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Become culturally competent to improve patient care

If ignored, beliefs and family dynamics can impede recovery

A few years ago, **Claire Creech**, CRC, CCM, CDMS, CLCP, was managing the brain injury cases of an older Korean man, a Japanese man, and three male Hispanic patients — all at the same time. Having a multicultural caseload made Creech acutely aware of the changing demographics of the patients served at the Shepherd Center in Atlanta, where she was case manager for the brain injury service.

"They were from three very diverse cultures, and there were a lot of differences in the responses from their families. It created a lot of conflict and miscommunication," says Creech, who now is senior case manager for the Center for Diagnostics and Evaluation at Shepherd Center.

As a case manager, you are likely to encounter an increasing number of patients from different cultures, all of whom have varying beliefs and family dynamics, yet they all need someone to understand them and where they are coming from in order to facilitate their recovery.

Our country's demographics are undergoing radical changes. The U.S. Bureau of the Census estimates that by 2050 nearly half of U.S. residents will be from a different culture.

"In case management, no one is immune any longer. We all need to understand how to deliver culturally competent care," says **Kathleen Moreo**, RN, Cm, BSN, BPSHSA, CCM, CDMS, CEAC, co-founder of Professional Resources in Management Education, an international health care education and case management company.

Both Washington, DC-based URAC, a leader in the accreditation of managed care and specialty organizations, and the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, have mandates that require providers to prove they deliver culturally competent care, Moreo points out. "Our health care industry has recognized the necessity for this," she notes.

Because of the world's changing demographics, whether your case management clients have successful outcomes will depend on your

ability to provide services in a culturally relevant and culturally responsive manner, asserts **Josepha Campinha-Bacote**, PhD, RN, CS, CNS, CTN, FAAN, president of Transcultural C.A.R.E. Associates in Cincinnati.

"Changing demographics, along with long-standing disparities in the health status of people from diverse ethnic backgrounds, have challenged case managers to seriously consider cultural competence as a priority," Campinha-Bacote says.

As a case manager, you are liable to encounter problems with cultural issues from all sides, Creech points out. "The doctor, the family, and the therapists are all frustrated, and it's up to you to intervene," she says. This means that case managers should develop an understanding of other cultures and know how to deal with cultural values and beliefs that conflict with Western medicine.

Sometimes, understanding cultural issues and being able to communicate with people of other cultures literally can be a matter of life and death, such as when it comes to patients' use of alternative or folk remedies that might have serious negative interactions with prescribed drugs. "Case management is very enmeshed in medication side effects and compliance," Moreo says. "This is one of the issues we are faced with all the time."

It's also important to understand that cultural sensitivity is necessary when dealing with all patients, regardless of their nationality or ethnic origin. "That blonde, blue-eyed person from Appalachia has family traditions and beliefs that are far more complex than those of my Cape Verdian culture," Campinha-Bacote says.

Because Moreo has been involved in health care and education on a national and international level, she has been sensitive to cultural competency for a long time.

"It is important for us to recognize that when we talk about barriers to care, many times the problem is not with patients but with the providers. We have barriers because the provider and the patient have different languages, different beliefs, and different value systems. Sometimes we are the ones who cause the problem because we are unable to cross over that bridge," Moreo says.

To help you understand how difficult it may be for people from other cultures to articulate their beliefs, consider how reluctant a relative of yours might be to tell health care providers about his or her use of herbs, acupuncture, or other forms of alternative medicine. "We can understand from a cultural competency standpoint how much more uncomfortable people of other cultures and races must be," Moreo says.

Keep in mind that patients with no cultural barriers still may be labeled noncompliant for a number of reasons.

"If you add culture into the mix, it compounds the problems that inevitably occur in a convoluted health system. Our entire health care system has an effect on how the patient recovers and complies with treatment," Moreo points out. "There are enough barriers without cultural issues."

Moreo, a past president of the Little Rock, AR-based Case Management Society of America, is co-chairing the review of the organization's standards of practice. Cultural competency and sociocultural barriers to health care are among the areas slated for review. ■

Cultural diversity 101: Avoid stereotyping

Here's a model to make you culturally competent

As soon as you make a statement about a particular culture, you're going to find that many more people from that culture don't fit into that particular stereotype, says **Josepha Campinha-Bacote**, PhD, RN, CS, CNS, CTN, FAAN.

Campinha-Bacote, president of Transcultural C.A.R.E. Associates in Cincinnati, has developed a model framework to guide health care professionals in providing culturally and linguistically appropriate services.

(Cont. on p. 148)

COMING IN FUTURE MONTHS

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- Bridging the gap between physicians and case managers

Twelve steps to cultural competency

1. Find out about the family's internal dynamics, as family members' beliefs, and what those beliefs mean to them and to the patient.

For instance, ask what kind of significant illnesses the family has faced in the past and how the family handled them, advises **Claire Creech**, CRC, CCM, CDMS, CLCP, senior case manager for the Center for Diagnostics and Evaluation at Shepherd Center.

Asking what happened when Uncle Joe had cancer can help you determine how family dynamics operate and what resources the family has to call on during crises.

"What is more important than anything else is for case managers to show a willingness to learn," Creech says. "Let the family know that you respect their culture and want to understand it and incorporate it into the discharge plan."

2. Look at the length of time the family has been in the United States. This can give you an idea of how much the family has assimilated into American culture, and how much of the old culture remains.

3. Don't make an assumption based solely on the country of origin. Cultures and beliefs vary according to regional and demographic differences. "I live in Atlanta, a large city, and there is a difference in how I view things from the way a person from a small town in Georgia may view things," Creech says.

4. Don't make assumptions about why people act the way the do. For example, not making eye contact is a sign of respect in some cultures. You shouldn't misinterpret it as the person being indifferent, Creech notes.

5. Don't be afraid to ask questions in a respectful manner. "If there is something I don't understand about a family's behaviors or requests, I ask about it, " says Creech.

6. If you need an interpreter, find someone who is not a family member, if possible. If resources are available, use a neutral medical interpreter. "Try not to put the family in a dual role. I like to make sure the information that is being interpreted to me is a strict interpretation and not an opinion," explains Creech.

7. Compile a list of available translators and have it at your fingertips.

Include information on who they are and what the costs are, and have a good understanding of the health plan with which you are working to know if the services will be paid for, advises **Kathleen Moreo**, RN, Cm, BSN, BPSHSA, CCM, CDMS, CEAC, co-founder of Professional Resources in Management Education in Miramar, FL.

8. Go out of your way as a clinician to learn basic language skills for members of the predominant patient groups you are likely to encounter.

9. Develop a "cheat sheet" of cultural issues that affect case management. For example, you might need a simple consent form signed for a pediatric case. From a legal standpoint, you could get either parent to sign. But in many cultures, the mother has no decision-making powers and you need to get the father's signature.

"Case managers need to be culturally sensitive so they don't seek out the mom," says Moreo. "They may be fine legally, but they have breached a fundamental cultural belief and lost the trust of that family."

10. List the cultures you may be coming in contact with and do some basic research on their beliefs. "When I went to China, I was immediately faced with the fact that the Chinese never say 'no.' They associate it with disrespect. If they disagree, they are silent," Moreo says.

In the American culture, silence typically means confusion, and a case manager probably would prod the patient to answer.

"That's the worst thing you can do with a Chinese-American," says Moreo. "You've immediately lost their trust because they have made a decision and you are trying to prod them."

11. Find the resources you need to education yourself. "It's not something we learned in nursing schools, although today's schools are beginning to embrace the need for cultural competency," Moreo says. She suggests Internet-based programs and books from the local bookstore.

12. Above all, treat the families with respect and let them know that you care.

"I am never going to be an expert on Hispanic culture, but I am an expert on family culture, and I can communicate to the family that I want to know their beliefs about wellness," Creech says. ■

(Cont. from p. 146.)

"My whole model is to prevent stereotypes and reinforce the concept of intra-ethnic variation. There are more differences within cultural groups than across cultural groups," she says.

The components are cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.

Here is an overview of each component:

• **Cultural awareness:**

You have to be aware of your own biases and prejudices toward a particular group and deal with them, Campinha-Bacote says.

Being aware of your own cultural or professional values helps you avoid the tendency of an individual to impose his or her beliefs and values on members of another culture, she says. "For instance, take homeless people. The homeless are a transient population," she notes. "One day you work, and one day you don't. Every homeless person is not the same."

Case managers shouldn't be quick to label a particular group as noncompliant, she points out. Instead, explore what kind of case management services may be required to meet the needs of that particular group.

• **Cultural knowledge:**

"People have stereotypes, but they need to get cultural knowledge about other people," Campinha-Bacote says.

She recommends that case managers consult web sites and books to learn more about other cultures, especially their values, beliefs, and life ways.

Biocultural ecology is one area where case managers need knowledge so that they know what diseases are common to a particular group and what drugs may be contraindicated, Campinha-Bacote points out.

For example, certain Asian groups have a high incidence of tuberculosis, and African Americans are more susceptible to cardiovascular disease and diabetes than other groups.

Don't just become aware of the values, beliefs, life ways, and practices, but learn about the physiological, anatomical, and pharmaceutical differences in the patients you deal with, she says.

• **Cultural skill:**

This may be a key issue for case managers, Campinha-Bacote says.

"Maybe you can't get to a web site, you don't have a book with you, and you are standing in front of someone. Cultural skills [represent] your ability to do a cultural assessment, to know what questions you can ask to elicit their cultural beliefs," she says.

Use open-ended questions that are culturally relevant. She cites examples that include:[1]

— What do you think caused your illness?

— What kind of treatment do you think you should receive?

— What do you fear most about your illness?

— What are the chief problems your sickness has caused?

— What do you think is the way to cure it?

More than 30 different cultural assessment tools are available, Campinha-Bacote says.

Review all the tools available and develop questions that fit your specific caseload.

• **Cultural encounters:**

"There are certain things that only face-to-face interaction will validate. Make sure your expose yourself to a few encounters to validate the knowledge you've learned by books and web sites and people," says Campinha-Bacote.

For instance, in her own Cape Verdian culture, if you offer someone water, they say, "no thank you" the first time to be courteous. "In some cultures, 'yes' doesn't mean 'yes' and 'no' doesn't mean 'no'," she says. If you have encounter after encounter, you will realize these things, she adds.

However, keep in mind that interacting with a few people from a specific ethnic group does not

Internet resources on cultural competency

• **Office of Minority Health**, U. S. Department of Health and Human Services: www.ohmrc.gov.

• **Diversity RX**: www.diversityrx.org

• **National Mental Health Association** cultural competency position paper: www.nmha.org

• "Getting Started," a checklist from the **National Center for Cultural Competence**: www.dml.georgetown.edu/depts/pediatrics/gucdc/cultural.html.

• **Agency for Health Care Research and Quality Minority Health Research**: www.ahcpr.gov/research/minorix.htm

• **Transcultural Nursing Society**: www.tcns.org

• **Cross Cultural Health Care Program**: www.xculture.org ■

make you an expert on the group.

• **Cultural desire:**

You can have the right words for someone of another culture, but if your heart isn't there, whatever you try won't work, Campinha-Bacote says.

"If you can't get to the part that shows you care, then you don't really care, no matter how much knowledge you have. People respond to caring," she says.

Remember that learning cultural competence is an ongoing process. "The process of cultural competence is a process of becoming and not being. When you ever think you get it all, you don't."

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1. Kleinman A, Eisenburg L, Good B. (1978) "Cultural illness and care," *Annual of Health*, 88(251):136-147.

For more information, see: Campinha-Bacote J. (1998). The Process of Cultural Competence in the Delivery of Healthcare Services, 3rd edition. Cincinnati: Transcultural C.A.R.E. Associates Publishers. Contact: Dr. Campinha-Bacote, President Transcultural C.A.R.E. Associates, 11108 Huntwicke Place, Cincinnati, OH 45241. ■

Work around beliefs to solve treatment problems

Be flexible, keep the lines of communication open

To serve people of other cultures, you have to have the patience to keep the lines of communication open and know that you will have to work at accommodating their beliefs and values, says **Claire Creech**, CRC, CCM, CDMS, CLCP, senior case manager for the Center for Diagnostics and Evaluation at Shepherd Center in Atlanta.

"As case managers, we are the ones who have to be flexible and do things differently. The family members have to adapt to the illness or injury, and we have to help them learn to do it in a context that is meaningful to them," Creech adds.

Creech has encountered families from a variety of cultures and worked to solve problems for badly injured patients. Here are some examples of how Creech worked with families from other cultures to help meet their medical needs and at the same time not violate cultural values:

Only one Hispanic worker's family ever was willing to discuss the option of care in a skilled nursing facility. The family of the worker, who was in a persistent vegetative state, wanted to get him back to Mexico but allowed him to stay in a nursing facility when they weren't able to do so.

"The care needs of these patients are very demanding, and many non-Hispanic families choose a skilled nursing facility. But the Hispanic families often choose to bring in female family members to provide care at home," Creech says.

A similar issue arose in the case of a brain-injured Korean man whose young adult daughters lived nearby. He was not comfortable with his daughters in a caregiving role because of cultural modesty. Instead, Creech arranged for his sister to move from Korea to Atlanta to assist in his care.

"We had to solve the problem in a way that he could tolerate," Creech says.

Creech was working with a Native American brain injury patient who lived with his tribe on a reservation that was six hours from the nearest city. The family adamantly opposed the idea of moving to be near the medical care he needed.

"Their heritage and their life was on that reservation with that tribe," Creech says.

When she designed the life care plan for the patient, Creech built in the cost of transportation to the city for scheduled medical follow-up care.

Often when Hispanic patients were treated at Shepherd Center, the entire extended family came from Mexico to be at the bedside.

"There is a belief that the family needs to always be vigilant," Creech says.

When large groups are in the room with a brain injury patient, the patient often is overstimulated and becomes anxious, Creech points out. In that case, she often calls a multigenerational family conference, sometimes with as many as 25 to 30 people. She explains what happens with brain injury patients and how they get overwhelmed when there is a lot of confusion. She suggests drawing up a schedule so one or two family members can be in the room for a while.

"Sometimes it may take dropping in and pointing out that the patient is agitated, then suggesting that the family step out for a few minutes," she says.

In some Hispanic cultures, illness is seen as an imbalance between hot and cold in the body. Sometimes family members bring food to counteract the imbalance.

"While I encourage and support that, I make sure it's OK for the patient medically. For instance, there may be swallowing issues," she says.

Creech cautions other case managers to be aware that even though the wife is the legal next-of-kin, in some cultures, she may not be the formal decision-maker in the family. Often, it's going to be the patient's father or another male relative.

"You have to work through confidentiality issues and have the decision-makers participate in the treatment and discharge planning," she says. "If I don't take time to find out who is the decision-maker in the family and include [him or her], the discharge plans get wrecked pretty quickly."

Sometimes patients have beliefs in alternative health methods and want to have alternative healers present. This often creates a conflict between clinicians trained in Western medicine and the family. Creech recommends devising a way to honor family beliefs if it doesn't harm the patient. ■

CM faces challenges of adolescence

CMSA president emphasizes patient interaction

If you're not talking to patients, you aren't doing case management, asserts **Catherine M. Mullahy**, RN, BS, CRRN, CCM, the new president of the Case Management Society of American (CMSA, with headquarters in Little Rock, AR). Mullahy is on a mission to make sure that everyone — payers, providers, patients, and the public — understands exactly what case management is and what it is not.

Case management is not a new concept. It is firmly entrenched in the health care delivery system, says Mullahy, who also is president of Options Unlimited in Huntington, NY. "Our goal is to clarify our role as advocate, educator, and facilitator," she says. "We address the needs of critical and chronic care patients in ways that benefit patients and all partners in care."

That's why CMSA sponsors Case Management Week, an annual event to recognize case managers, educate the public about case management, and increase recognition of the contributions case management makes to quality health care for the patients, providers, and payers.

"Case Management…the heart of health care" is the theme of Case Management Week, Oct. 7-13.

"Case management is not brand-new anymore. It is in its adolescence, with the typical challenges of any evolving group of individuals," Mullahy says. "The problem is that, although there are standards of practices and codes of conducts and definition, case management still is not well understood — even by those who profess to practice it."

Mullahy's goal is to make the distinction between what is and what is not case management and to let people know that the patient is at the heart of case management.

Case managers tackle the kind of cases that can't be solved by algorithms, care maps, or critical pathways, Mullahy points out.

"There are all kinds of computerized systems, software systems, and databases to analyze data to death, but the people who need case management have complicated and diverse problems that do not lend themselves to the technological advances that are out there," says Mullahy. "They need a human solution."

"Case management is a collaborative process, and I am amazed at how people can think they can do it well without having a conversation with a patient or a family member who is the patient representative," she adds. "How can you develop a care plan, assess the needs of patients, and know if the interventions are working unless you have input from the patient or family members?"

Mullahy calls on other case managers to join CMSA in helping define the role of the profession.

"As CMSA collaborates regularly with people involved in managed care and case management, we have a responsibility to our members to communicate what case management is. Not everyone who calls himself a case manager is indeed a case manager. If we aren't making those distinctions, then who else could?" she says.

Mullahy suggests that case managers use Case Management Week as an opportunity to begin letting the public know about the role of case managers. *(For tips on what to do, see p. 151.)* "We continue to talk only to each other and wonder why people don't understand."

"The 3% to 5% of the population with major illnesses and convoluted problems can be served very well by case management. If more people understood how we help bridge the gaps in care, and how we can improve compliance and care outcomes, more people would be asking for a case manager," she says.

"The fact that the majority of case managers are women, with either a nursing or social work background, may make it more difficult for the profession to assert itself, Mullahy says. "Nurses or social workers often chose our profession to be team players and to make a difference in a supporting role. Now we find ourselves taking on the challenges and many opportunities to make a difference in leadership positions." ■

How to spread the word about case management

Who can better tell the public about case management than case managers themselves?

"We are the best people to communicate our contributions, but many of us are not comfortable in that role," says **Catherine M. Mullahy**, new president of the Case Management Society of America.

She urges case managers to develop the skills they need to articulate the health care and financial contributions case management makes. "If more people knew what we do, more would be asking for us. If employers start to recognize the value we provide, our profession will explode in terms of growth," Mullahy says.

Here are some suggestions on how to educate your community:

- Go outside your comfort zone and educate the people with whom you come in contact about case management.
- Talk to family members of your clients to let them know how you help.
- Volunteer to speak at career day at local schools or at civic clubs.
- When health care issues are being discussed in your community, volunteer to be a speaker.
- Write letters to the newspaper or respond to columns in the newspaper. For example, if there is an article about how the health care system didn't work, write a letter to the editor and explain how case management would have solved the problem.
- Volunteer to write an article about how you, as a case manager, made a difference. ■

Demonstrate your value in financial terms

Speak the language your CFO understands

The best way to make sure case management is taken seriously is to demonstrate its financial value, says **Victoria Champeau**, BSN, CCM, MS, director of quality and care management for the Bloomington-based Minnesota Healthcare Network, a group of more than 600 primary care and specialty physicians who joined together and formed a health care system.

"Chief executive officers and chief financial officers don't understand quality of care, but they do understand value if you put it into financial terms, " she says.

If you're squeamish about looking at your job in financial terms, remember that without your job, or the money to support your department, you can't continue to be a patient advocate.

When you want money to support your job or your department, think of it as putting a business plan together and going to a bank, Champeau suggests. "You don't talk about quality of life to a banker. If you want to make a point with them, you tell them about return on investment. That's how to get support for case management."

Case managers often become intimidated when people start talking about financial points, but they can put everything they do into financial terms and demonstrate the value, she says.

It's not difficult to put the value of case management in financial terms. You simply take historical information from your file, or demographic information from the government or health plans, and compare your outcomes after you implement a case management project.

At a basic level, case managers are doing cost-benefit analysis every day when they manage a patient's benefits by pointing out that a particular test or procedure will save X amount of dollars.

"Case managers do it on an individual incident level," Champeau says. "They need to do the same cost-benefit analysis on an entire episode of care or an entire department over time."

Here's an example of how you can calculate a return on investment for a program.

For a disease management program, you might want to calculate how much was saved by reducing hospitalizations or lengths of stay:

• Calculate the number of days in the hospital for your patient population during a base period, such as a year, before you had the disease management program. Or take information from government statistics, health plan data, industry benchmarks, or actuarial standards.

• Then look at the actual number of days in the hospital after you implemented the program and subtract that from the hospital days of the previous period.

• Multiply by the cost of hospitalization.

If hospitalization for a particular group of patients costs an average of $1,000 a day and you have a 200-day decrease in hospitalization length of stay, your cost savings amount to $200,000.

• Finally, add the cost of putting the program together, such as salaries, supplies, and equipment, and subtract that amount from the cost savings to get the value of the program.

You can measure the cost of medicine, the number of home care visits, the number of days in therapy, the reduction in readmissions, or cost savings by using out-of-hospital treatments — anything that can affect the cost of care.

You can calculate the value of case management on an individual case basis, for a patient population, patients in a particular program, or the case management department as a whole.

Champeau urges case managers to learn to take credit for what they do. If you don't give yourself credit, no one else will, she says.

She gives an example of a pharmaceutical sales person who is paid a bonus based on product sales in the ZIP codes she covers. The sales person doesn't say, "The sales might have occurred because I talked to the doctors, but maybe that wasn't the case," Champeau says.

"But case managers' normal reactions are, 'Maybe I kept the patient out of the hospital, but maybe it was a fluke.' Case managers should take credit that the patient avoided hospitalization because of their intervention," she adds. ■

Five Steps to Calculating the Value of Case Management

1. Know your historical information.
2. Know your actual information.
3. Calculate gross savings.
4. Subtract the cost of case management and get net savings.
5. Calculate your return on investment. ■

HMO, PHOs collaborate for disease management

System tracks patients with diabetes, CHF

Three separate health care organizations — two PHOs and an HMO — have joined forces to design a disease management program for congestive heart failure (CHF) and diabetes.

The program is a unique collaboration between St. Francis Health Network, St. Vincent Hospitals and Health System, and ADVANTAGE HEALTH plan, a statewide HMO, all based in Indianapolis.

The HMO and the PHOs have developed a disease management program that tracks patients across a number of categories. The partners plan to expand beyond CHF and diabetes to include patients with other diseases and conditions in the future.

The program uses Pfizer Health Solutions' Clinical Management System disease management software to track the patients being served by the three organizations.

"We haven't figured out who loses. We share the expenses and have an opportunity to improve the health of members and improve their quality of life and quantity of life," says **Bernard Emkes**, MD, a medical director at St. Vincent's. "In the long run, we also hope that there is decreased cost — less retinopathy and renal failure and all the complications of diabetes and congestive heart failure."

The two PHOs have contracts not only with ADVANTAGE but also with other payers.

Between them, the three organizations have more than 104,000 members.

Emkes and his counterpart at St. Francis, Richard Need, MD, had been talking for some time about inconsistency in treatment programs.

"The physicians in our PHOs were becoming confused. One HMO sets certain guidelines, and another tells you something else," says Emkes. "We wanted to make life simpler for physicians and care more consistent to members."

The three partners decided to go in together to purchase the system from Pfizer Health Solutions.

"It came down to a matter of convenience and effectiveness for the three partners to purchase the system. The cost was reduced for each, and we can bring value to a large number of patients — more than 100,000 members from three entities," he says.

The partners looked at a number of systems and chose one that allowed local control. The program is unusual because it allows each of the partners to track its own patients without having access to patients from the other entities.

Pfizer Health Solutions was willing to set up segregated databases to give all the partners access to their data but not to data from other partners. For example, ADVANTAGE has access to data from all its members but can't go into the St. Francis database for information on their patients in other plans.

The collaborative effort creates an efficient workflow and saves time spent on phone calls between the HMO and the networks, says **Isaac Myers**, MD, vice president of Medical Affairs at ADVANTAGE.

"From a resources standpoint and a sense of time spent, it's more efficient. I can go into the system and find answers," he says. "There is a much better flow process, and it's more efficient from an operational side to do good case management."

ADVANTAGE has had disease management programs, but never a nucleus connecting the health plan and the networks.

"We would mail information and meet the networks, but we didn't have a tracking process in place to integrate the whole process. This ties [everything] together to make it flow," he says.

When the program began, the network sent a letter to all its primary care physicians, telling them that when the case manager calls and suggests that members come in for a visit, it's not elective.

The physicians in both PHOs welcomed the program, he adds.

"We've reached an age where providers are getting inundated from various sources, whether it's a health plan or a provider network. They welcome the efficiency in the process because they aren't getting contacted by multiple sources," Myers says.

Before beginning the program, the partners identified patients who were diagnosed with heart failure and diabetes and solicited their participation in the program.

Based on the information entered in the system, the software electronically prompts the case manager to call the patient at specific time intervals. She enters the information she receives during the conversation into the computerized system, which triggers responses based on the data entered.

For example, if the patient says he weighs 191 pounds and weighed 180 two weeks ago, this triggers a set of questions designed to get to the root of the problem.

If the patient doesn't know what a low-salt diet is, the system will e-mail literature to the patient or the case manager can print out diet instructions and mail it to patients.

At the end of the intervention, the program generates a synopsis report for the case manager, a letter to the patient enumerating what was discussed, educational literature for the patient based on his responses to the questions, and a letter to the patient's physician identifying areas where the patient is having difficulty.

"This clearly allows for a more focused visit. I have my agenda and the patient has his agenda, and this puts us on the same page," Emkes says. "It causes a more focused physician visit and in the long run leads to more appropriate treatment with less hospital costs."

In addition to relying on the system triggers, the case manager can add her own impressions of the patient's condition. For example, if the case manager notes that the patient sounds short-winded, the system will prompt her to call again the next day.

The fact that the program tailors the educational pieces to the membership and sends triggers to case managers is one of its strong points, Myers says.

"A lot of times, you have guidelines and processes you want to follow but you forget to do certain things. The program is designed to make sure key elements are there," Myers says. ■

DM program shows early successes

Partners anticipate long-term savings

The congestive heart failure disease management program had been in effect only a few weeks when the staff at St. Vincent Hospitals and Health Services in Indianapolis began to see a major improvement in care for patients.

For example, one patient, a woman in her early 40s, had major issues in self-care for heart failure. She was on disability, had children to support, and couldn't afford the co-payment for some of

her medications. The physicians were not aware of her personal problems until she was enrolled in the heart failure program.

The case manager started calling the woman on a daily basis. She arranged for the health plan to provide a scale and for her employer to use some of its charitable funds to pay for the drug co-payment. She provided the woman with information on managing her disease, such as foods to avoid and the importance of weighing herself.

After a month in the program, the woman told the case manager that for the first time in months, she was able to get her shoes on and that she felt like she might be able to return to work.

St. Vincent Hospital and Health Services, St. Francis Health Network, and ADVANTAGE Health Plan began collaborating last spring on a joint disease management program for diabetes and congestive heart failure, two of the most pervasive diseases in Indiana.

It's much too soon for outcomes data to be available from the program but the anecdotal success stories have convinced **Bernard Emkes**, MD, medical director at St. Vincent, that the program will be a long-term success. "This is the kind of success we like to see. You need only one or two [cases] like this to pay for the program. And, the patient is enjoying a new level of quality of life that you can't begin to put a price on," Emkes says.

Here's how the program works:

The ADVANTAGE Health Plan identified initial patients targeted for the program from retrospective claims review. To help identify new patients, ADVANTAGE includes a questionnaire with 10 key health management questions in its welcome packet for all enrollees.

"This allows us to be proactive. Otherwise, we're running on a three-month claim lag. We don't even know someone has a condition until [he or she is] hospitalized, and it's usually three months later because that's when we get the claims," says **Isaac Myers**, MD, vice president of Medical Affairs at ADVANTAGE.

If an enrollee or family member is identified with congestive heart failure or diabetes, the system sends a more detailed information sheet, which stratifies the member into four classifications, based on severity.

The collected information is sent out to the networks so they can put the member into case management if needed.

The two PHOs also have identified and are tracking their own targeted patients.

"From our perspective, the system provides a very efficient case management process," Myers says. He foresees decreased admissions and emergency room visits in the future, but the plan is not yet at the point of measuring them. ■

In the future, data will help manage patient resources

Technology will help get a better handle on costs

Geoff Deutsch has a vision for the future of case management. In his vision, case managers will have information at their fingertips about how good a job each individual physician does with a particular diagnosis or severity level, and what each physician's costs are for each diagnosis and each episode of care.

"The case managers might know that Dr. A does a good job with patients with this degree of severity in a certain diagnosis and won't intervene to manage those patients' care. But they know that Dr. B may need some management with a particular patient. They will be able to intervene aggressively and earlier on with some patients and save resources by not doing an early intervention on patients whose doctors have better outcomes," says Deutsch, senior vice president of HealthShare Technology, a Waltham, MA-based health care technology company.

Case managers will have specific information and benchmarks for individual physicians and their handling of specific types of cases, he says.

"Instead of calling a doctor to review the care, the case manager can start the process by knowing where the issues are likely to be," he says.

For example, when questioned about cost of care, many physicians will say that their patients are different. "With the type of data they'll have available, case managers will be able to say that the data indicate that this doctor's average length of stay tends to be 25% longer than any other physician in the hospital with the same outcomes," he says.

Case managers will be able to look at mortality, postoperative infection rate, and whatever other quality indicators are appropriate.

Deutsch envisions a case manager being able to say, "I know cost issues tend to be in blood products, but your blood products are 40%

higher, and the use of the lab is 26% higher."

"Data can give depth and meat and productivity to a discussion. Case managers are now coming in blind, knowing that quality and high cost are a problem. This will enable a more constructive fact-based discussion, a healthier and more productive approach," he says.

Data tools offer a tremendously exciting vision of how case management can be data-driven, Deutsch says. "The game has become how to manage and utilize resources to make the most impact where we can," he says.

Every hospital releases data on Medicare patients, such as charges, outcomes, and cost data down to the department level. This allows comparative benchmarking.

Hospital case managers can access more detailed hospital information, but the challenge is to find it buried within a series of complex data management systems.

Deutsch's company has developed two Internet-based tools, HealthShare One and HealthShare Two, that generate information from a variety of public and private sources, including clients' existing information systems, provider and payer systems, and state and federal government health care provider filing information.

For more information, contact Deutsch at gdeutsch@healthshare.com. ■

Physician dissatisfaction still growing

Physicians' satisfaction with their professional lives has declined substantially in the last 15 years, according to a study sponsored by the Agency for Healthcare Research and Quality (AHRQ) and the Robert Wood Johnson Foundation. The study compared findings from surveys of primary care physicians practicing in Massachusetts in 1986 and 1997.

Nearly half of the physicians who work in practices that contract with multiple insurers reported one or more insurance company denials of patient care in the past year.

These physicians reported being highly dissatisfied with methods for obtaining health plan authorization for patient care, and fewer than half would recommend the health plans with which they were associated to family members or friends.

Physicians who contracted exclusively with one health plan did not express the same level of dissatisfaction.

Fewer than two-thirds of 1997 respondents were satisfied in most areas of practice, and fewer than half were content with the time they spent with patients, the amount of leisure time they had, and incentives for providing high-quality care as compared to physicians responding to the 1986 survey.

"This important research shows that changes in the way health care is delivered affect those who are dedicated to providing care for their patients. Both the public and private sectors need to work together to help health professionals adapt to the changes in the structure and organization of the American health care system," says

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Editorial Questions

Questions or comments? Call **Mary Booth Thomas** at (770) 934-1440.

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John M. Eisenberg, MD, director of AHRQ.

The study was confined to Massachusetts physicians, but researchers believe similar findings would occur in other parts of the country with similar health care markets.

Physician satisfaction is important because dissatisfaction leads to increased physician turnover, which leads to decreased continuity of care for patients and higher costs to the medical system, says **Dana Gelb Safran**, SC.D, of the New England Medical Center in Boston, principal investigator for the project. ■

CE questions

13. According to the U.S. Bureau of the Census, by 2050, how many people living in the United States will be from a different culture?
    A. Nearly two-fifths
    B. Nearly half
    C. Nearly two-thirds
    D. Nearly three-quarters

14. Which of the following is not one of the components of the cultural competence model developed by Josepha Campinha-Bacote, PhD, RN, CS, CNS, CTN, FAAN, president of Transcultural C.A.R.E. Associates in Cincinnati, OH?
    A. Cultural awareness
    B. Cultural knowledge
    C. Cultural immersion
    D. Cultural skill

15. List the first of twelve steps to cultural competency outlined by Claire Creech, CRC, CCM, CDMS, CLCP, senior case manager for the Center for Diagnostics and Evaluation at Shepherd Center in Atlanta.
    A. Find out about the family's internal dynamics, beliefs, and what those beliefs mean to them and the patient.
    B. Don't make an assumption based solely on the country of origin.
    C. Don't be afraid to ask questions in a respectful manner.
    D. Develop a "cheat sheet" of cultural issues that affect case management.

16. List the last of five steps to calculating the value of case management, according to Victoria Champeau, BSN, CCM, MS, director of quality and case management for the Minnesota Healthcare Network.
    A. Know your actual information.
    B. Calculate gross savings.
    C. Subtract the cost of case management and get net savings.
    D. Calculate your return on investment.

CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

Reports From the Field™

Lack of specialty care factors into diabetics' mortality

Lack of specialty care, particularly for minority patients, is a contributing factor to the continued increase in mortality for people with diabetes, according to the American Association for Clinical Endocrinologists (AACE).

"Patients with diabetes have special health needs which they and their physicians need to address," says **Rhoda H. Cobin**, MD, president of AACE. "Studies have shown that patients who receive care from endocrinologists have better health outcomes. It is a critical component for managing this chronic condition."

Cobin cites statistics from the Atlanta-based Centers for Disease Control and Prevention that show deaths from diabetes and its complications continue to increase despite an overall decrease in other causes of death.

Many patients are not even aware that there are diabetes specialists, she says. "Minority patients — who are disproportionately impacted by diabetes — are the least likely to seek or have access to specialty care," she adds. ▼

Headache test can determine potential lost productivity

There is a direct correlation between productivity at work and scores on a self-administered test that measures the impact of headaches, a new study has concluded.

The study, presented at the International Headache Congress, demonstrates that patients lose the equivalent of two days a month at work because of severe migraine headaches.

The study gave the HIT-6 (Headache Impact Test), a list of six questions, to 648 headache sufferers to determine the impact headaches have on lost productivity in the workplace.

"The adverse effect of headaches on businesses is a worldwide problem. Workplace productivity can be considered impaired as a result of migraine headaches," says **Andrew Dowson**, director of King's Headache Services at King's College Hospital in London. "It is essential to treat the condition appropriately to reduce the attacks and the cost to industry."

According to Dowson, studies have put the annual direct cost of migraine headaches at $11.8 billion worldwide. He anticipates that employers could save $5,154 per year per migraine patient by treating the condition. ▼

Multi-drug resistant TB remains a national threat

The current education and treatment of multi-drug resistant tuberculosis (MDR TB) does not adequately reflect the seriousness of the disease as a national public health concern, according to a new study.

The disease remains a threat, particularly in areas that are heavily populated by immigrants, the elderly, and people with immune system problems, researchers reported in the August issue of *CHEST*, the journal of the American College of Chest Physicians based in Northbrook, IL.

MDR TB is a deadly form of tuberculosis that is resistant to two or more of the primary drugs used to treat the disease. It is transmitted through the air and can develop because of a lack of treatment, improper treatment, or non-compliance with drug therapy in patients who have active TB.

"With expert care, we have the tools to diagnose and the means to cure TB and MDR strains, yet this disease continues to kill people in the U.S. and around the world," says study author **David Ashkin**, MD, FCCP, medical executive director at A. G. Holley State Tuberculosis Hospital in Lantana, FL.

In the study, Ashkin examined the outcomes of Florida patients treated at least partially in a specialty treatment center and those treated only in outpatient community care.

Of the 81 patients with MDR TB (out of 5,516 cases of active TB), 45% of patients who received outpatient care died vs. 18% of patients treated in the inpatient specialty facility. ▼

Few seniors are screened for peripheral arterial disease

Less than half of the older Americans who have symptoms commonly associated with peripheral arterial disease are being screened for the disease by health care professionals, according to a survey by the National Council on the Aging (NCOA). The survey also showed that two-thirds of Americans older than 50 are unaware of the disease.

"It is clear that we need to increase consumer and physician awareness so that seniors can get testing, timely treatment, and the advice they need about this potentially critical disease," says **James Firman**, MD, president and chief executive officer of Washington, DC-based NCOA.

The disease is characterized by blockage of the arteries in the legs and sometimes the arms due to plaque formation. The most common symptom is leg pain including muscle cramping, tightness and fatigue during moderate exercise.

People who smoke, who are over age 70, and who have diabetes have a one-in-three chance of developing the disease.

Peripheral arterial disease is determined by a simple test comparing blood pressure readings from a patient's arm and ankle.

For more information, see the NCOA website at www.ncoa.org or the Vascular Disease Foundation website at www.vdf.org. ▼

Chicken pox vaccination campaign launched

An estimated 3 million children are at risk of chicken pox, according to the National Association of Pediatric Nurse Practitioners (NAPNAP) in Cherry Hill, NJ. These are children who have neither been vaccinated against the virus nor have had chicken pox.

The organization has launched a campaign to make sure that the children who are risk for chicken pox are vaccinated. The campaign is aimed at children ages 6 to 12 who were born before the vaccine became available in 1995.

A NAPNAP-sponsored survey shows that 50% of parents whose children are at risk for chicken pox say they would rather their child have the disease than the vaccine. One in four parents are reluctant to vaccinate because they don't feel it's important, and 42% of parents said they didn't know a vaccine for chicken pox is available.

More than 90% of the parents were unaware the chicken pox could have serious complications, including death, and 36% believe that is it only as harmful as acne.

Older people, including teenagers and young adults, are much more likely than children to develop complications from chicken pox, points out **Linda Juszczak**, DNSc, MPH, CPNP, spokeswoman for NAPNAP.

For more information, visit the NAPNAP website at www.napnap.org. ■

Send us Resource Bank items

If you have a new resource, conference, or seminar that can help other case managers do their jobs better or more efficiently, *Case Management Advisor* wants to hear from you.

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