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Disaster response: Take proactive stance in case a tragedy hits your community

Develop a secondary plan to deal with emotional aftershocks

In addition to a disaster plan to deal with an immediate crisis, health care organizations need to have a secondary disaster plan to deal with the aftershocks of the tragedy, says **Eileen Hanley**, RN, MBA.

Hanley should know. She manages the supportive care program at St. Vincents Hospital in New York City, the closest trauma center to the World Trade Center.

The supportive care program offers nursing, psychological, social, and spiritual support for people with advanced life-threatening illnesses. In addition to Hanley, the staff include three full-time nurses, two part-time social workers, a part-time nurse, and a part-time chaplain.

Disaster Planning Audio Conference

The unimaginable has happened in New York City. At Saint Vincents Hospital, less than three miles from the site of the World Trade Center attack, the disaster plan was put to the test as dedicated professionals rose to the unique challenge of responding to the attack. American Health Consultants, publisher of *Case Management Advisor*, invites you to learn — from the firsthand experience of the professionals at Saint Vincents — how to take a new look at your disaster plans so that you will be ready if the unimaginable happens in your community:

- Responding to the Unimaginable: How Saint Vincents Coped with the World Trade Center Attack
- Wednesday, Nov. 14, 2001
- 2 to 3:40 p.m. EST
- An audio conference educating you and your entire staff on how to respond effectively in a crisis situation.

Each participant will have the opportunity to earn 1.5 free AMA Category 1 CME credits or approximately 2 free nursing contact hours. For details, visit www.ahcpub.com, or call (800) 688-2421 to register today! ■

Since the tragedy of the World Trade Center attacks, the St. Vincents staff have been dealing with the emotional traumas suffered by people who had loved ones in the twin towers, emergency workers, and more recently, hospital staff.

"In my experience, everyone — whether they're a hospital, a home care agency, or any other health care organization — should have a secondary plan that goes into effect after a disaster of this magnitude," she says.

Her words were echoed by the Case Management Society of America (CMSA) in Little Rock, AR, which sent out a special mailing urging local case management chapters, particularly those in the New York, northern New Jersey and Washington, DC areas, to develop outreach programs to help their communities deal with disasters. The letter included a list of information and resources to help in case of a disaster. The information also is on the CMSA web site at www.cmsa.org.

When the first plane hit the World Trade Center, St. Vincents Hospital's disaster plan went into effect. The nurses in Supportive Care went to the nursing command center, and the program's nonnursing staff went into the general personnel pool.

"Within an hour or so after the disaster, we realized that our responses and our skills could be used other than in a medical manner," Hanley says.

Her staff worked at St. Vincents Family Crisis Center, initially helping families find out information about their loved ones who might have been injured, and later providing bereavement counseling in the hospital's emergency room.

Within 10 days of the tragedy, Hanley realized that although most of the hospital could go back to its pre-crisis mode, in many ways her work was just beginning.

"The medical crisis was over very quickly," she says. "My understanding is that the vast majority of people were treated and released. It was very sad for the medical personnel on the front lines in the emergency room when they realized that the numbers we were prepared for were not coming in."

The supportive care staff was concerned about the effects that being a part of the crisis could have on the hospital employees. "We left the management of the Family Crisis Center to psychiatry and started focusing our efforts on employee support," Hanley says.

The staff circulated throughout the building in an informal way to see how the staff and patients were handling the crisis. Many patients witnessed the disaster from the hospital while waiting for surgery or treatment.

"It is important to let our employees know that everybody was affected by this tragedy," Hanley says. "They didn't have to know someone who was hurt or is missing. They didn't even have to be working that day. We also wanted them to know that even during the disaster, it was OK to do their normal job, whether it was performing surgery or answering the telephone."

Because the hospital was close to the disaster site, all hospital personnel were aware of the tragedy every time they left the hospital. With the help of human resources and other departments, the supportive care staff developed a curriculum on responses to stress and ways to combat it. Because of the size of the hospital and the number of staff, more than 40 sessions of the curriculum were presented.

"The other department heads and I felt strongly that this shouldn't be a human resources presentation, but should be presented by people who are sensitive and have the ability to provide emotional support in case someone has a severe reaction or starts to break down," Hanley says.

Hanley anticipates having St. Vincents aftercare model in place at least a year to help hospital staff and people in the surrounding community deal with the long-term effects of the tragedy. "The plan needs to take into account that people feel different reactions to different things, and that different things will trigger a reaction to the original disaster," she says.

For instance, the holidays, a birthday, or an anniversary may be particularly difficult for people. She anticipates that critical times for the community surrounding St. Vincents will be

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Staff swung into action after Trade Center crisis

Supportive care staff manned hospital crisis center

Shortly after terrorists destroyed the twin towers of the World Trade Center, the supportive care staff at St. Vincents Hospital in New York City started working in what later became St. Vincents Family Crisis Center.

Later that day, because of the throngs of people who were came by seeking information about their loved ones, the Family Crisis Center moved to a school about a block away.

Until Sept. 13, the center served as the only crisis center in the area because the city's office of emergency management was in one of the buildings that was destroyed.

"My staff spent most of Tuesday afternoon and evening and the next several days meeting face to face with families of the missing or answering phone calls from people who were looking for information," says **Eileen Hanley**, RN, MBA, manager of the supportive care program.

For the first few days, the staff provided concrete information rather than formal counseling.

"It was helpful to have professional staff who could identify whether the people looking for information on their loved ones were having an appropriate response or if they needed a more intensive assessment or to call someone because they were alone," Hanley says.

The Family Crisis Center was a collaborative effort of the hospital's spiritual care, social work, psychiatry, and supportive care departments. In the first two weeks, more than 6,000 people were seen at the Crisis Center.

By the middle of the week of Sept. 17, as hopes dimmed for finding any more injured, the flow to the Crisis Center lessened, and it was moved back to St. Vincents Hospital.

The supportive care department is continuing to provide bereavement and grief counselors in the emergency room in case rescue workers and people from the community come in for support. After the first two weeks, the ER counseling services were cut back from around-the-clock to 8 a.m. to midnight.

"People may be coming in for some type of physical complaint, but they benefit from having someone offering some support and a kind ear and allowing them to talk about what's going on," she says. ■

when the debris is finally cleared up and everyone is able to move back, when the companies that were located in the World Trade Center move into other offices, and next year's Sept. 11 anniversary.

"We're wisely taking proactive action. We are anticipating what this trauma may mean to the community around the hospital," she says.

Hanley suggests that other health care providers develop a steering committee to think about what will happen if there is a disaster in your community.

Think about what kinds of demands it will place on the services you provide, what needs there will be in the community, and what your organization can provide.

"Obviously, it will have to be adapted to the individual community, but it is very important that the institution really look on what they can do as an institution," she says.

Consider your community resources, what they are, and how they can help. "In New York City, there are a lot of resources and a lot of places where people can go for help. In a small community, this might not be true," she adds.

Don't feel you have to react to everything. Instead, be proactive in your planning and decide what you can do in a cogent and thoughtful way, she adds. "If an organization decides it is going to focus on its employees and the immediate community, it needs to decide how it is going to react when someone comes in who is two streets outside the area it delineated," she adds. ■

Aging of America presents unique care challenges

Soon-to-be seniors are going to need care

Statistics show that someone in this country turns 55 every seven seconds. And with the biggest wave of baby boomers, those born in 1947 — turning 55 next year — the number is only going to increase. People ages 55 to 65 are twice as likely to have the same health problems as people

just 10 years younger, according to the Department of Health and Human Services. And according to the 2000 U. S. Census, the number of people ages 65 and older is expected to double in the next 30 years.

This means that every year, more and more people are going to need intensive medical care, chronic disease management, and long-term health services, and it will be up to case managers to juggle the resources they need for their care.

Consider these current statistics:

- 18.4% of Americans age 65 or older have diabetes.
- 17% of older adults suffer from chronic obstructive pulmonary disease.
- 74% of all people age 75 and older have hypertension.
- Between 15% and 30% of the elderly have urinary incontinence, a condition that is often the primary cause of institutional care for the elderly.
- 85% of all cancers occur in people over age 50.

With the number of senior citizens increasing, case managers have their job cut out for them. At the same time that the number of elderly is increasing, strides in medical care are prolonging the lives of people who once would have died at a much younger age from stroke, heart attacks, kidney disease, cancer, or other conditions.

"The good news is that more and more people are living longer. The bad news is that the opportunities for them to crash and burn are huge," says **David Kibbe**, MD, chief executive officer of Canopy Systems in Chapel Hill, NC.

Most elderly require complex care for multiple chronic illnesses that involve multiple interventions. They're frail, their health is unstable, and their care is costly, Kibbe adds.

Their care is likely to occur in a multitude of settings — the doctor's office, the hospital, the rehab facility, the skilled nursing facility, at home with home health.

They're probably going to need community services for care that Medicare doesn't cover and their family will need help coping with the changes in their loved ones and juggling their care.

And somebody is going to have to keep up with all these venues, all the prescriptions, and all the interventions they need. "That's where care coordination comes into play," Kibbe says.

In this issue of *Case Management Advisor*, we examine some of the aspects of health care for senior citizens. We'll show you the importance of knowing about long-term care insurance and why your younger clients should be buying it. You'll learn about how incrementally innovative drugs can benefit the elderly, what Department of Health and Human Services researchers found in the nation's assisted living facilities, and ways others are managing the care of patients with congestive heart failure, one of the most pervasive and expensive chronic conditions of the elderly. ■

Disease management saves $520,000 a year

CHF program targets Medicare risk patients

Harbor Medical Associates' (HMA's) in South Weymouth, MA, disease management program involving everyone in the entire continuum of care has decreased hospitalizations and emergency room visits, increased quality of life for its congestive heart failure (CHF) patients, and saved a projected $520,000 a year.

In 1998, the total cost of providing care for (CHF) patients was about $1,330 per member per month. After just five months into the program, the cost had dropped to $1,140 a month, according to **Nick Cleary**, MBA, chief operating officer for the 34-provider practice, which has seven locations in southeastern Massachusetts.

The CHF program includes 3,000 patients who are members of HMA's Secure Horizon Medicare risk population, the physician practice's fully capitated product. The program is coordinated by the practice's case managers, who follow patients through the entire continuum of care — hospitalization, home care, and skilled nursing admission, should they have one, says **Hilja Bilodeau**, RN, CCM, director of case management.

Staff from Secure Horizon's preferred provider home care program and vendors who provide oxygen therapy and other durable medical equipment helped develop the home care portion of the program and work closely with the case managers to monitor patient conditions, Bilodeau says.

"If homebound individuals can't come into the clinic to be seen, we educate whoever is going to see them in the home about our program and its parameters. They are our eyes and ears in the field," Bilodeau says.

The case managers work closely with all the providers who see the patients in the home and meet monthly with them to get feedback.

If the vendors notice that any patient is having problems, they call the primary care physician, the nurse practitioner who runs the program, and the case manager.

The disease management program is a joint venture among Harbor Medical Association, CVS Health Connections, and Pfizer Health Solutions. CVS has located a Center for Wellness Education, a disease management center, in the same building as the medical practice's main location.

CVS Health Connections already has similar operations within its pharmacies. This was the first time it had partnered with a physician group.

"They had studies, a care plan, outcomes measurements, and a software program to bring to our group in a strategic partnership," Cleary says.

The center is staffed by a nurse practitioner, a pharmacist, and a receptionist. **(For a detailed look at how the program works, see related story on this page.)**

The case management department developed the program and identified patients at high risk.

After the patients join the program, the case manager meets with the nurse practitioner who runs it. A medical director oversees the program but is not always on site.

"We work closely with her in establishing plans of care and reviewing the protocols in place, as well as enhanced services for patients who need them," she says.

The practice began looking at disease management programs in 1997 as a way to survive in Massachusetts' mature managed care market.

"We felt like we had exhausted most of the normal strategies, such as stronger case management and better cost reduction. We decided that the next generation of strategies would be disease state management. It's not only a managed care strategy, but a strategy that involved better managing of care," Cleary says.

The practice considered creating its own disease management program or purchasing an existing program and decided that the practice didn't have the internal resources to create its own. That's why Cleary considered the partnership with CVS such a good option.

"For us it was a turnkey operation, but we retained control over the clinical aspects of the program," Cleary says. The practice negotiated an arrangement to share its savings with CVS Health Connections as funding for the project.

The partnership also oversees care for diabetes and asthma patients but not all of them are part of the Medicare risk contract. ■

Program slashes ED visits, admission rates

Education effort pays off

Since South Weymout, MA-based Harbor Medical Associates began its disease management program for congestive heart failure (CHF) patients, hospital admission rates and visits to the emergency room have decreased dramatically for the 3,000 Medicare risk patients in the program, says **Hilja Bilodeau,** RN, CCM, director of case management.

The disease management program is a partnership among the medical practice, CVS Health Connections, and Pfizer Health Solutions.

Here's how the program works:

The physician practice's case management staff identified the initial patients for the program by examining ICD-9 codes.

Subsequent patients have been identified by their primary care physician or the hospital staff.

If a patient is admitted to the hospital for the first time with a diagnosis of CHF, the case managers are notified immediately and are able to speak to the primary care physician and the family about putting the patient in the program.

"A lot of times we have the opportunity to interface with the family early on and establish expectations right away," she says.

When the patients' physician approves their participation in the program, the staff invite them in for a 90-minute visit at the CVS Center for Wellness education, located in the same building as the medical group's main office.

They are assessed by the nurse practitioner, who collects baseline information on their health status. The nurse practitioner and pharmacist review the patient's medication and work with the physician office case manager to develop a care plan that is submitted to the physician for approval.

"We make sure the patients receive every opportunity they can for quality medical care and that they are getting everything that can be provided for them," Bilodeau says.

The information is entered into Pfizer Health Solutions' Clinical Management System software, which tracks and analyzes the outcomes.

During the first visit, the nurse and pharmacist spend 45 minutes or more talking with the patients about their conditions, the medications they are taking, diet, exercise, nutrition, and

answering questions and concerns.

"Most patients have a lot of questions that they can't get answered in a 15-minute office visit," Cleary says.

On subsequent visits, patients go through an intensive educational program that typically lasts two to three months.

"There is a significant enhancement on the educational side, and we feel like we are moving the patients toward a joint compact of compliance, buy-in, and understanding," Cleary says.

Many patients with chronic diseases are not compliant. They don't follow their diet and don't exercise.

"This type of approach gets them owning what needs to be done and improving their health and lifestyles. And by having a better lifestyle, they are less likely to be hospitalized as often," Cleary says.

The aim of the Center for Wellness Education is for the staff to spend as much time as necessary with the patients. For instance, if a diabetes patient has elevated blood sugar and needs to get it under control, he or she may come in several times in a week.

"The staff can spend a lot more time educating. A physician may not have 90 minutes to spend with a patient," Cleary says. ■

Long-term care isn't just about nursing homes

Be aware of all the options available to elderly

With people living longer and health care costs escalating, it's likely that you're going to have elderly clients who cannot take care of their daily needs, such as bathing and dressing, but who don't need the kind of medical care they would receive in a hospital, rehabilitation facility, or skilled nursing facility.

The bottom line is, people are living longer and are likely to need some type of custodial services. They may be disabled after a stroke, suffer from a chronic condition such as congestive heart failure, or have Alzheimer's. These patients don't need to be hospitalized or receive skilled care. But they do need help with bathing, dressing, feeding, and transportation.

"Any case manager, other than those in a workers compensation environment, is likely to encounter patients who need long term care," says **B.K. Kizziar**, RNC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

Medicare and commercial insurers have strict limits on necessity and time frames for skilled nursing care. Few Medicare supplement policies cover custodial-type care.

Long-term care insurance policies often pay for the types of services that elderly patients need. These policies may include home health benefits, assisted living benefits, adult day care — "everything you can imagine," Kizziar says. "Case managers are going to see more and more people who have purchased long-term care policies."

That's why case managers should become familiar with long-term care policies, what they cover, and what options they provide, she adds. "When an elderly patient becomes a client, case managers should ask if [he or she has] a long-term care policy. Family members may or may not know about the policy, and if they do know, they aren't likely to know what it covers," Kizziar says.

Treat it like a regular health care policy and ask clients to bring in the book so you can determine what their benefits are and what they can do.

"It gives the case manager an opportunity for a more comprehensive plan of care. They can address the custodial issues as well as the needs for skilled care," Kizziar says.

Armed with this information, you can help your clients and their family members come up with the most cost-effective way to meet their needs for care.

"Knowing what the elderly person has available in terms of health care benefits, whether it's private insurance, Medicare, Medicaid, and how the benefits work is the most important part of managing care for the elderly," she adds.

But managing care for your elderly clients doesn't stop there.

Case managers also must be aware of community resources in the event that an elderly client doesn't have a long-term care policy. "Case managers need to be aware of what unique services are available in their community, including transportation and services for care," Kizziar says.

Look at family resources, such as how much time family members have to help with the patient's care.

Ask the patient about organizations they belong to that may be helpful. For instance, the patient's church family may be able to help.

Look for community resources that may be available, such as Meals on Wheels, volunteer

groups that visit the elderly, and organizations that provide transportation to and from medical appointments. They may be able to provide the kind of care your patients need part of the time, allowing the family members to pitch in when they aren't at work.

Adult day care is an affordable alternative to in-home custodial care for some families who may want to help care for their elderly parent but who have jobs and families of their own. "For family members who are willing to help but who have obligations of their own, adult day care is something that has been wonderful," she adds.

The programs also are covered by many long-term care policies, often on a sliding scale for payments. "Most of them will work with the family on the type of reimbursement they are able to make," Kizziar says.

Some tips for helping your clients choose adult day care:

Make sure the programs meet the requirements of the state, whether it's certification or licensing.

Check out the type of staff and the ratio of patients to staff. If the program is for Alzheimer's patients, make sure the staff is sufficiently skilled to give the patients the attention they need.

Look at the types of activities that are offered during the day. Choose a program that has controlled activities and outings.

"You certainly don't want a bunch of patients sitting around doing nothing," she says.

Look for a program that encourages family participation and volunteerism.

"If the family can come to lunch one day a week or volunteer a few hours a week, they can see what goes on and are more likely to get a good idea of how the patients are treated. It gives them an idea of whether the staff are capable of handling the patient population," Kizziar says. ■

Suggest a long-term care policy to your clients

Rates are lower for people in their 50s and 60s

B.K. Kizziar, RNC, CCM, CLCP, learned the hard way how useful long-term care insurance can be when she had her first knee replacement before the age of 45.

"I needed someone to help with the activities of daily living — the things I wasn't able to do for myself while I recovered. And, even though I was a case manager for a large payer, I didn't have benefits to provide custodial care," says Kizziar, owner of B.K. & Associates, a case management consulting firm in Southlake, TX.

As the baby boomer generation ages and human life expectancy continues to increase, the need for your clients to have long-term care insurance is going to be more acute, Kizziar adds.

Medicare and commercial insurers all have strict limits on the number of days in the hospital and seldom pay for home health or other services for patients who don't have medical needs, she points out.

This often leaves people who need help with their activities of daily living with only a few, expensive options, unless they have family members who are available 24 hours a day.

Kizziar recommends that her younger clients consider purchasing long-term care insurance.

She urges her clients not to wait until they are 65 or 70 years old to start thinking about long-term care. People in their 50s also should look into coverage, she says.

"Premiums are more affordable at age 55 or 60 than at age 70," she points out. ■

HMO, hospital case managers to combat CHF

QI project targets Medicare patients

Hospital and HMO case managers in the University of Alabama in Birmingham Health System have joined together for a congestive heart failure (CHF) quality improvement project.

"All case managers are working together to monitor care across the continuum," says **Karen Knight**, RN, CCM, CDMS, director of health services for VIVA Health.

VIVA is owned by the University of Alabama in Birmingham (UAB). About 75% of its patients go to the UAB health system.

CHF was chosen because it is one of the most frequent diagnoses for admission and readmission with VIVA's Medicare population.

The UAB case management department administration and VIVA's administration meet

monthly to identify problems and trends.

"One of the things we noticed is that congestive heart failure has the highest admission and readmission rate," Knight says.

Knight is hopeful that the project will help case managers in various setting across the continuum learn to work together for better patient care.

"In the last few years, everybody wanted to be a case manager. You have case managers in home health, in the hospital, in managed care companies. At times, it's almost been adversarial, but if we're going to reach the next level of outcomes and better benefit our patients, we've got to learn to work together," she says.

The project is part of VIVA's initiatives to meet HCFA guidelines for Medicare Plus organizations. HCFA requires the organizations to implement two quality improvement studies per year over a three-year period. This is the first year of this project for VIVA and the UAB Health System.

VIVA has purchased kits with materials that CHF patients need to monitor and manage their disease. The kits, called Careguides, are produced by Chicago-based Care Products and include a scale, a blood pressure cuff, a journal, a medication organizer, and educational materials that include step-by-step instructions on what patients should do as well as information on the disease.

"Education is an important way case managers can empower people to take care of themselves," Knight says.

The University Hospital case managers deliver the kits when the patient is in the hospital and start the patient education program. Once the patients go home, the VIVA Health case managers follow up with phone calls and home visits.

"You can have a great impact on CHF with patient compliance. So many times when patients don't follow instructions, it's because they didn't understand. Especially with the elderly, it has to be a repetitive process. You think they've got it, and then call back three days later, and they have no idea what you're talking about," Knight says.

Confusion and failure to follow instructions are particularly prevalent when patients are newly diagnosed, she adds.

The patients in the program require frequent monitoring. The case managers call them at least once a week, asking about weight gain, diet, and other symptoms.

"As they identify the needs, they can act on those needs," she says.

The case managers do far more than just talk to the patients about their weight and blood pressure.

"My case managers recognize that patients have needs outside the disease itself and act upon that," she says.

For example, one patient set up his medicine regime and the plan did not cover the expense of sending a nurse out. The case manager found that the man's pastor visited him once a week. She got the home health nurse to visit with the pastor and teach him how to set up the patient's medicine.

"We have reached a time that the needs of patients, especially Medicare patients, have become so complex that you can't accomplish a lot unless you are actively involved and have frequent contact with the patients and their families," Knight says.

She cautions her case manager to find out more before labeling patients as noncompliant. For instance, one patient who was receiving home health had missed a doctor's appointment because he didn't have transportation. The home health agency wanted to drop him because of noncompliance, but the case manager intervened and arranged for a wheelchair service to pick him up. The patient was very compliant after that.

"It took some digging and research to find out what was going on," she says.

The program started in August after more than two months of planning. The effort is starting out with hospitalized patients. "Due to staff resources — we're small — we had to start small," Knight says.

The health plan is looking at alternative ways to enroll CHF patients who are not hospitalized. "But patients who are frequently hospitalized fit in nicely with this program," she says.

(Editor's note: Careguides are a series of disease management and other health care product kits available from Chicago-based Care Products. The kits include materials and step-by-step instructions for post-surgical care and disease management in the home.

For more information, contact Care Products at (847) 855-8777 or visit their web site at www.carekit.com.) ■

HHS report cites concerns over assisted living

Number of staff and turnover are key concerns

Residents of the nation's assisted living facilities generally are satisfied with the treatment they receive but express concerns over the number of staff available and staff turnover, a new report from the U.S. Department of Health and Human Services (HHS) shows.

The report *High Service or High Privacy Assisted Living Facilities, Their Resident and Staff* is the result of a national study of assisted living facilities that has been under way since 1994.

"With the nation's rapidly growing elderly population, it's important that we have information on the long-term care options that are available for our grandparents, our parents, and ourselves. This study provides the first comprehensive look at the most rapidly growing form of senior housing — assisted living," says HHS Secretary **Tommy Thompson**.

Researchers surveyed residents and staff and visited a sampling of the nation's assisted living facilities. Their report is a mixed bag of positive and negative findings.

On the positive side, the residents felt they were treated with respect and dignity. However, 12% of residents who needed help with locomotion and dressing, and 26% who needed help with using the toilet reported having unmet needs for assistance.

Staff were knowledgeable about issues concerning the care of common health problems among the frail elderly. However, the report concludes, in many facilities, a significant number of staff members were poorly informed about antipsychotic drugs and care for people with dementia.

The researchers found that the majority of staff in assisted living centers were completely unaware of what constitutes normal aging and what is a potentially reversible condition.

"Given the goal of enabling residents to age in place and the advanced age of the current residents, these results are particularly disquieting," the report says. Poor training and knowledge in these areas may in the future become more and more troublesome and risky, both for providers and residents since many of the conditions staff identified as a normal part of aging were potentially treatable and reversible."

The report looks at assisted living facilities that provide a high level of service and those that offer residents a high level of privacy. These two categories make up about 41% of all assisted living centers in the country. "High-service" assisted living facilities, which have licensed nurses on their staff and are able to meet the needs of more severely impaired residents, make up about 23% of all facilities, according to the report.

High-service facilities provide at least two meals a day, housekeeping, 24-hour staff oversight, personal assistance with medications, and activities of daily living. They have at least one full-time registered nurse on staff and provide nursing care.

"High-privacy" facilities have more than 80% private accommodations. However, the study points out, residents of assisted living facilities have more privacy and more choices than residents of nursing homes.

The study found that, on average, residents of assisted living facilities are less severely disabled than are nursing home residents. Nearly one-fourth of the residents in the survey had significant cognitive impairment and one in five required assistance with activities of daily living.

The facilities are well maintained, clean, and relatively home-like, and most are in suburban areas, according to the report.

Here are some other findings from the study:

- The median price was $1,800 a month with a wide variation in services covered by the base rate.
- More than half of the residents were 85 and older. Most were educated and relatively affluent.
- The vast majority of residents were female.
- Median staffing level was 14 residents for each caregiver.
- Staff reported being satisfied with most aspects of their work, except salary and advancement opportunities.
- Two in five staff members reported themselves to be in fair or poor health. ■

MCOs' performance improving, NCQA reports

Preventative care, disease management scores up

Health plans that publicly reported their performance data to the National Committee on Quality Assurance (NCQA) markedly improved their clinical performance in the past two years.

National averages improved in all key areas of

care and service, according to the report.

"For two years in a row, we've seen that participating health plans are getting better; the rest of health care is still a real question mark," says NCQA president **Margaret O'Kane**.

The information in the fifth edition of NCQA's State of Managed Care Quality report is based on data collected for Quality Compass, NCQA's database of managed care information and for NCQA's accreditation program.

The report is based on HEDIS data reported to NCQA by 372 health plans. Of those plans, 273 allowed their data to be reported publicly.

According to the study's results, health plans demonstrated increased success in preventive and disease management services. For instance, the reported rate of patients who received a cholesterol screening after a cardiovascular event was 74%, an increase from 60% just a year earlier.

The rate of diabetics screened for low-density lipoprotein cholesterol increased from 69% in 1999 to 77% in 2000. Those monitored for kidney disease rose from 36% to 41% over the same period.

Rates for controlling high blood pressure increased from 29% in 1999 to 52% in 2000. Average rates for cholesterol control went from 45% to 53%.

The report also pinpointed areas of weakness, such as chlamydia screening and mental health care, where performance is below acceptable levels.

Only about 25% of women who should have been screened for chlamydia received the screenings. Less than half of patients received recommended follow-up visits within seven days of being discharged from an inpatient mental health facility.

The 2001 report marks the fifth year that the NCQA has issued an assessment of the industry's performance and its impact on American overall health. This year's version expands on previous versions and includes a cost-benefit analysis of results, measure-by-measure results and analysis, and a discussion of the importance of provider groups in improving quality, including profiles of quality improvement initiatives.

The report contains a new section this year designed to quantify the effect of quality improvement. The NCQA is developing an economic model to allow employers to calculate the financial benefits of selecting high quality vs. low quality health care.

For instance, the report points out that indirect costs related to lost productivity, sick days, and related wages totaled $3.8 billion for asthma in 1998. In 1990, major depression cost $23 billion in lost workdays.

The report includes an analysis of a hypothetical manufacturer with 20,000 employees which showed that choosing an NCQA-accredited plan vs. an unaccredited plan would help save more than 1,500 sick days and more than $800,000 in indirect costs per year among the employer's diabetes population alone.

Some other findings:

Members participating in health plans are more satisfied than in past years in areas such as customer service and claims processing. Results for the Overall Rating of Health Plan section rose nearly three percentage points to 59.3% in 2000.

Plans that give HEDIS data to NCQA but do not allow them to be shared with the public typically received lower scores than those who allowed the data to be made public.

The gap between the top and bottom performers is shrinking. Plans that have performed poorly in the past have registered impressive gains. For instance, for plans performing in the 10th percentile, the average rate of cholesterol screenings increased from 53% in 1999 to 63% in 2000.

The State of Managed Care Report: 2001 is available at NCQA's Web site, www.ncqa.org. ■

Consider 'step-up' drugs for elderly patients

Formularies should give providers range of options

Small, incremental improvements to existing drugs can provide important benefits to patients, especially the elderly, a Temple University study has shown.

"People look down their noses at little changes in existing drugs in favor of blockbuster drugs and new chemical families. But new drugs in a therapeutic class often have fewer side effects, improved safety and effectiveness, and are used more easily," says **Albert Wertheimer**, PhD, director of the Center for Pharmaceutical Health Services Research at Temple University in Philadelphia and lead researcher on the study.

Wertheimer urges provider and insurers not to dismiss such drugs because they may have a whole new series of benefits.

"By nature of human genetic components, not all drugs work for all people," he says.

CE questions

17. According to the Department of Health and Human Services, people ages 55 to 65 are how much more likely to have health problems than people just 10 years younger?
A. Twice as likely
B. Three times as likely
C. Four times as likely
D. Less likely

18. Define the total cost per member per month of providing care for congestive heart failure patients at Harbor Medical Associates in 1998.
A. $3,400
B. $1,330
C. $1,140
D. $1,072

19. According to a report from the National Committee on Quality Assurance (NCQA), what percentage of women who should have been screened for chlamydia actually received a screening?
A. 100%
B. 75%
C. 50%
D. 25%

20. According to the NCQA report, in 1998, what were the indirect costs of asthma related to lost productivity, sick days, and related wages?
A. $800 million
B. $1.2 billion
C. $3.8 billion
D. $15 billion

Incrementally innovative medicines have a molecular structure or method of action similar to the first drug that is approved. However, the drugs typically provide improved benefits, such as fewer side effects, improved safety, greater ease of use, or product alternatives that permit treatment to be better tailored to the individual.

"These improvements are especially important for optimal treatment of elderly patients because their diverse response to medications requires individualized care," he says.

There are many plusses to including such drugs in the formulary and not too much downside, he says. "It's penny-wise and pound foolish not to have at least one alternative. Providers owe it to themselves to see if it has a clinical advantage or a price advantage," he says. ■

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Editorial Questions

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

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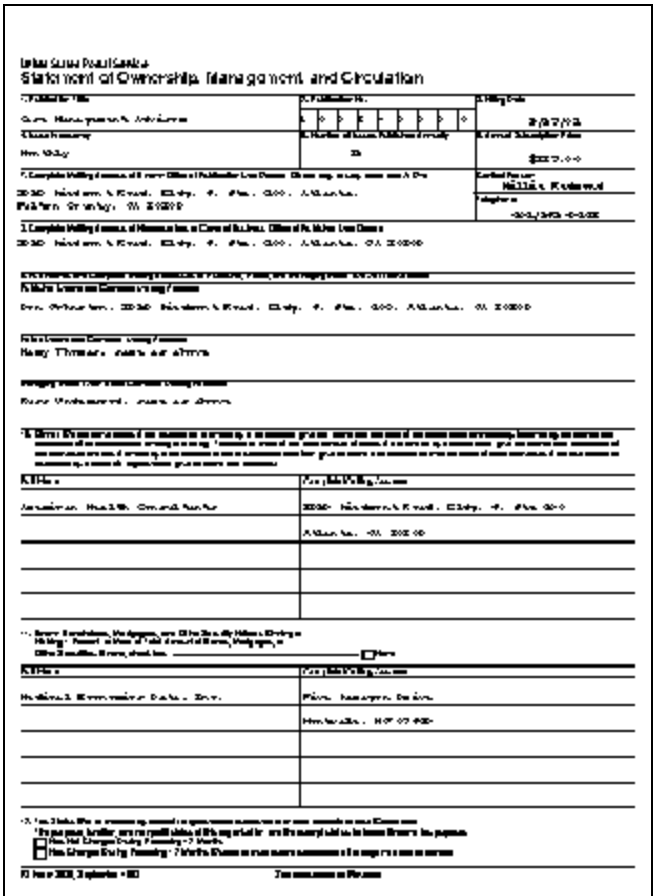

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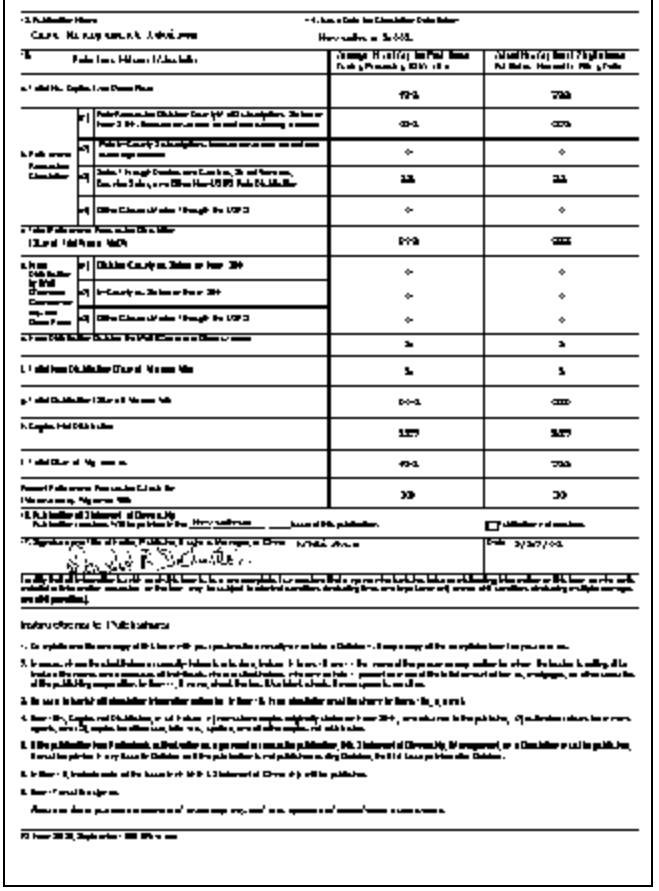

CE objectives

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. ■

Resource Bank™

A monthly compilation of news you can use from *Case Management Advisor*

Care by specialists can reduce deaths from endometrial cancer

The increased rate of deaths from endometrial cancer can be reduced by making women aware of the warning signs and risks for the disease and by treatment by a gynecologic oncologist once diagnosed, according to the Society of Gynecologic Oncologists (SGO) in Chicago.

Concerned that the rate of women dying from endometrial cancer has increased by 128% since 1987 while the mortality rate from other forms of gynecologic cancers has decreased or remained stable, the organization launched an initiative to educate women about the disease.

Endometrial cancer is the most common cancer of the female reproductive system, but when it's detected early and confined to the uterus, the cure rate is greater than 85%, says **Beth Karlan**, MD, director of the division of gynecological oncology at Cedars-Sinai Medical Center in Los Angeles.

Factors associated with increased risk include obesity, hypertension, diabetes, inappropriate estrogen use, tamoxifen use, and late menopause. The most common warning signs are vaginal bleeding after menopause or irregular vaginal bleeding in pre-menopausal women.

The SGO has developed four steps as an educational path to help women protect their gynecological health:

- Get to know your family history.
- Conduct an on-line cancer risk assessment at The Women's Cancer Network, www.WCN.org.
- Ask questions and educate yourself about gynecologic cancer.
- Make an appointment for your annual gynecologic exam and Pap test.

Endometrial cancer should be treated by a specialist, the SGO says. "Just as you would see a cardiologist for heart problems, women need to have a gynecologic oncologist involved in the treatment of reproductive tract cancers because they are specially trained to manage these diseases," says **Karl C. Podratz**, MD, PhD, professor in the department of obstetrics and gynecology at the Mayo Clinic Cancer Center in Rochester, MN. ▼

Exercise may help patients with chronic fatigue syndrome

Increasing activity and physical exercise may improve the quality of life and the ability to function in some patients with chronic fatigue syndrome, according to a new report from the Agency for Healthcare Research and Quality (AHRQ).

The researchers did not find that one form of exercise was better than another form.

The report was conducted for AHRQ by the San Antonio Evidence-Based Practice Center at the University of Texas Health Science Center and the Veterans Evidence-Based Research, Dissemination, and Implementation Center.

The researchers reported insufficient evidence to draw any conclusion about other treatments for the condition, which include immune therapy, corticosteroids, antidepressants, and complementary therapies.

The summary of Evidence Report No. 42: Defining and Managing Chronic Fatigue Syndrome is available at www.ahrq.gov. ▼

Hopkins guide to AIDS care now available

The 10th edition of Medical Management of HIV Infection is available from the Baltimore-based Johns Hopkins AIDS Service.

What started out as a 28-page booklet in 1991 has grown to a 356-page book with more than 260 pages devoted to anti-HIV therapy and treatment of opportunistic infections and complications.

The increase from 28 pages to 356 pages

reflects the revolution in AIDS medical care over the past 10 years," says **John G. Bartlett**, MD, who co-authored the book with **Joel E. Gallant**, MD, MPH.

"We started out with just a few lab tests and a few antiretroviral drugs that didn't work for more than a year. AIDS and HIV infection is no longer a death sentence. Now it can be treated as a chronic, manageable disease," Bartlett says.

Bartlett has been chief of the Infectious Disease Services at Johns Hopkins since 1980. Medical Management of HIV Infection is available for $8 through the Johns Hopkins AIDS Service web site, www.Hopkins-AIDS.edu. ▼

AHRQ database tracks hospital care of children

The U.S. Agency for Healthcare Research and Quality (AHRQ) has launched a database of inpatient hospital care for pediatric patients from birth through age 18.

The Kids' Inpatient Database (KID) was developed to make national and regional estimates of children's treatment, including surgery, and to be used in estimating treatment outcomes and hospital charges.

"The KID is a major step forward in the study of children's health care," says **Lisa Simpson**, MB, BCh, AHRQ deputy director. "Not only does it make it easier for researchers to obtain the data they need, but the size and power of the database enable them to study hospital care for even the rarest conditions by specific age groups of children."

The database includes information on 1.9 million children's hospital inpatient stays at more than 2,500 hospitals. Children were included whether they had insurance, received public assistance, or were uninsured.

Included is information on principal and secondary diagnoses, tests, surgeries, other procedure, lengths of stay, hospital charges, payment sources, and type of hospitals.

Data from the KID are included on AHRQ's HCUPnet, an interactive on-line service to answer questions about hospital care, outcomes and charges. HCUPnet is available without charge at www.ahrq.gov.

For other information on the KID including costs and software requirements, contact the HCUP Central Distributor, Social and Scientific Systems Inc., at (866) 556-4287. ▼

Web site may help patients manage their asthma

An on-line Allergy and Asthma Condition Center from MayoClinic.com connects people with information and tools to help them manage symptoms of asthma and allergies.

The site features an adult-onset asthma self manager to help adults cope with asthma and provides tips on getting a good night's sleep, exercising with asthma, and asthma management.

"It is important for people to understand that asthma is a manageable disease. With proper education and medication, you can keep asthma's interference with your life to a minimum," says **Ashok Patel**, MC, a pulmonary and asthma specialist at Mayo Clinic in Rochester, MN. ■

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.

Send all items for potential publication to Mary Booth Thomas, Editor, *Case Management Advisor*, P.O. Box 740056, Atlanta, GA 30374. Phone: (770) 934-1440. E-mail: marybootht @aol.com.

CMA must receive information about conferences and seminars at least 12 weeks prior to the event to meet our publication deadlines. ■