemented a very aggressive P4P program in its ambulatory pediatric center that included all staff levels. Although it added to the budget, we increased productivity, increased quality, and achieved higher patient satisfaction levels. The staff has stated that it likes the program and wants it to continue.

With some changes, we will continue the program and evaluate it once again after the second year. We feel, however, that the P4P approach is the future and provides some excellent opportunities to reward the staff for quality and efficiency of patient care. ■

Gloria Mayer, RN, EdD, FAAN, is president and chief executive officer of the Institute for Healthcare Advancement, operators of the Friends of Children Health Center in La Habra, Calif. For more information, please visit www.iha4health.org or call 800/434-4633.

On the Frontlines of a New Era in Health Care with Personal Health Support

The “look and feel” of personalized medicine may be a little different from company to company, but the general concept is the same. It is the ability to tailor programs to the individual level and to meet the needs of individual patients in a more holistic fashion. It is about working with patients to empower them and

support them instead of just managing a disease. The rationale is straightforward: not only is it good for individuals, but ultimately, it will help benefit managed care organizations as well as their clients — particularly employers looking to manage costs and improve productivity in a slowing economy.

“We recognize that the best way we can help individuals is with an approach that involves a positive outlook about changing health outcomes and focusing on health behaviors that they feel they are ready to change,” explains Ron Loeppke, MD, executive vice president of health and productivity for Alere, a leader in specialized health management services. Alere’s services include wellness solutions, disease management, and complex case management as well as maternity and NICU-management services.

“The theory is that engaging the patient and letting him or her experience a positive outcome, however small that outcome may be, gives the person the confidence to change their behavior and impact their health for the long haul,” says Loeppke. “It’s about providing information, communication, and education — as well as physician support — but also having empathy for patients and meeting them at their level of readiness to change. Ultimately, our goal is to improve behaviors and create a healthier, more productive population.”

Historically, disease management tended to focus on the condition or disease and tried to close quality gaps in care around that disease. Personalized medicine looks at more than just the condition or disease. It seeks to understand all the elements that a patient has going on in his or her life and tries to find the best way possible to help that individual. It is a more integrated approach that strives for a more holistic experience at the individual level.

It is through this integrated approach that organizations get the full impact of investing in better health, says Loeppke. This is true not just from a financial perspective (although that is part of it) but also from a clinical perspective. For example, for a diabetic patient, it not only means getting the hemoglobin A1c level to the optimal range and keeping it there but also looking at utilization indicators to see if people are using fewer emergency room services and hospitalizations. It means looking for improvements in productivity and absenteeism and evaluating health risk indicators

to see if a patient has experienced any gain in that area.

It also means going beyond the standard measurements to those outcomes and criteria that are important to all participants in the health management process. For example, Alere’s health management programs seek to reduce costs and improve productivity, which not only benefits the individual, the employer, and the managed care organization but also contributes financially to an organization’s bottom line.

The challenge is to communicate that value in a manner that is relevant and meaningful to the C-suite of an organization. In the past, many managed care organizations used terms such as return on investment (ROI) to highlight financial value. There are other key issues, however, that will help to better communicate the importance of a healthy workforce and the value of a personalized approach to health care.

“When you start talking about the impact of employee health on shareholder value, it speaks to the C suite,” says Loeppke. “They have their own language, and we have to be able to connect the dots and show them the value of health. For example, one of the things we found in our research is that consistently, for every \$1 of medical pharmacy cost that employers pay out, on average, they are spending \$2 to \$3 on health-related productivity losses — presenteeism and absenteeism. For some conditions, that ratio can be dramatically higher. These are the figures that get the attention of the C suite.”

The Value of a Healthy Workforce

Given the current economy, employers in general are starting to look at human capital a little differently. Thanks in large part to financial markets seemingly paralyzed by the current economy, many employers simply do not have the assets to drive growth through mergers and acquisitions; nor do they have the assets to buy new capital equipment. As a result, they are depending on human capital now more than ever because they know that is where they are

going to get incremental creativity, innovation, and productivity from their employees.

“This value of improved health and productivity to the employer community is a very hot topic right now,” notes Loeppke. “More and more we are hearing that employers are focusing on the value of health and looking at it as an investment to be leveraged rather than looking at the cost of health care as a cost that has to be justified and managed. That’s a pretty significant shift. Employers are beginning to understand that we can’t just reduce costs and manage our way out of this through financial arrangements. We have this increasing burden of health risk that leads to an increasing burden of chronic conditions, and employers know something has to be done.”

Health care industry leaders like Alere’s Loeppke believe that the incorporation of a more personalized approach to health care holds value not only to individuals and plan

sponsors but also to the nation as a whole. As the country continues to debate health care reform, one element that all constituents can agree upon is the need to help individuals help themselves as a cornerstone to improving care and lowering costs.

Loeppke is one of several leading clinicians who published a landmark study in 2007 in the *Journal of Occupational and Environmental Medicine* (JOEM) that helped to introduce the concept of health and productivity as a business strategy.¹ A follow-up study is scheduled to be published in the spring of 2009.

For additional information on personalized medicine, please visit Alere at www.alere.com or email info@alere.com. ■

Endnote:

1. Loeppke R, Taitel M. Health and Productivity as a Business Strategy. *J Occup Environ Med.* 2007 Dec; 49(12):1299-300.

Adverse Drug Events: What is the Impact and What Can Be Done?

While the focus on medication error and adverse drug events is nothing new in the health care industry, a settlement reached late last year involving a high-profile family and a hospital that inadvertently gave the couple’s newborn twins an overdose is a reminder that the problem is far from resolved.

For starters, it is important to understand the difference between a medication error and an adverse drug event (ADE). A medication error is any “preventable event that may cause or lead to inappropriate medication use or patient harm.”¹ An ADE is any unwelcome, harmful consequence that is the result of a given medication. An ADE may be the result of a medication error or a reaction to the drug itself. Nearly half of all ADEs, however, are the due to medication error.²

The first thing people think of when they hear the term “medication error” is probably a

case of a patient receiving the wrong medication, resulting in harm or possibly even death to the patient. While that is certainly one aspect of the problem, there are many contributing factors when it comes to medication error. Let’s start with physician ordering.

Statistics show that 40 to 50 percent of the root cause of medication error is caught on the physician ordering side, with the most errors stemming from duplicate therapy or harmful drug interaction.³ Errors also occur on the nursing side. A missed dose, for example, is considered a medication error. If a nurse fails to give a drug at the appropriate time, it may not lead to long-term effects; however, it could impact the patient’s length of stay and lead to unnecessary costs that could have been avoided.

If a health care professional uses the wrong technique to administer a medication, it is

considered an error. For example, if a drug is supposed to be given subcutaneously and is mistakenly given through an IV, it is a medication error. A transcription error, such as a pharmacist reading an order correctly but entering it wrong into the system, is another type of error. There is also dispensing error, which occurs when the individual tasked with filling the medication machine stocks it with the wrong medication or the wrong dosage of a medication. This, too, is considered a medication error.

The Institute of Medicine (IOM) estimates that on average, a hospital patient is subject to at least one medication error per day, with considerable variation in error rates across facilities.⁴ This results in 1.2 preventable ADEs per 100 hospital admissions. The increased cost required to treat these ADEs equals roughly \$4,600 per incident. Given these statistics, it doesn't take long for the money to start adding up. A hospital with 20,000 admissions, for example, could find itself saddled with over a million dollars in unnecessary costs associated with treating ADEs in a single year.

"This is not a new problem. It has always been around, but it has certainly started getting a lot more attention lately," notes John Cicero, RPh, CPh, MBA, director of Operations Improvement for IMA Consulting and co-author of a report published recently by IMA Consulting on adverse drug events. "The challenge is getting our hands around the actual numbers. Different people use different criteria for identifying ADEs, but no matter what numbers you use, there is a lot at stake — from a patient safety perspective and a financial perspective."

In 2002, the Joint Commission established its National Patient Safety Goals (NPSGs), which focus on patient safety within health care. In May 2005, the Joint Commission added several new goals and requirements, one of which required hospitals to accurately and completely reconcile medications across the continuum of care. In other words, a patient comes into a hospital, and a list is compiled of all the

medications the patient is taking upon admission. Any drugs given during the hospital stay are added to the list. The list is available upon discharge.

The Joint Commission is still striving for this goal, but many organizations have struggled to develop an effective and efficient process for complying, which begs the question — what can be done?

"It starts with education of the patient and improving the patient-provider relationship," says Cicero. "Patients, physicians, nurses, and pharmacists need to communicate better, and the only way we can do that is to get consumers to be more active in their health care. There are numerous interventions and education programs in place, but more needs to be done."

Strategies for Prevention

In its white paper, IMA Consulting offers several strategies for prevention at the hospital and pharmacy level. Without giving away the entire list, here are a few examples of the advice offered in the article:

- Evaluate the medication management process and behavioral elements that increase the potential for ADE characteristics.
- Confirm that technology planned for implementation (*e.g.*, computerized physician order entry, or CPOE) has the functionality to provide alerts for missing events, abnormal lab value alerts, drug interaction alerts, medication dosing, or monitoring prompts.
- Implement a drug use review program that assures appropriate and rational drug therapy.
- Target the most common and potentially fatal and life threatening preventable ADEs first.
- Require root cause analysis (RCA). Once an ADE occurs, the hospital must understand the reasons why. RCA offers a means by which to examine the contributing causes that led to the event.

"We, as health care professionals, need to do our part to make sure proper steps are being taken to ensure the safety of our patients and to reduce the risk of adverse drug events,"

notes Cicero. “It may not always be easy, but it is our responsibility.”

One of the greatest challenges is changing physician behavior when it comes to adopting new technology, such as CPOE, or using inappropriate abbreviations when writing orders, admits Cicero. “Physicians are overburdened. Many times they do not have time to learn new systems, or they feel that the way they have been doing it for the last 10 or 20 years has worked just fine. Steps must be taken to get physicians on board to help them see the value of new processes and requirements.”

It is also important to make sure technology works as intended. If alerts are not configured properly, typically they are turned off because too many alerts pop up every time a physician enters a drug, which does not do anyone any good. The ultimate solution involves moving to an integrated system that interfaces with all the departments involved in the patient’s care, says Cicero. “Initially, it may be costly and labor-intensive, but it’s where we need to focus as health care professionals,” he adds.

IMA Consulting is one of the largest privately held provider health care consulting firms in the United States. To learn more about IMA Consulting, go to www.ima-consulting.com. ■

Endnotes:

1. The National Coordinating Council for Medication Error Reporting and Prevention defines a medication error as “any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer...related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.”
2. National Institutes of Health. Improving Patient Safety. Bethesda, MD. 2001.
3. *Reducing and Preventing Adverse Drug Events to Decrease Hospital Costs*. Research in Action, Issue 1. AHRQ Publication Number 01-0020, March 2001. Agency for Healthcare Research and Quality, Rockville, MD, USA.
4. Institute of Medicine. Preventing Medication Errors. Washington DC: The National Academies Press, 2007.

Survey Shows Some Consumers Are Skipping Care, Switching Plans to Save Money

Roughly a year ago, the Deloitte Center for Health Solutions issued its “2008 Survey of Health Care Consumers.” The findings of the last survey emphasized the need for greater online connection to providers and medical records as well as customized insurance coverage and greater access to new innovation. The majority, however, also expressed anxiety and said they were not prepared for future health care costs. The future is now here, and this year’s survey findings paint a slightly different picture of where consumers stand when it comes to health care.

Approximately one in four consumers skipped care when they were sick or injured, according to the results of the “2009 Survey

of Health Care Consumers.” Two in five of those consumers have done so because they simply could not afford it, were not covered by insurance, or thought the costs were too high. In addition to skipping or delaying care, the high cost of health care is prompting many consumers to switch their physicians, prescriptions, or health plans to save money.

Of the 16 percent who switched physicians in the last year, one in four switched due to costs. Three in 10 switched medications in the past year; 38 percent switched to save money. Seventeen percent of enrollees changed health plans in the past year; 29 percent were seeking a lower-cost plan.

Other key findings from the survey include the following:

- Most (73 percent) of the respondents are confused about how the U.S. health care system works.
- Most (94 percent) believe that health care costs are a threat to their personal financial security (regardless of the insurance they have/don't have or their health status).
- Over half (52 percent) believe that 50 percent or more of the dollars spent on health care in the U.S. are wasted.
- Most believe that the system is performing poorly: 80 percent give it a grade of C (42 percent) or below (38 percent give it a D or F); only 20 percent give it an A or B.

The survey does reveal some gains since last year's survey. Fifty-three percent of insured consumers are satisfied with their plan this

year, an increase from 44 percent from last year's survey. Surprisingly, those that are most satisfied include Medicare (70 percent) and military health (67 percent) enrollees, compared with only 45 percent of individual policyholders that are satisfied with their health plans.

More than 4,000 U.S. consumers 18 and over were surveyed as part of Deloitte's second annual study examining health care consumers' attitudes, behaviors, and unmet needs conducted by the Deloitte Center for Health Solutions. The survey offers health care industry leaders and policymakers a timely look at how health care consumerism is evolving and provides a comprehensive perspective about how Americans approach their health, health care, and health insurance.

The full report is available at www.deloitte.com/us/2009consumersurvey. ■