Collaborative Case Management

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"Case management in hospital and health care systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The case management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of case management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient's right to self-determination."

Approved by ACMA membership, November 2002
BACKGROUND: THE NEED

While not new to case management, business acumen has become increasingly important for the financial health of a hospital. This increasing need requires greater knowledge, communication, and coordination between the clinical and business departments to allow for proactive problem solving. Every day offers a learning opportunity, and the lessons learned should be used to improve processes and further communication. Unfortunately, most case management programs are still centered on discharge planning and utilization management, and in many organizations this is a significant point of frustration for members of the executive suite. There is an expectation among some hospital administrators that case management should be a business program with a clinical perspective. As a result of this shift in strategy, many case management programs have transitioned from reporting to the Chief Medical Officer (CMO) or Chief Nursing Office (CNO) to the Chief Financial Officer (CFO). Every program in the hospital setting should be able to sustain itself and maintain a bottom line. Although there are a variety of business skills case management professionals should possess, this article will focus on three key areas: length of stay management, contract management, and clinical appeals management.

THE FOUNDATION

To begin the journey toward developing business skills, case managers need to have a basic knowledge of financial health care concepts. This includes understanding the profit and loss statement and how their activities contribute to the net income of the facility. Case managers should understand the contractual allowance process and how the failure to manage patient resources can increase cost, thus increasing the contractual allowance and reducing the net contribution margin. In addition, case managers need to understand all the financial components of the diagnosis-related group (DRG), to include the standard dollar amount (operating and capital costs), wage area index, other add-ons (disproportionate care, graduate medical education, indirect medical education, bad debt, etc.), case mix index and the transfer DRG impact.

As a result of this shift in strategy, many case management programs have transitioned from reporting to the Chief Medical Officer (CMO) or Chief Nursing Office (CNO) to the Chief Financial Officer (CFO). Every program in the hospital setting should be able to sustain itself and maintain a bottom line. Although there are a variety of business skills case management professionals should possess, this article will focus on three key areas: length of stay management, contract management, and clinical appeals management.

LEARNING OBJECTIVES

1. Identify opportunities to approach care from a business-oriented perspective
2. Understand the key case management business skills of length of stay management, contract management, and clinical appeals management
3. Apply business skills to daily practice

Business knowledge is becoming increasingly important for all departments in hospitals, and case management is no exception. Skill in contract management, clinical appeals management, and length of stay management can help case managers maintain their department’s bottom line and save the hospital from unnecessary spending in a time when every available dollar should be going toward quality, targeted patient care. This article will examine opportunities for case managers to approach care from a business-oriented perspective and provide insights into the fiscal implications of their practice that will help both their efficiency and their budgets.

The Business of Case Management

Reggie Allen, MBA, RN
Case Rate (MS-DRG) Reimbursement Does Not Change With Increases in Length of Stay

<table>
<thead>
<tr>
<th>Day</th>
<th>Charges</th>
<th>Daily Charges</th>
<th>Reimbursement/ Payment</th>
<th>Cost</th>
<th>Daily Cost</th>
<th>Profit/ (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>2,403.00</td>
<td>2,403.00</td>
<td>3,884.04</td>
<td>882.00</td>
<td>882.00</td>
<td>3,002.04</td>
</tr>
<tr>
<td>Day 2</td>
<td>4,762.00</td>
<td>2,359.00</td>
<td>3,884.04</td>
<td>1,753.00</td>
<td>870.00</td>
<td>2,132.04</td>
</tr>
<tr>
<td>Day 3</td>
<td>6,486.00</td>
<td>1,724.00</td>
<td>3,884.04</td>
<td>2,472.00</td>
<td>720.00</td>
<td>4,614.04</td>
</tr>
<tr>
<td>Day 4</td>
<td>8,125.00</td>
<td>1,639.00</td>
<td>3,884.04</td>
<td>3,176.00</td>
<td>704.00</td>
<td>4,840.04</td>
</tr>
<tr>
<td>Day 5</td>
<td>9,515.00</td>
<td>1,390.00</td>
<td>3,884.04</td>
<td>3,810.00</td>
<td>634.00</td>
<td>5,705.04</td>
</tr>
<tr>
<td>Day 6</td>
<td>9,990.00</td>
<td>475.00</td>
<td>3,884.04</td>
<td>3,922.00</td>
<td>112.00</td>
<td>(37.96)</td>
</tr>
</tbody>
</table>

EXPLANATION:
Case Rate (DRG) Payment - Case rates are determined by the diagnosis, and the payment is the same regardless of the length of stay. Since additional stay does not affect reimbursement and only increases cost, the impact of a reduction in the length of stay will increase probability for cases reimbursed on a case rate.

With (Medical) Per Diem Payment Reimbursement Increases With Increases in LOS

<table>
<thead>
<tr>
<th>Day</th>
<th>Charges</th>
<th>Daily Charges</th>
<th>Reimbursement/ Payment</th>
<th>Cost</th>
<th>Daily Cost</th>
<th>Profit/ (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>2,403.00</td>
<td>2,403.00</td>
<td>882.00</td>
<td>882.00</td>
<td>882.00</td>
<td>(22.00)</td>
</tr>
<tr>
<td>Day 2</td>
<td>4,762.00</td>
<td>2,359.00</td>
<td>1,753.00</td>
<td>870.00</td>
<td>870.00</td>
<td>(52.00)</td>
</tr>
<tr>
<td>Day 3</td>
<td>6,486.00</td>
<td>1,724.00</td>
<td>2,472.00</td>
<td>720.00</td>
<td>720.00</td>
<td>78.00</td>
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<tr>
<td>Day 4</td>
<td>8,125.00</td>
<td>1,639.00</td>
<td>3,176.00</td>
<td>704.00</td>
<td>704.00</td>
<td>224.00</td>
</tr>
<tr>
<td>Day 5</td>
<td>9,515.00</td>
<td>1,390.00</td>
<td>3,810.00</td>
<td>634.00</td>
<td>634.00</td>
<td>440.00</td>
</tr>
<tr>
<td>Day 6</td>
<td>9,990.00</td>
<td>475.00</td>
<td>3,922.00</td>
<td>112.00</td>
<td>112.00</td>
<td>1,178.00</td>
</tr>
</tbody>
</table>

EXPLANATION:
Medical Per Diem Payment - The payment is the same for each medical day regardless of the patient’s diagnosis. Costs per patient day are relatively equal, dropping off toward the end of the stay. Generally, profitability will increase toward the end of the stay, since reimbursement is the same each day but daily costs are decreasing gradually.
### EXPLANATION:

**Surgical Per Diem Payment** - Although surgical per diems are usually higher than medical per diem, the payment is the same for each surgical day regardless of the acuity of the patient. The costs per patient day are typically high on the rst day of the stay, with OR costs typically being incurred on day one. Generally, profitability will increase toward the end of the stay since reimbursement is the same each day but daily costs decrease significantly.

**Explanation: Percent of Charges Payment** - This is the most protable payment method since charges correlate with costs (utilization of resources). As the length of stay increases, reimbursement also increases.

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#### With (Surgical) Per Diem Payment

<table>
<thead>
<tr>
<th>Cumulative</th>
<th>Charges Daily Charges Reimbursement/ Payment</th>
<th>Cost Daily Cost Profit/ (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 1</strong></td>
<td>18,332.90 18,332.90 1,000.00 5,591.83 5,591.83 (4,491.83)</td>
<td></td>
</tr>
<tr>
<td><strong>Day 2</strong></td>
<td>21,218.90 2,886.00 2,200.00 7,186.67 1,520.84 (4,958.87)</td>
<td></td>
</tr>
<tr>
<td><strong>Day 3</strong></td>
<td>24,056.90 1,724.00 3,300.00 8,628.71 1,510.04 (5,518.77)</td>
<td></td>
</tr>
<tr>
<td><strong>Day 4</strong></td>
<td>27,345.90 3,289.00 4,400.00 10,270.05 1,614.04 (5,914.51)</td>
<td></td>
</tr>
<tr>
<td><strong>Day 5</strong></td>
<td>29,054.65 1,708.75 5,500.00 10,956.62 714.97 (5,441.64)</td>
<td></td>
</tr>
<tr>
<td><strong>Day 6</strong></td>
<td>29,422.15 367.50 6,600.00 11,103.80 118.38 (4,505.80)</td>
<td></td>
</tr>
</tbody>
</table>

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#### With Percent of Charges Payment

<table>
<thead>
<tr>
<th>Cumulative</th>
<th>Charges Daily Charges Reimbursement/ Payment</th>
<th>Cost Daily Cost Profit/ (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 1</strong></td>
<td>2,403.00 2,403.00 2,403.00 2,403.00 892.89 892.89 1,521.00</td>
<td></td>
</tr>
<tr>
<td><strong>Day 2</strong></td>
<td>4,762.00 2,359.00 4,762.00 1,752.00 1,752.00 3,010.00</td>
<td></td>
</tr>
<tr>
<td><strong>Day 3</strong></td>
<td>6,486.00 1,724.00 6,486.00 2,472.00 2,472.00 4,014.00</td>
<td></td>
</tr>
<tr>
<td><strong>Day 4</strong></td>
<td>8,125.00 1,639.00 8,125.00 3,176.00 3,176.00 5,449.00</td>
<td></td>
</tr>
<tr>
<td><strong>Day 5</strong></td>
<td>9,515.00 1,390.00 9,515.00 3,810.00 3,810.00 5,705.00</td>
<td></td>
</tr>
<tr>
<td><strong>Day 6</strong></td>
<td>9,990.00 475.00 9,990.00 3,922.00 3,922.00 6,068.00</td>
<td></td>
</tr>
</tbody>
</table>
LENGTH OF STAY MANAGEMENT

Although most organizations intensely focus on length of stay, the net revenue realized on the bottom line of most income statements can be minimal. However, managing length of stay is important, and an increase in operating income can be achieved.

When calculating the length of stay impact, facilities tend to use the average cost of the overall stay. As illustrated in the previous graphics, care is front-loaded, and the last-day costs are primarily medical/surgical nursing costs. For example, if the average cost is $653/day and the patient’s length of stay is two days over the geometric mean length of stay (GMLOS), the apparent cost savings would be $1,306. However, since the last days are usually less resource intense, the real cost savings is approximately $746, which is $560 lower than by calculating the cost using a simple average. Because nurses are not staffed one to one on a medical/surgical unit, a reduction in stay does not necessarily result in a staff reduction.

Frankly, the main two reasons to receive a positive operating income impact from decreasing the length of stay are:

- Capacity - If a facility can empty a bed, another patient can fill it
- Staff reduction - The days on a particular unit can be reduced to the degree that it would require less nursing staff, thus reducing nursing cost

In addition to managing length of stay, efforts must be focused on:

- Setting of care (avoiding unnecessary admissions, overutilization of the intensive care environment, diagnostic tests, and procedures which can be performed in an outpatient setting)
- Avoidable delays and days
- Care coordination/facilitation (unnecessary diagnostic tests and procedures, transitioning patients to a lower level of care)
- Outcomes of care (adverse events, infections, etc.)

The cost of all of these elements must be measured and managed with evidence-based solutions consistently employed to ensure highly reliable results, or there will be a false assumption of success.

The table below (See Figure A.) demonstrates how looking only at length of stay can generate a false sense of accomplishment. When looking only at length of stay, Dr. B. would be considered a star; however, his cost of providing care is higher than Dr. A. and Dr. C.

Dr. B.’s case was admitted late in the evening, and the patient was admitted to the ICU, which is a comfort zone for Dr. B. after hours. The patient did not meet the hospital’s ICU criteria level of care. The patient was placed on triple antibiotic therapy (expensive drugs) when the patient could have been treated with older-generation antibiotics. The patient also underwent several diagnostic tests unrelated to the reason for admission that could have been performed on an outpatient basis.

Dr. C.'s patient was a transfer DRG case that was discharged before the GLMOS. However, the patient had several diagnostic and laboratory tests that could have been performed on an outpatient basis. Dr. A.'s patient stayed 1.3 days longer, under Dr. A.'s recommendation for observation. Upon examination, the patient was treated with appropriate antibiotic therapy and only had one unnecessary diagnostic tests performed.

Figure A.

MS-DRG 178-Respiratory Infection & Inflammation W CC

<table>
<thead>
<tr>
<th></th>
<th>Dr. A</th>
<th>Dr. B</th>
<th>Dr. C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative Weight</td>
<td>1.4403</td>
<td>1.4403</td>
<td>1.4403</td>
</tr>
<tr>
<td>GMLOS</td>
<td>5.30</td>
<td>5.30</td>
<td>5.30</td>
</tr>
<tr>
<td>Actual LOS</td>
<td>6.60</td>
<td>5.3</td>
<td>4.04</td>
</tr>
<tr>
<td>LOS Variance</td>
<td>1.30</td>
<td>0.00</td>
<td>(1.26)</td>
</tr>
<tr>
<td>Charges</td>
<td>$16,734</td>
<td>$24,920</td>
<td>$15,505</td>
</tr>
<tr>
<td>Cost</td>
<td>$6,694</td>
<td>$9,968</td>
<td>$6,202</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$7,202</td>
<td>$7,202</td>
<td>$5,435</td>
</tr>
<tr>
<td>Margin</td>
<td>$508</td>
<td>($2,766)</td>
<td>($766)</td>
</tr>
</tbody>
</table>

| Standard Dollar Rate | $5,000.00 |
| Cost/Charge %        | 40% 40% 40% |
| Avg. Medical/Surgical Nursing Cost/Day | $225.00 |

**Dr. C case is a Transfer DRG thus there is a decrease in the reimbursement**

Another method used by financial leaders to manage length of stay is calculating excess days over the geometric mean length of stay (GMLOS). This method only looks at cases greater than and not below the GMLOS. Although this method makes good financial sense, operationalizing this calculation is challenging for medium, large, and tertiary facilities. The assumption is that all cases should be discharged at the GMLOS. It equates to a belief that all women will deliver their babies on the expected due date. Although a convenient assumption, it is neither practical nor realistic. If financial leaders are interested in using this metric as a proxy, one should consider using a net day opportunity as opposed to excess days over the GMLOS.

Case managers must be aware of the two methods used to calculate length of stay and why they are used. The first method is mostly used by finance for budgetary purposes. It involves dividing the number of patient days in the month by the number of discharges. This same formula is also used to calculate the length of stay by various payers. This number can be skewed if based on the number of days in the month – the more days in the month, the greater the opportunity for a lower length of stay. It does not provide a sense of how a particular patient population was managed.

The second method for length of stay calculation, which is more preferable for patient management, involves dividing the patient days of the actual patients discharged for the month by the actual patients discharged for the month. This provides an apples-to-apples comparison of the patient population. It allows for examining how well the patient population is managed. It can be
About CHRISTUS Health

Christus Health, an international, Catholic, faith-based, not-for-profit health system, is headquartered in Dallas and is comprised of almost 350 services and facilities, including more than 60 hospitals and long-term care facilities, 175 clinics and outpatient centers and dozens of other health ministries and ventures. CHRISTUS services can be found in 60 cities in six states in the U.S., six states in Mexico, and in Chile.

used to evaluate the effectiveness of the case manager’s care coordination/facilitation skills. When evaluating the data for trends and patterns, remove length of stay outlier patients (patients with length of stay twice the geometric mean).

At CHRISTUS Health, length of stay is displayed as a ratio. For example, the organization divides the average length of stay by the GMLOS. This methodology brings a context to length of stay. Length of stay by itself can be influenced by various types of DRGs for the month—those with high expected length of stays and cases with lower expected length stays. In addition, there are cases on both ends of the bell curve (one- to two-day stays and outliers). By using the length of stay ratio, one is comparing the actual length of stay against the expected or geometric length of stay. The geometric length of stay minimizes the impact of outliers and provides context for the average length of stay. If only the average length of stay is examined, one might falsely see a decline or incline, since averages only measure the central tendency of the entire population.

CONTRACT MANAGEMENT

Sara was a seasoned case manager who many thought had memorized the standard inpatient criteria. She was surprised when the Medical Director showed her a list of insurance denials for patient services, which she had thought were approved. Her first lesson in the business of health care payments came when she recalled the payer utilization coordinator saying, “This certification is no guarantee of payment.”

One of the fundamental lessons to understand is that insurance companies are in the finance business, not health care. Many serve their stockholders by collecting and holding onto money gained through premiums or administrative fees from self-insured companies. With these Employee Retirement Income Security Act (ERISA) programs, insurers maintain the administrative service organization contract by managing the employer’s money, as they do their own. This concept adds a layer of complexity when dealing with insurers, as it can encourage denial of claims and delayed payments.

One of the most neglected aspects of case management is knowledge of the contracts between the insurers and the hospital. Since contracts are usually negotiated by a non-clinical department, the details of these contracts are frequently filed, rather than shared with those responsible for operationalizing the contract. These contracts contain or reference specific requirements needed for payment, and case managers need to understand the variation and nuances of each contract. One glaring area of neglect occurs when a requirement for adherence to the insurer’s utilization management or quality management is included, but these programs are not included in the contract or supporting material. This requires the case management leaders to ask for these programs in writing and communicate these variances and special requirements to the case managers. This may require the clarification of terms and conditions with the provider representatives of the individual insurance plans.

Knowledge of each insurer’s utilization criteria forms the basis of preparing for denial and down-coding appeals. Case managers and the business office should work closely together to either ensure appropriate payments or prepare for clinical appeals based on the contract terms, conditions, and required utilization programs. Too often, insurers will try to pay at observation or lower level of care rates than the service and care actually required and provided. Case managers should not accept observation rates via telephone, for this is equivalent to renegotiating a contract. If the case manager followed the appropriate utilization review criteria set and the patient met the criteria, the case should be appealed.

Case managers should understand the concept of carve-outs and stop loss. Most managed care departments, after analysis of facility data, perform well in negotiating carve-outs and stop loss. For example, if the hospital has better rates for laparoscopic and arthroscopic procedures on an outpatient basis, case managers should utilize observation versus inpatient. Remember, the payer knows which status is more favorable, even though the care provided is the same. Care given can be transitioned for billing purposes from inpatient to outpatient even if the regular inpatient surgical suite or diagnostic equipment is used.

With increased pressure for public reporting of insurers’ quality indicators used
for health plan comparatives, contracts usually reflect requirements and targets for hospital quality indicators. Meeting these goals can have a major financial impact for the hospital above and beyond the contracted rates. Some contracts can withhold or retain payments if goals are not met. These quality targets require case management to work closely with nursing and other clinical departments to optimize these payments.

**CLINICAL APPEALS MANAGEMENT**

The management of clinical appeals requires a strong relationship between patient financial services and case management. Without this working relationship, case management may not recognize that the facility is receiving clinical denials, thereby impacting the hospital's cash flow. All clinical denials should be forwarded to case management to appeal or determine if the payer utilization criteria were met and if the case should be appealed or written off. In addition, inpatient cases that lack prior authorization should be reviewed, as some payers will allow clinical appeals if the case can be justified medically.

To ensure case managers can spend their time coordinating care and focus on concurrent patient flow activities, CHRISTUS Health has centralized all clinical appeals management. The objectives of this program include:

- Identifying and analyzing root causes of payments/denials, and redesigning current practices in response
- Identifying areas of revenue risk related to governmental/managed care audits and quantifying the potential impact
- Creating a system-wide approach to managing/eliminating governmental denials and increasing appeals success
- Implementing processes and solutions that are key to reducing risk of revenue loss in areas of high exposure

To meet these objectives, several mandates were required. There is now mandatory screening of patients for medical necessity regardless of hospital location prior to the physician's written order. This is accomplished through a comprehensive clinically-driven, pre-admission program via 24-hour pre-admission nurses. All cases that fail inpatient criteria are referred to a physician advisor. The hospital appeals all medical necessity denials if they met the medical necessity criteria in the hospital, and refuses to accept an observation rate. A strategy was also established for Part B billing through an established claim check.

The process involved establishing a tight communication between Patient Financial Services, Managed Care, and the Clinical Appeals Unit. The group meets every other week. The group began by flowcharting the current process for denials and created new flows by each discipline and each type of denial from start to finish. As much as possible, all notifications and results are sent to a centralized mailbox. The requests are logged into a centralized system, where all disciplines are notified and appeals can be tracked from start to finish. This allows the Clinical Appeals team to:

- Identify the denial as soon as possible
- Collect medical necessity information
- Connect with the payer to enter into a discussion to avoid an appeal and, if needed, generate the appeal letter
- Manage the payer appeal response process
- Track payments recouped and refunded
- Perform data management, metric reporting, and performance and financial improvement.

To close the loop, all letters written by the Clinical Appeals Nurses are sent to the facility to be signed by the attending physician prior to mailing. This allows case management to see the type of denials requiring an appeal. In addition, an analysis is performed on the reason for the denial, particular DRGs, procedures, and payers. Results are shared with the case management team at each location, the CFO, and other members of the senior management team. The facility is expected to make these reports part of the Utilization Management Committee meeting. Enhanced and new processes are put in place to mitigate or eliminate denials for the future.

**CONCLUSION**

As health care continues to evolve together with payment models, case management’s fiscal responsibilities and accountability will only increase. Developing key business skills and building a strong foundation of knowledge in the financial elements of health care will ensure case managers are able to adapt to a changing health care system. By seeking opportunities to gain experience and learn more about the concepts outlined above, case managers will understand the “business of case management,” and will be well positioned to respond to rapid developments in their professional practice.

**ABOUT THE AUTHOR**

Reggie Allen, MBA, RN, is the System Director of Clinical Operations at CHRISTUS Health in Irving, Texas.

THIS AUTHOR HAS NO FINANCIAL RELATIONSHIPS WITH COMMERCIAL INTERESTS TO DISCLOSE.
Engaging Physicians in Utilization Management

Kevin Smothers, MD

A partnership between case managers and physicians can help patients and hospital systems negotiate the tremendous changes occurring in the health care industry today. This article explores opportunities and techniques for helping case management staff engage physicians in the utilization management process as they work to correctly certify the patient’s admission status, reduce readmissions and increase patient, physician and staff satisfaction.

LEARNING OBJECTIVES
1. Describe at least one effective method to engage physicians in the care management process
2. Discuss recent changes in health care that affect physician practice and engagement with care management staff
3. Understand ways care management staff can partner with physicians to reduce readmissions

ADDRESSING THE ISSUE OF RISING HEALTHCARE COSTS

Hospitals across the country face the dual challenge of controlling the cost of patient care while continuing to maintain a high standard of patient care. With the recent focus in the medical billing landscape shifting from the fee-for-service payment model to the global payment model, greater pressure has been placed on health care providers to develop new strategies to meet this new objective of value over volume. While the need to control costs and still deliver quality care is not new, the strain that health care costs are putting on the national budget have created a new urgency to find solutions. As demonstrated in the chart below (see Figure A), in 2007 health care spending as a percent of the gross domestic product (GDP) was...
about 15%. By 2032 the Congressional Budget Office projects that percent will rise to almost 30%, which is unsustainable. Health care providers can count on increasing pressure from government leaders to find innovative ways to curtail costs without impacting patient treatment outcomes.

An often proposed solution to the current dilemma is to optimize health care delivery through the Triple Aim — the simultaneous pursuit of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.

In a press release issued on January 26, 2015, the Centers for Medicare and Medicaid Services (CMS) signaled a renewed effort to shift from volume-based to value-based purchasing. “When it comes to improving the way providers are paid, we want to reward value and care coordination – rather than volume and care duplication. In partnership with the private sector, the Department of Health and Human Services (HHS) is testing and expanding new health care payment models that can improve health care quality and reduce cost.” Case managers play a vital role in their organization’s efforts to meet these objectives.

**WHY PHYSICIAN ENGAGEMENT IS IMPORTANT IN UTILIZATION MANAGEMENT**

Physicians account for approximately 80% of all health care expenditures through doctor’s orders. While these orders are generally appropriate, there are times when other treatment options can meet the patient’s needs and be more cost effective. Case managers, through utilization management, can help physicians understand both the treatment and financial impacts of various levels of care. Physicians usually have no preference as to how their patient is bedded, just that their patient is receiving the best and most appropriate care possible.

**HEALTH CARE CHANGES THAT AFFECT PHYSICIAN’S PRACTICES**

The health care landscape has changed dramatically for physicians in recent years. Many entered the profession expecting a reasonable work-life balance, autonomy to run their practice as they saw fit, job security, respect within their community and higher than average income. Instead, the new reality is that physicians are held to greater accountability by various oversight agencies, have experienced higher workloads with lower income, must be more accessible to patients, are required to work with teams of health care professionals, evaluated through HCAHPS mandates and are exposed to a growing culture of blame and malpractice claims. As a result, physicians have become increasingly dissatisfied and resistant to adding tasks which they view as an unnecessary drain on their time.

**ESSENTIAL STEPS TO EFFECTIVELY ENGAGE PHYSICIANS IN THE PROCESS**

1. **EXPLAIN THE WHY**: How to Inspire Others (Physicians Included) to Take Action

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**Figure A.**

*Healthcare Spending as a Percent of GDP*

![Healthcare Spending as a Percent of GDP](Image)

- **All Other Health Care**
- **Medicaid**
- **Medicare**

*Source: Congressional Budget Office | Note: Amounts for Medicare are net of beneficiaries’ premiums. Amounts for Medicaid are federal spending only.*
In his 2009 TedX Talk, Simon Sinek said, “There are leaders and there are those who lead... those who lead inspire us... we follow those who lead because we want to.” Sinek suggests that leaders’ begin conversations from the inside of The Golden Circle and work their way out. Leaders start with the “why” – the purpose, the cause or the belief – and inspire action. Non-leaders start with “what” and “how,” delivering facts and figures that make rational sense, but people seldom make decisions based solely on rational considerations. Looking at a cross-section of the human brain, it is evident that the brain is laid out in a way that correlates perfectly with The Golden Circle. One’s newest brain, the neo-cortex, corresponds with the “what” level and is responsible for all rational and analytical thought and language. The middle two sections make up the limbic brain, the one responsible for all feelings – like trust and loyalty – behavior and decision-making, but has no capacity for language. When people communicate from the inside-out, they speak directly to the part of the brain that controls behavior and decision-making. People tend to choose one product, service or company over another because they feel they can trust them more. People naturally communicate from the outside-in, because it’s easier. One goes from the clearest thing – the “what” and “how” to the “fuzziest” thing – the “why.” If case managers want physicians to take them seriously, they must tell them why they are asking them to consider a particular utilization management or disposition plan. Just telling them what the plan is will not inspire physicians to make a change. Starting with the why requires passion and a strong commitment to what one believes is their role as a case manager.

2. NEGOTIATION: The Art of Influencing

Look at every interaction as an opportunity to influence the decision-making process. Ask physicians to comment on why they chose a particular course of action and what they want the action to achieve. Listen carefully for clues that indicate points of resistance to the plan so those issues can be addressed. Keep the focus of the conversation on how to improve the patient’s outcome and work to create a win-win situation. Avoid being judgmental and offer information and data without judgment. Despite one’s best efforts, tempers may flare. Tips for dealing with an angry physician include:

- Accepting that anger is often the first step in negotiation on the way to reaching an agreement – use it as a tool to understand why the physician is reluctant to change course
- Avoid an emotional response and acknowledge the anger
- Know when to disengage. Some physicians cross the line and create a dangerous and hostile environment. Care should always be taken to avoid putting oneself in jeopardy

3. EFFECTIVE COMMUNICATION

Effective communication is essential in order to create the necessary environment for a successful negotiation. One key strategy is to be present and fully engaged in the conversation through actively listening and making eye contact. Be curious rather than judgmental. Respect what the other person has to say. Be authentic and humble but “say what you mean.” Ensure reasoning is as transparent as possible. Offer praise whenever possible, apologize when a mistake is made and thank the other party for their time. Most of all ensure the conversation is purposeful. Be prepared with as much supporting documentation as needed to help explain why the course of action recommended will not diminish the patient’s quality of care and will achieve the desired results.

4. CONFLICT RESOLUTION

The art of conflict resolution involves taking people with different expectations over outcomes and bringing them to a place of agreement. This agreement can take the form of accommodation as the least desirable outcome, compromise as the middle ground or collaboration as the desired state. The key to successful conflict resolution often lies in understanding the motivations and challenges of the other party. Case managers need to understand that many doctors are not well versed in managing others, driving performance, building alignments, resolving conflict and collaborating as part of a team. They are small, independent business owners whose primary income source is their practice. Any task that pulls them away from their practice diminishes their productivity and wealth. It is the case manager’s job to help physicians understand that both are working toward the same goal – creating a treatment plan in the best interests of the patient.

WORKING WITH PHYSICIANS TO REDUCE AVOIDABLE VOLUME

Everyone involved in creating a treatment plan wants the same end result – the patients receiving appropriate care for his or her condition(s). The physician’s expertise lies in identifying the course of treatment the patient needs while the case manager’s expertise centers on knowing which health care options satisfy those needs. Working together, physician and case manager can develop a plan that offers the patient the best care at the lowest possible cost.

1. Emergency Department Case Management

Physicians who see a patient for the first time in the emergency department (ED) often admit them to the hospital for treatment. This is the venue with which they are most familiar and comfortable. It is the case manager’s responsibility to assess whether or not there are other, more cost efficient – though equally appropriate – options for treating the patient. A better alternative might be for the patient to be treated and released to the care of his or her primary care physician, placed
in observation, scheduled for home care, enter a skilled nursing facility or receive hospice care.

2. Inpatient Programs

There is a strong bias toward funneling inpatient program traffic through the emergency department before admitting them. Patients often remain in ED care until an appropriate hospital bed is available. The case manager should be part of the team of professionals making daily, multi-disciplinary rounds assessing patients and determining whether or not the hospital setting is the best option. Being part of the multi-disciplinary team also leads to timely discharges and better inpatient flow. A physician advisor in case management is a vital member of this team.

3. Coordinate Care Transition Programs

In helping transition patients from hospital to other forms of care, the case manager should assume the lead role. Successful transition planning reduces readmission rates. Consider developing a program based on proven models like the Coleman model, BOOST program or Project RED. The case manager should meet with the patient prior to discharge to ensure that suitable support is in place and continue the follow-up after the patient returns home. The patient or caregiver should also be given a specific follow-up with the primary care provider, a reconciled medication list, and instructions about what constitutes a red flag so they seek care if necessary to avoid a worsening condition.

4. Develop a Clinically Integrated Network (CIN)

Successful CINs – groups of physicians who practice under their own tax IDs but have formed a legal network of health care service providers so they may contract as a single entity – rely on strong case managers to ensure coordinated care. With disparate practices participating in the patient’s care, case managers utilize their clinical expertise, communication skills and organizational skills to ensure the CIN delivers value-based, integrated care that improves overall care to a population.

5. Stronger Partnership with Post-Acute Care

As post-acute care providers expand on-site services with the help of the INTERACT II (Interventions to Reduce Acute Care Transfers) program, case managers are a vital link in the communication and collaboration process required to coordinate care among a variety of agencies. One goal of the program is to implement strategies that efficiently use emergency room services that the post-acute care facility cannot provide without discharging them from the facility or admission/readmission to the hospital.

CONCLUSION

Case managers are leaders in their organizations; organizations that depend upon the case manager’s expertise to help spend its health care dollars wisely. Case managers play an important role in the continuum of treatment planning and need to work closely with physicians to ensure that the organization meets the twin mandates of providing quality care for the patient, and doing so at the lowest possible cost. Working with physicians can be challenging for the case manager and requires every ounce of communication, negotiation and conflict resolution skill that they possess. But in the end, case managers should feel empowered to work side-by-side with physicians as equals.

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REFERENCES


Strategic Innovations: Developing a Thriving and Sustainable Post-Acute Care Network

Marcia Colone, PhD, ACM

Increasing health care costs, the emergence of accountable care organizations (ACOs) and the rise of unfunded patients – coupled with new managed care populations’ demands strategies “outside the box.” Creating a post-acute care network that includes skilled nursing facilities (SNFs) and home health agencies is an innovative way to partner in the new health care model. This article will discuss how two existing partnerships created a well-defined accountability model of care, focused on quality outcomes and successfully reduced 30-day readmissions.

LEARNING OBJECTIVES
1. Understand the driving forces and mandate to build an innovative and sustainable post-acute care network
2. Discuss the design, challenges and successes of the Bed Reservation Program and Home Health Enhanced Program
3. Discuss the issues and complexities of developing a robust, post-acute care network

FACTORS BEHIND THE PUSH FOR POST-ACUTE CARE NETWORKS

With rapid escalation in the costs of health care delivery, hospitals especially are under increasing scrutiny by Congress to reduce the cost of patient care. In 2013, Hospitals accounted for approximately 80% of national post-acute care expenditures (See Figure A).

In a September 2008 report by Medpac to the Senate Finance Committee, the organization reported, “Providers need to increase care coordination and be jointly accountable for quality and resource use. There is a focus on procedures and services rather than on the beneficiary’s total needs. This becomes a particular problem for beneficiaries with several chronic conditions and for those transitions between care providers. Poorly coordinated care may result in patient confusion, overtreatment,
duplicative service use, higher spending and lower quality of care.”

Hospitalization cost control has become the primary focus of much of the legislation passed in the past decade. Below are seven initiatives having the greatest impact on the way in which hospitals currently do business.

- **ACOs (The Medicare Shared Savings Program incentive):** The Medicare Shared Savings Program (MSSP) incentivizes the creation of Accountable Care Organizations (ACOs). The Centers for Medicare and Medicaid Services (CMS) define ACOs as “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.”

- **Bundled Payment Initiative:** Using four innovative new payment models, this initiative requires organizations participating in this program to enter into payment arrangements that include financial and performance accountability measures for episodes of care.

- **Value-based Initiatives:** The Home Health Value-Based Purchasing model is designed to test whether a system of financial incentives and penalties can improve the outcomes in the delivery of home health services.

- **Readmission Penalties:** The 2010 Affordable Care Act (ACA) implemented a number of provisions with corresponding penalties that target readmissions. Section 3025 reduces payments to hospitals where data shows an excessive readmission rate. Section 399KK created the Patient Safety Organization program designed to help hospitals with high readmission rates improve their performance. The Community-based Care Transitions Program (CCTP) under section 3026 focuses on improving transitions from inpatient hospital settings to other appropriate care facilities.

- **RAC Audits:** The Recovery Audit program’s mission is to identify improper payments made by CMS to health care providers, as well as identifying process improvements that will reduce or eliminate future errors.

- **MSPB (Medicare Spending Per Beneficiary effective October 1, 2014):** In recent updates to the ACA, Congress placed new emphasis on valued-based care and decreasing the over-utilization of acute hospital care.

- **Improving Medicare Post-Acute Transformation Act of 2014:** This legislation creates a robust data collection and assessment program so that hospitals can be more accurately compared to each other.

The goal of each of these initiatives is to improve the quality of patient care, reduce costs and ultimately ensure a healthier population. These measures use financial incentives and disincentives/penalties to reduce readmission rates and the costs associated with chronic illness.

**CASE STUDY: UCLA HEALTH SYSTEM’S BED RESERVATION PROGRAM (BRP)**

**ABOUT UCLA HEALTH SYSTEM**

The UCLA Health System is comprised of Ronald Reagan Hospital – a Level-1 trauma center with 520 Beds, Santa Monica Hospital with 266 beds, Resnick Neuropsychiatric Hospital with 74 beds, Mattel Children’s Hospital with 100 beds and the UCLA Medical Group – a wide-reaching system of primary-care and specialty-care offices throughout the region.

**ESTABLISHING THE BRP**

Prior to creating the BRP in 2011, the Ronald Reagan and Santa Monica Hospitals had an average 95% occupancy rate, too few beds, increasing length of stay rates, increasing queuing in the emergency department and high patient acuity. The hospitals serve a significant homeless population and often experience complex discharges, most of which occurred after 4:00 P.M. when coordination of transfers are more difficult. UCLA needed a strong post-acute care network in order to accommodate its challenging population and increase patient flow efficiencies.

Not only did UCLA Health need more beds, it needed the right kind of beds. Following a comprehensive search, UCLA Health selected two Skilled Nursing Facilities (SNFs) to work with and leased a total of six beds. These facilities were selected based on their quality scores, UCLA Health’s current relationship with them and the facility’s capacity to manage the hospital’s patients. The resulting agreement established a daily bed lease rate to hold beds and was based on acuity to facilitate discharges for unfunded/underfunded patients. Negotiations ensured that funded care included board and care, medications and PT/O. The agreement also incorporated the concept of “Backfill” (meaning UCLA Health could fill unused beds with other patients already placed at the respective SNF) as a way to reduce daily bed lease costs. However, the agreement does not mean the SNFs will accept every patient and may deny transfer based on specific

![Figure A. 2013 National Health Care Expenditures](image-url)
criteria. Funding for the BRP began in 2012. By 2015, two additional SNF partners were added to increase the number of leased beds to 25.

In the early planning stages of the bed reservation program, UCLA Health realized success would depend upon effective and coordinated oversight of the process and communication with SNF staff. As a result, the organization created a position for two nurse practitioners whose responsibilities were to manage the patients in the program. The nurse practitioners see patients at the SNFs on a daily basis to assess them for clinical changes, write new orders and determine when and if a patient needs to return to the emergency department due to worsening symptoms.

OUTCOMES

The chart in Figure B. outlines the success of the program. UCLA Health’s BRP readmission rate was lower than those of its Ronald Reagan and Santa Monica Hospitals, its region and that of the average in California.

LESSONS LEARNED

When UCLA Health established the BRP, it started small hoping to find a viable way to lower costs and reduce readmissions without sacrificing the quality of patient care. As with any new program, trial and error is part of the process, but the following were keys to the success the organization has experienced to date:

- Align with facilities that share common goals for patient care and invest in relationships over the long term
- Build a training program for SNF staff, keep the lines of communication open and visit sites quarterly
- Nurse Practitioners assigned to the BRP patients are essential to ensure clinical quality and continuity of care
- Develop a process to review metrics, address issues, (referral denials, etc.) and readmissions
- Constantly review referral process/handoffs, especially during non-business hours
- Daily identification of BRP patients
- Claims reconciliation system
- Standard reporting system

While UCLA Health learned much in the process of developing the initial BRP, there are still a number of opportunities for improvement. Here are the primary issues the team is addressing:

- Communication between external and internal providers
  - To/from PMD
  - Inpatient teams
- Lack of accountability infrastructure
- Understanding the reasons behind a high number of patient refusals of service when home health arrives
- Enumerating the differences in referral processes from the inpatient and outpatient setting, and developing compatible processes
- Absence of electronic home health orders so that all parties involved in the patient’s care have immediate access to the same information

MOVING BEYOND SNFS

In addition to creating a process to ensure successful transitions to SNF care, the hospital also needed to comply with mandates to increase effective home health transitions. In November 2013, UCLA Health established the Home Health Enhanced Program. The goal was to develop a strategy to ensure the delivery of reliable and consistent home health services across the continuum of UCLA Health (inpatient and ambulatory) and identify actionable steps for quality improvement.

As outlined in the Figure C., UCLA Health is currently testing procedures that it believes will greatly improve quality outcomes. A minimum of seven touchpoints have been identified. These touchpoints must take place within the first two weeks of discharge to create a successful transition.

UCLA Health’s team identified the following measurements to analyze the efficacy of the initiative:

- 30-day all-cause readmissions
- Percent of patients who refused home health services
- Percent of patients whom staff were
unable to locate post-discharge

- Percent of patients who had a delayed start to care; defined as care that should have started per the physician orders but was delayed for some reason

While the results have been inconclusive in finding an impact on readmission rates, the touchpoints have proven to have tremendous benefits for patients, as well as the relationships UCLA Health has developed with home health agencies. Benefits include the sharing of data across continuums, standardization of practices and the creation of the Home Health Council. The hospital’s planned next step is to tailor interventions to specific populations and initiate another round of data analysis.

Lessons learned from the Home Health Enhanced Program:

- Invest in the relationships over the long term
- Establish expectations for quality
- Develop a process to review metrics, address issues (denials, refusals, etc.) and readmissions
- Establish a process to review real-time failures
- Establish a claim reconciliation system for funded patients
- Constantly improve referral processes/ handoffs, especially for referrals that occur during non-business hours

THE FUTURE OF POST-ACUTE CARE NETWORKS

Given the governmental mandates to reduce readmissions, improve the quality of patient care and reduce treatment costs, UCLA Health believes care coordination must focus on transition planning versus discharge planning. A number of issues need to be addressed to make this happen:

- Develop a transition mentality
  - Cross-continuum care coordination
  - Admission-triggered discharge planning
  - Frontloaded post-acute care referral pathways and resources
  - Risk stratified transition plans
- Embrace admission-triggered discharge planning
  - Within 24 hours of admission, the patient is comprehensively assessed to determine clinical and psychosocial needs
  - Risk Stratification of patients (i.e. LACE)
  - Family/partner/caregiver is also assessed
  - Address emotional/readiness components of patient/family related to needs
- Frontload post-acute care referral pathways
  - Electronic predictive software required to make referrals and generate responses within preset timeframes
  - Care coordination team must have access to appropriate post-acute care resources and match resource to patient’s clinical needs, insurance, quality scores and patient/family preference
- Initiate value-added innovations
  - Risk stratification in acute and post-acute connectivity
  - Expansion of home health services: home-based transition program
  - Predictive Software in SNFs: (i.e. Interactive) and train nurses in procedures when red flags arise
  - Extensive training in SNFs to increase capacity to accept higher acuity

CONCLUSION

In the post-Affordable Care Act era the directives are clear. Hospitals will be the treatment option of last resort followed closely by SNFs as the industry works to increase its capacity to manage the post-acute care of medical and surgical patients and decrease patients’ length of stay rates. Home health care services will expand as patients are directed to lower levels of care, including home care, assisted living, private duty nursing, remote monitoring and other services, which help patients receive care at home. The reality is now. Incentives are, and will continue to be, aligned to discourage hospital care. Emergency rooms will transfer patients directly to SNF care rather than hospital inpatient services. Expect to see an increase in telemonitoring options, frequent home visits and, with the help of case managers, an expansion of home health to ambulatory patients. For UCLA Health, the Bed Reservation Program has proven to be a valuable asset in its arsenal of post-acute care treatment options, but the organization continues to examine innovative opportunities to provide the best possible care to its patients.

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Mood Disorders Affect Length of Stay, Complication Risk in Pediatric Pneumonia

At Pediatric Hospital Medicine 2015

SAN ANTONIO – Pediatric pneumonia patients were found to have a significantly longer length of hospital stay and a higher rate of complications when they also had mood or anxiety disorders, in a study of nearly 35,000 hospitalizations.

Children with chronic complex illnesses have been shown to have longer hospital stays when they also have mood or anxiety disorders; less is known, however, about how these disorders affect children hospitalized for more common conditions, according to Dr. Stephanie Doupnik.

At the Pediatric Hospital Medicine 2015 meeting, Dr. Doupnik of the Children’s Hospital of Philadelphia presented research aimed at understanding the effect of mood and anxiety disorders on complications and length of stay in pediatric pneumonia patients.

Dr. Doupnik and her colleagues used the 2012 Kids’ Inpatient Database to identify 34,795 hospitalizations nationwide for pneumonia among children and adolescents aged 5-20. Of those 13 and older (28% of the cohort), a mood or anxiety diagnosis was recorded at discharge for 9.3%, and in school-age children, for 1.1%. Those diagnoses included major depressive disorder, generalized anxiety disorder, and posttraumatic stress disorder. (Some studies have looked at attention-deficit/hyperactivity disorder and those outcomes, but children with ADHD were not part of the current study.)

Pneumonia complications such as respiratory failure, sepsis, and suppuration were seen in 10.7% of the younger children, and 18.7% of those 13 and older.

The researchers found that the odds of experiencing any complication were significantly higher in children with mood and anxiety disorders, regardless of age. The older children saw an odds ratio of 1.8 (95% confidence interval, 1.3-2.0) and the younger children, 1.6 (95% CI, 1.3-2.0) (P less than 0.001 for both). Length of stay also was prolonged among the patients with mood and anxiety disorders by 11% in the younger children and by 13% in the adolescents and young adults.

Dr. Doupnik and her colleagues suspected that an increased rate of complications might explain the differences in length of stay. But they found, in analyzing records for adolescents without complications, that length of stay was still longer (6.8 vs. 5.4 days) for those with mood disorders. Among adolescents with complications, length of stay was still slightly higher in the mood disorder group (4.4 vs. 3.7 days). These differences were statistically significant.

No statistically significant interaction was seen between complications and a mood or anxiety disorder diagnosis at discharge. “If complications were accounting for that prolonged length of stay, we would have expected differences between those groups,” Dr. Doupnik said at the meeting, sponsored by the Society of Hospital Medicine, the American Academy of Pediatrics, the AAP Section on Hospital Medicine, and the Academic Pediatric Association.

“It appears that complications do not account for the increase in length of stay among patients with mood and anxiety disorders,” she said.

Dr. Doupnik noted as a limitation of her study a lack of granularity in the data “that would allow us to identify other factors that might be contributing to this association.”

Dr. Doupnik said in an interview that she came to the study having noted that many patients with mental health disorders had more trouble during their hospitalizations. Although this phenomenon has been studied among children with chronic complex illnesses, such as sickle cell disease, diabetes, and cystic fibrosis, “there was a gap in the literature around general pediatric conditions” such as pneumonia, she said.

One potential reason for the association between mental health disorders and length of stay might be delays in presentation to the hospital, Dr. Doupnik said. Also, “there’s the possibility that patients interact differently with staff and providers in the hospital. If they can’t cope as well with the things that need to happen during a hospitalization, that could prolong their length of stay or increase risk of complications.”

Because absolute length of stay differences seen in the study were not very great, it was unlikely that the mood and anxiety disorders developed in the hospital, she noted, adding that the discharge diagnoses likely reflected preexisting diagnoses.

Dr. Doupnik is now planning a prospective cohort study among children admitted to her institution for pneumonia, hoping to help clarify some of the lingering questions surrounding the associations seen in this study.

She disclosed no outside funding or conflicts of interest.

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