accountable aging CARE MANAGEMENT®

Making Sense Out of Eldercare Options
Managing the Eldercare Experience®

September 2013

In this issue: Patient Safety, Medicare Open Enrollment for 2014, AACM News

AACM and You:
Finding the Right Plan

Open Season for Medicare beneficiaries to review their plans for Medicare Advantage or Part D begins October 15th. Each year during this period, we encourage our clients and their family members to review their current Part D and supplemental coverage. Not only do plans change on an annual basis, but an individual's situation also continues to evolve. It is important to compare current coverage to other available plans.

Take advantage of this open season by alerting friends, family members and clients to do a comprehensive review of their coverage. Where possible, use a third party service such as the Medicare website or an independent insurance agent who is knowledgeable about these products. Of course, AACM is available to assist you as well.

At Accountable Aging, we see the benefit of having plans that support a person's specific medication needs, finances and potential health situations. If you need assistance in reviewing your plan or have clients/family members who need this assistance, our firm has a service offering designed to do just that. We charge a flat fee for this service. The charge is $150 for an individual and $250 for a couple. We are almost always able to find better financial options with fewer restrictions. The person who needs the review can live outside of our service areas.

Patient Safety

The term "patient safety" is self-evident. However, what you may not realize is that "patient safety" also refers to a specific discipline both in Academia and within the healthcare continuum. What follows is a summary of AACM's research into the domain followed by subjective commentary.

Mick and Mary have been regular presenters in recent years at "Aging in America" - the national conference of the American Society on Aging (ASA). This year was no exception. They made two presentations at the conference, which was held this past March in Chicago.

The subject of this article is one of those presentations - "Patient Safety Science in the Hands of Geriatric Care Managers." Given the audience, the ASA presentation focused on the Care Manager's role in patient safety. Accountable Aging Care Management (AACM) believes, however, that the topic ought to be immensely important to a broad range of audiences, including non-healthcare professionals of all kinds and family/friends of patients, regardless of their age. In general, everyone.

AACM's interest in patient safety stems from its long-held passion for some of its elements, namely, care transitions and medication management. Each of these topics has been the subject of prior ASA presentations. We continue to deliver these presentations to healthcare professionals for continuing education and to general audiences. Furthermore, each of these elements was addressed in one form or another in the recent healthcare reform act of 2010 - the Patient Protection and Affordable Care Act, sometimes referred to as Obamacare.

As a concept in healthcare delivery, patient safety has its roots in a late 1980s study dubbed the "Harvard Medical Practice Study." This study is the source of the Institute of Medicine's (IOM) estimate that medical errors are the source of 44,000 to 98,000 deaths annually. To put these numbers in perspective, they are equivalent to a jumbo passenger jet crashing every day – a jumbo jet unit!

What really accelerated the patient safety movement was the publication of the IOM's *To Err Is Human: Building a Safer Health Care System*. Amongst other things, this publication finally generated public and media attention on medical errors.

(continued)

Perspectives about patient safety have changed over the years. At the start of the movement, the focus was on measuring the incidence of errors and then trying to prevent or at least reduce that rate. The focus has shifted to highlight preventable adverse events, which are sometimes discussed simply in terms of preventing harm. So, less time is spent finding and dealing with errors after they have occurred.

To understand the issues surrounding patient safety, you need to understand that the problems are not the result of "bad apples." While there may be a few "bad apples," the vast majority of preventable adverse events are caused by committed, hardworking health care professionals who do not want to harm patients. Their problem is that they are working in dysfunctional systems. That is, the problems facing safety for patients are much more about management and systems than they are about incompetent health care professionals.

Before proceeding, let's define patient safety. Patient safety is the freedom from accidental or preventable injuries produced by medical care. You can see from this definition why hospitals and perhaps some rehabilitation facilities have virtually monopolized concern for the issues surrounding patient safety. Yet, in AACM's opinion, many health care providers are not prepared to, or simply cannot deliver the "uniquely interdisciplinary effort" needed to address patient safety issues that Robert M. Wachter, MD, describes in his book Understanding Patient Safety (2nd ed., pg. xiv).

AACM agrees with Dr. Wachter's assertion that many diverse areas of expertise must be brought to bear on the issue of patient safety. However, we disagree with his use of the word "interdisciplinary." This word suggests a reaffirmation of the traditionally-held "silos" of professional health care expertise which are actually the source of many of the communication problems inherent in patient safety today. AACM thinks that the word "multi-disciplinary" is much more inclusive and descriptive of the intersection of professional expertise and competencies. Not all patient safety issues have to deal with medical procedures or technology. Remember, patient safety is as much a management and systems issue as anything else.

The opinion that not every aspect of patient safety deals with "medical" issues opens the door to the possibility that non-healthcare professionals, and even family and friends, can have a role in protecting the well-being of someone who has entered into the healthcare environment.

In today's healthcare environment, patient safety is more of a function of culture than most anything else. Historically, and until *To Err Is Human,* the dominant culture was that quality improvement exists with a large authority gradient from the top down, and everyone should wait until an incident happens. The culture is shifting to one where everyone is involved with a commitment to patient safety and all that entails while the authority gradient in minimized. In a patient safety culture, all involved are responsible for and committed to noting errors/issues and requesting change.

The Agency for Healthcare Research and Quality (AHRQ) - an agency in the Department of Health and Human Services - has developed tools with which to measure patient safety culture. In addition, there are "Safety Attitudes Questionnaires" similar to AHRQ's surveys for the measurement of same. These tools are oriented towards healthcare organizations. Still, knowing about them and asking whether a healthcare organization has used the tool or tools will increase awareness about patient safety. Any family member or friend can ask this question.

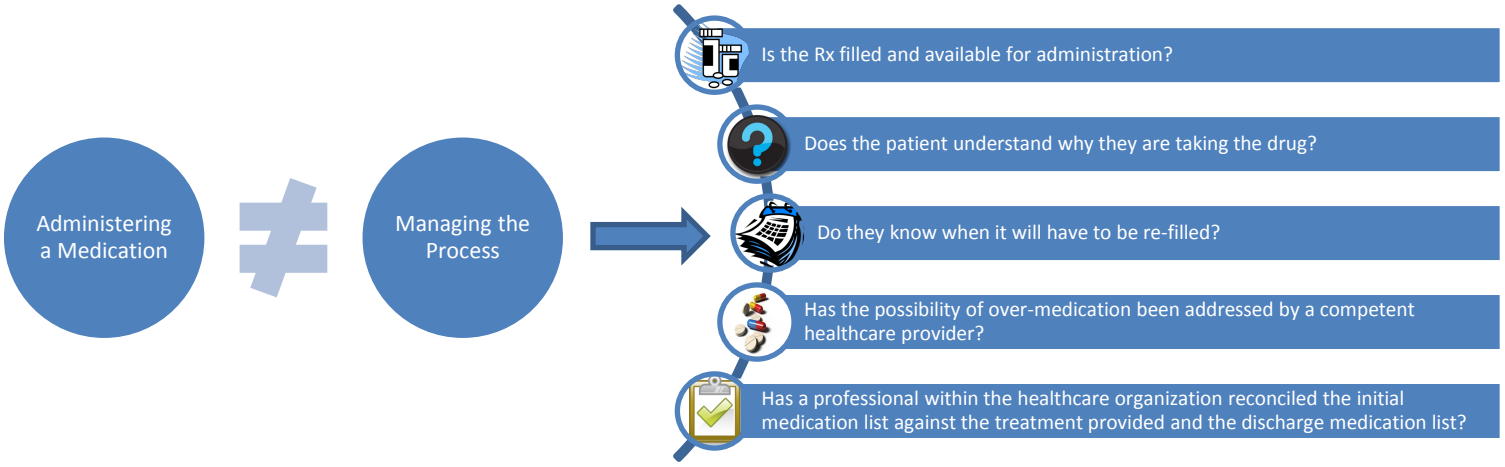
Other areas where non-healthcare professionals and family/friends can contribute include care transitions, communication, awareness of the patient safety culture, and medication management.

Useful Resources:

- Understanding Patient Safety by Robert M. Wachter
- American Society of Professionals in Patient Safety (ASPPS)
- ASPPS e-Newsletter (free to subscribe)
- Patient Safety & Quality Healthcare magazine
- The Agency for Healthcare Research and Quality
- National Quality Forum
- Institute for Healthcare Improvement

Care transitions are defined by a change in level of care. We typically think of them as going from a higher level of care, such as a hospital, to a lower level of care, such as a rehabilitation facility or home health. However, going from home to a hospital's Emergency Department is a care transition as well. While healthcare professionals have developed protocols and tools to address care transitions, such as those codified by the National Transition of Care Coalition (NTOCC), one does not need to be a healthcare professional to understand discharge orders or communicate with the patient's primary care physician regarding the healthcare episode. Non-clinicians playing a role in patient safety should insist on communications that are understandable by all and free of jargon.

Many folks are inclined to abdicate medication management to clinicians. We suggest that you consider an alternative. At the heart of what we suggest is drawing a distinction between administering a medication - which only licensed healthcare professionals can do legally in the State of Texas - and managing the process.



None of these questions requires an answer by a healthcare provider, but rather by someone who is aware of patient safety issues and is committed to providing the management of the process with an eye towards the safety and well-being of the patient.

Regardless of intelligence or background, non-healthcare professionals, family members and friends can all communicate. With communication comes the possibility of teamwork, and teamwork is critical to success in patient safety. Offering to assist with workload items, such as communications with primary care physicians, or showing partnership in commitment goes a long way towards flushing out the issues inherent in patient safety. Again, it is not necessarily about knowledge, but rather attitude and the concomitant culture of everybody involved, particularly at the service delivery levels of the hierarchy.

To be clear, we are not suggesting that the healthcare domain should hand over the reins when it comes to patient safety – quite the opposite. There are many elements of patient safety that healthcare organizations are singularly positioned to address. However, not *all* patient safety issues occur in a healthcare organization. For this reason, we believe that the best possible outcome can only be made possible by collaboration among various individuals – medical professionals, non-medical professionals, family/friends, etc. - who share a common interest in the health and well-being of any given patient.

Accountable Partners®

We are in the process of updating and expanding the Accountable Partners® program. Accountable Partners® is a program that enables us to better serve our clients by providing up-to-date and in-depth information on the agencies, service providers and facilities available in our markets. While we continue to research all providers we recommend, this program enables us to make a broader sweep of available service providers in Central Texas and gather important information for clients. In addition, AACM is now asking if nursing facilities, rehabilitation facilities, assisted living facilities and home health agencies have a Patient Safety Officer supported by either a Patient Safety Culture Survey or Safety Attitude Questionnaire.

occurs every year from ***October 15 to December 7***. This is the annual opportunity for Medicare subscribers to make changes to their coverage. An individual may choose to join a Medicare Advantage plan for the first time or switch to a new plan, or she may choose to return to original Medicare with or without a stand-alone prescription drug plan (PDP). If you enroll in a plan during this period, your coverage will begin on January 1, 2014. It is important to remember that, in most cases, ***this is the only time you can pick a new Medicare Part D or Medicare Advantage plan.***

The Medicare Advantage Disenrollment Period (MADP) runs from January 1 to February 14 each year. The purpose of the MADP is to provide an opportunity for individuals who are dissatisfied with their Medicare Advantage plan to disenroll from that plan and join Original Medicare. Please note that an individual CANNOT choose a new Medicare Advantage or Part D plan during this time period, under normal circumstances.

On October 1, 2013, the first of the health insurance exchanges mandated by the Affordable Care Act will begin open enrollment for uninsured/underinsured Americans. Even though this period happens to coincide with the Fall Open Enrollment period for Medicare, individuals with Medicare should not use this open enrollment to make any changes to their health insurance. ***The exchanges are not intended for those with Medicare.*** To review and change policies, these individuals should continue to use the Fall Open Enrollment period - which has not changed.

Even if you are satisfied with your current coverage, it is important to review your policy for any pending changes. Every plan provides an Annual Notice of Change (ANOC) that explains any changes to pharmacy/provider networks, any changes to the plan structure and associated costs, and any changes to the cost and covered drugs in the plan's formulary. You can use the Plan Finder utility on the Medicare website to explore Part D plans available in your area. Of course, AACM is available to help you assess your options and select the optimal plan for your situation (our service offering is outlined on pg 1). Small differences among PDPs can yield either massive expenses or massive savings. Last open enrollment period, AACM helped a client to achieve a savings of about $3,000 annually. We were able to identify one medication that was not covered under her current plan but was included in a different one. *The inclusion of that single medication netted our client a cost savings of about $300/month.*

AACM Supports Team No MáS

Accountable Aging Care Management again was a co-sponsor of Team "No MáS," which is a group of friends who love to ride and want to make a difference for folks living with Multiple Sclerosis. The team goals are pretty simple: Make a significant impact for people living with MS and have fun doing it. For this year's ride, the team raised over $67,000, once again surpassing the previous year's yield. For 2013, all teams have combined to raise nearly $18 million so far.

Mick Koffend was one of the Team No MáS cyclists who participated in the 175-mile ride from Houston to Austin the weekend of April 20 & 21; unlike in 2012, he did not crash.

If you'd like to learn more about multiple sclerosis and the challenges facing those who have the disease, we encourage you to check out our team videos for the ride in 2011 and for the ride in 2012. Each of these videos spotlights a different team member who is currently living with MS. The videos are also a good source of information if you've ever been curious about what participating in one of these events is like. Both of the videos were produced by yet another teammate - the very talented Kurt Neale.

New Faces

Since the publication of our last full-length newsletter, AACM has made two major additions to the team. Some of you may have already had the pleasure of working with these two, and we are excited to *officially* announce the additions of Abbie Theobald and Patty Hamilton!

Abbie Theobald has taken over the role of primary Care Manager for the Dallas-Fort Worth area. Abbie has a Bachelor's in Applied Gerontology with a minor in Management. She later achieved a Master's of Science in Gerontology with an emphasis on senior housing and long-term care services from the University of North Texas. Her passion for eldercare has placed her in numerous settings, including hospice, assisted living, memory care and personal care administration. Like most of our team, she also has some personal caregiving experience. She has participated in multiple international aging studies, including a graduate project in the state of Jalisco, Mexico and a vocational study sponsored by the Rotary Club throughout the state of Goias, Brazil. We are happy to have her on the team and expect great things.

Patty Hamilton has joined our team as a Benefits Specialist. She recently retired from a career of thirty-five years with the Social Security Administration where she was a Supplemental Security Income (SSI) technical specialist. She is readily available to use her knowledge to assist clients with issues related to Supplemental Security Income, Social Security, Medicare and Medicaid benefits. In addition, she is able to assist in providing referrals for other benefits for which clients may be eligible. Patty's relationship as liaison with other local, state and federal agencies during her career enables her to serve as a valuable resource to our clients as well as to other members of the Accountable Aging Care Management team. Her presence reflects our commitment to finding new ways to provide value to our clients. We are excited to add her to the team.

Because referrals are the lifeblood of our business, the best way you can thank us, as a satisfied client, is by referring a friend, neighbor or colleague to us! We appreciate all your referrals.

Accountable Aging Care Management Team

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Spencer Brown, MSG, LNFA, CMC, Care Manager
Mary Cooper, BS**,** RN**,** Care Manager
Lessa Ennis, Office Manager
Shannon Gray, Marketing Coordinator
Patty Hamilton, Benefits Specialist
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John Lloyd, Client Coordinator
Heidi Shanklin-Spock, LMSW, C-ASWCM, Care Manager
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Visit us online: www.accountableaging.com

Accountable Aging Care Management is an eldercare consulting and care management firm.

Accountable Aging is a single source for older adults and their families to attain knowledge, resources and on-going assistance with the challenges related to aging or caring for an elder loved one. We serve older adults in Austin, Dallas, San Antonio and the surrounding areas.

With this newsletter, our aim is to provide a trusted conduit for eldercare information and resources and to highlight the services we offer that meet the needs of older adults and their families.

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