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INSIDE

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New year heralds increased need for case managers in health care

Look for emphasis on communication, disease management, technology

The new year is likely to bring more changes in the health care environment, and some of the changes could affect the way case managers do their job. The good news is that case managers will be needed more than ever as the health care system evolves. The challenge is that case managers are going to have to adapt to new ways of doing things in order to succeed.

The next phase of case management will involve much greater collaboration with payers and providers, and an increased flow of information among all parts of the health care system, predicts **David Kibbe**, MD, MBA, chief executive officer of Canopy Systems Inc., a health care technology firm based in Chapel Hill, NC.

"The next generation of case managers is going to have to be part of a team that is making care more efficient and more effective. They're going to have to think more about information management and using technology. It's going to be a real challenge that all case managers are going to have to face," he says. **(For more information on the need for technology in case management, see related story on p. 3.)**

Case managers are the glue that holds a fragmented health care system together, and if the current system is to survive, case managers will have to be increasingly involved in coordinating among the various levels, asserts **Brian D. Klepper**, PhD, president of Healthcare Performance Inc., a Jacksonville, FL-based health care business development practice, and executive director of the Center for Practical Health Reform.

"Case management is the professional embodiment of managed care. It is a professional role that has the job of taking a multifaceted, compartmentalized system and being the intermediary link within it, being the advocate for all the players in the system," Klepper says.

The combination of increasing health care costs and the current financial downturn could wreak havoc with the current system, Klepper says. **(For details, see related story on p. 5.)**

"If we are going to save the existing health care system, we're going to have to develop standards requiring that things are done in a relatively consistent way within a complex and fragmented system. Case managers are the only ones who are in a role to provide oversight in that process," Klepper says.

As the system becomes healthier, the case management role will become more and more important, Klepper asserts.

But increased autonomy for case managers is not a done deal, Kibbe says. He tells of a CEO of a 15-hospital system who commented that if things ran smoothly with the patients and payers connected, there wouldn't be any need for case managers.

"Case managers need to be very smart about showing their value and adopting the appropriate information technology to make them part of an efficient system," Kibbe says.

He recommends that case managers be able to show that they are tracking avoidable days and how their interventions are decreasing costs. "Case managers will come into their own, provided they are smart about proving their value, and ask for and receive the right tools and resources. They are going to have to get better at the business side of health care," he says.

As the consumer movement in health care grows, case managers are likely be on the front lines, helping patients make appropriate choices about treatment options and health care providers, says **David B. Nash**, MD, MBA, the Dr. Raymond C. and Doris N. Grandon Professor of Health Policy and Medicine and Director of Health Policy and Clinical Outcomes at Thomas Jefferson University in Philadelphia. Nash will make a keynote presentation at the Case Management Society of America conference in June. "The consumer movement in health care is a powerful force. Case managers are going to be leading the charge and even, perhaps, reluctantly dragged along," he says.

Instead of just going where their primary care physician recommends for care, health care consumers of the future are likely to shop around and look for providers with the best published outcomes that they can track online, Nash says.

"With the growth of the Internet, consumers are becoming savvier shoppers for health care services, and they are going to turn to case managers to guide them to the appropriate web sites for patient education materials and provider settings, and for their personal advice," he adds.

That's why case managers need to educate themselves to help consumers make the most appropriate choices, he adds.

New technology is going to make tremendous changes in the way health care is delivered, and case managers need to keep up in order to help their patients, Nash adds.

For instance, already patients are able to send information on blood sugar, cholesterol levels, lung status, and other conditions to their physicians over the Internet.

"Case managers need to educate themselves and be up to speed on the new technology so they will be in a position to explain it to the patients. Physicians aren't going to be able to take the time to educate the patients," he says. Case managers will be on the front lines of consumerism in health care, Nash asserts. ■

What does the future hold for case managers?

Experts make their predictions

Case Management Advisor asked a panel of experts for their predictions of how the health care system will change in the next few years and what case managers need to do to stay in step.

Here are some of their predictions:

• **Job opportunities are likely to increase.**

There's not a shortage of case managers yet, but a lot of companies are looking for people with case management skill sets, says **Liza Greenberg**, RN, MPH, vice president, research

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and quality of Washington, DC-based American Accreditation Healthcare Commission (URAC).

The larger insurers are looking for new ways to work with their data and to identify which patients can benefit from more intensive services early on, she says. Case managers can be part of the early warning system to show which cases are going to be high-cost as well as coordinating care and making sure patients move swiftly through the continuum, she says.

"Case managers are going to be more involved in getting people through the system more efficiently and making sure they're not being held up because of a test and to make sure patients are at the right level of care," she says.

The recent URAC survey of 115 companies registered to do utilization management showed an increased interest in an expanded role for case managers, she says."The companies are using their data to predict patterns of high use in the future and to get the case manager involved earlier," she says.

• The increasing threat of bioterrorism will change the role of traditional case management and result in a new job — public health case managers.

Public health departments, particularly in large cities, are likely to employ case managers to manage vulnerable populations of patients in case of an infectious disease outbreak or other public health threat such as the anthrax scare, predicts **David Kibbe**, MD, MBA, chief executive officer of Canopy Systems Inc., a health care technology firm based in Chapel Hill, NC.

"There is going to be a need for a nurse case manager to be available when there are alerts and potential attacks," he says.

Case managers in all settings may encounter the need to transfer information about patients or groups of patients securely among facilities in the event of a catastrophe or emergency, he adds.

• There will be a new emphasis on disease management.

Recognizing that complications from chronic illnesses consume large chunks of the nation's health care dollars, payers, providers, and employers are looking at ways to avoid hospitalizations and improve the lives of people with diabetes, hypertension, congestive heart failure, and other chronic illnesses. "If we can't get a handle on patient care, the cost of health care is going to continue to increase. Case managers are going to be part of the solution to manage these populations," Kibbe says.

A small group of case managers on the payer side have been working with population-based health care guidelines, identifying target populations and high-risk patients and working with physicians to try to change patient behavior, Kibbe says.

"The disease management case management model involves guidelines that adhere to best practices. It's moving into the provider organization," he adds. Large health plans, PPOs, and self-insured companies are turning to disease management to [achieve] better outcomes for people who are sicker or have more potential to get sick in the future," Greenberg adds.

• A new generation of patients will demand more computer-related health care information.

The Depression-age population is dying off and being replaced by baby boomers who are more involved with their own care and who demand more information about their conditions, Kibbe points out.

"Patients want a computer-literate information exchange. They want to know what their options are when they are sick, and payer organizations are going to have to provide that," he says.

If it hasn't happened already, it's likely that a patient will call you with information about a new treatment he or she learned about on the Internet and ask your advice, says **David B. Nash**, MD, MBA, the Dr. Raymond C. and Doris N. Grandon Professor of Health Policy and Medicine and Director of Health Policy and Clinical Outcomes at Thomas Jefferson University in Philadelphia. ■

Get on the tech bandwagon or be left behind

It's not just HIPAA, it's good business

If you're a typical case manager, you likely spend more than 50% of your time pushing paper, 10% of your time faxing documents, 10% of your time on the telephone, and only 2% to 3% of your day with patients, says **David Kibbe**, MD, MBA.

"It doesn't make good sense to use a nurse's time this way. Big payers are recognizing the fact that automation is going to be the only way to remain profitable," adds Kibbe, chief executive officer of Canopy Systems Inc., a Chapel Hill,

(Continued on page 5)

Seven ways to prepare for the future

1. Become more data-savvy.
Learn to manipulate the data you have to identify patients who are likely to need complex care, suggests **Liza Greenberg**, RN, MPH, vice president of research and quality of URAC.

2. Familiarize yourself with the clinical literature for evidence-based practice.
"Companies are really trying to develop care management protocols along evidence-based guidelines," Greenberg says. For instance, know that asthmatics are supposed to have this kind of treatment or that people with congestive heart failure need to follow a certain protocol. "If they know this, case managers will be an asset to the companies they work for," she says.

3. Continue to push for standards and regulations to give case management's role in health care the recognition it deserves.
"Case managers have an opportunity to expand their role in health care, but they have to gain credibility in order to do so," asserts **Brian D. Klepper**, PhD, president of Healthcare Performance Inc., a Jacksonville, FL-based health care business development practice and executive director of the Center for Practical Health Reform. "If they don't have the power within their individually organizations to do it, they should continue to strengthen their ranks through professional organizations," Klepper adds.

4. Be prepared to show that your interventions work in order to have credibility within your organization.
Case managers should track quality of care indicators and show how their interventions work and the cost savings they generate. For instance, be able to show that not only did a higher percentage of congestive heart failure patients get discharged at 100% adherence because of your intervention, but be prepared to show how much money it saved your organization. This undoubtedly means that you will have to eliminate your paper records and switch to a computerized system to manager your patients, Kibbe says. "You cannot do that on paper unless you have many more staff. And if you think any case management department is going to get more staff, you are mistaken," he says.

5. Take a role in clinical practice guidelines being developed by your organization. Familiarize yourself with specialty society web sites, as well as the National Institute of Health, and Agency for Health Care Research and Quality web sites, which have national guidelines, Greenberg suggests.

6. Educate yourself on health care sites throughout the continuum where you patients may seek treatment.
For instance, there probably are a variety of settings for rehabilitation. Educate yourself so you can help patients choose the best ones for their particular needs and help them make sense of the outcome-based information that may be on the facilities' web sites, suggests **David B. Nash**, MD, MBA, the Dr. Raymond C. and Doris N. Grandon Professor of Health Policy and Medicine and Director of Health Policy and Clinical Outcomes at Thomas Jefferson University in Philadelphia. Start with those in your geographic area and expand your knowledge base to include regional and national center of excellence.

7. Prepare for the next generation of patients by becoming Internet savvy.
There's no way around it. Your patients, your employer, and the people with whom you communicate are going to mandate the use of the Internet for communication, business, and referral purposes. Kibbe cites statistics that show that two-thirds of all households have computers. Many people use web browsers and communicate by e-mail daily, he says. "Patients are increasingly demanding to know what their options are. The Internet is another technique that case managers can take advantage of," he says. ■

NC, health care technology company.

Rising costs are increasing the emphasis on efficiency in health care, and that is going to mean adapting technology and eliminating paper pushing, Kibbe adds. "Anyone who thinks he or she is going to stay valuable without trying to be more efficient in health care is in trouble," he says.

Payers are spending an enormous amount of money to re-engineer their systems to comply with regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA), Kibbe points out. "And when that happens, they are not going to want to maintain 600 cubicles of people doing low-end clerical work. They're going to want automation from everyone they deal with," he says.

And while changing from a paper-based to a computer-based system may be a headache at first, ultimately it will allow case managers to spend more time doing what they are trained to do — improving patient care.

"Automation allows case managers to focus on appropriate care, adherence to guidelines, and explaining options to patients. With complex patients, they need to conduct medication reviews, help patients with pharmacy issues, and do many things that are important to quality of care and cutting costs. But they can't do it if they spend all their time pushing paper or faxing information," he says.

Case managers have a lot of good clinical and administrative information available to them, but it's going to be necessary to update their business office information system so they can instantaneously communicate changes in patient status with the business office and payers, Kibbe says.

"One of the major issues is business-to-business automation. It involves a complex set of administrative and clinical information that case managers have within their normal workload. It's not just HIPAA requirements. It makes good business sense to have this automated," he adds.

Health care costs are going to continue to go up, particularly as the baby boomers age, putting an even bigger strain on hospitals, health care systems, and other providers.

"There is going to be a huge emphasis on doing things more efficiently. We spend between 25 cents and 30 cents of every health care dollar pushing paper. And this sometimes leads to clinical events that are costly," Kibbe says.

For instance, patients who take numerous medications can experience side effects and end up in the emergency room. Or they can't afford to take their medicine, leading to a need for greater acute medical care.

"This is an area where management of individual patients and groups of patients is going to be critical, particularly using information technology that is secure and Internet-based," he says.

Health care providers and insurers are going to have to automate their admissions, discharge planning, utilization review, coordination of benefits, denial management, coordination of information and communication with the business office, and other parts of the health care system, Kibbe says.

"Over time, there is going to be increasing collaboration between the payers and case managers, not only in the hospital but for large provider organizations of any kind. It will be good for the case managers because they will be able to spend more time with their patients and communicating with physicians," he says.

Canopy Systems provides software for hospital case managers that help them collect, manage, store, and transmit information between themselves, the patients, payers, and other providers. "We are seeing a demand for our software as hospitals bring case management out of the Dark Ages. They are replacing lists, sheets, and other inefficient methods and replacing them with software tools," Kibbe says. ■

Reform needed to save flagging health system

Communication, accountability are the keys

The health care system as we know it could experience significant difficulties over the next few months, says **Brian Klepper**, PhD, president of Healthcare Performance Inc. in Jacksonville, FL. He cites rising health care premiums and a flagging economy as reasons the health care industry is in trouble. But the system can be fixed, and case managers are likely to have a big role in the solution, Klepper says.

His assertions are backed up by a group of reinsurers, providers, and HMO representatives who came up with seven principles for how to fix the system, Klepper says.

Among the issues they called for were uniform adoption of best practices and public availability of performance information. "We need to find ways to eliminate variabilities in the system

through traffic controllers, who are essentially case managers. The only way it can be done is if the case managers have guidelines to follow, and the authority and buy-in they need," he says.

A major cause for problems within the health system is soaring health insurance premiums that have gone up at double the rate of inflation for the past four years, he says."This year, the premium increase that has been leveled on employers is four times inflation, about 18% - 20% for large businesses and 30% - 50% for small businesses," Klepper says.

Rising premiums were no problem when the economy was prospering, but now that the economy is in a recession, business leaders are saying they will significantly increase employees' share of the cost, Klepper says, predicting a dramatic increase in the number of uninsured, beginning this month. "Nobody who makes $35,000 a year can afford to pay $7,000 a year for family coverage," he adds.

He predicts a big increase in the number of emergency room visits, and a spike in the inpatient days in the public hospitals as private hospitals stabilize patients and send them to public hospitals. "Since 40% of American hospitals are already running in the red, if you get a spike in inpatient costs and a reimbursement vacuum, they are going to start to go under," he says.

Klepper has operated a health care consulting practice offering operational audits and business development services. This has given him a bird's-eye view of the system, he says. "As a result of the way health care has grown up, it's become Wyatt Earp land. Everybody is out there for himself. Everybody is trying to make money. Everybody is less interested in the system than they are in their specific benefits from the system. That's why the system is getting ready to fail," he says.

The tremendous variation among providers in quality of care and the lack of accountability among providers, insurers, and patients has put the system in jeopardy, he says.

Seven Principles to Change the Health Care System

During a discussion of the current health care crisis, a group of senior managers representing a cross-section of the health care profession in Florida developed seven principals to change our health care system. The group, assembled by **Brian Klepper**, PhD, included health plan executives, physician practice managers, disease management professionals, a nurse, a provider network manager, a hospital system managed care coordinator, and practicing and administrative physicians.

"The group came to consensus with startling speed, which suggested that these principles are obvious to the people who work the front lines every day," Klepper says.

1. Universal coverage of basic benefits for everyone so that gaps in the system won't become large enough to cause it to collapse.

2. Supplemental coverage: Anyone who wants it and can afford it gets as much health care as he or she wants.

3. Private sector management of health systems. This includes financial incentives tied to accountability for performance and innovation.

4. Uniform adoption of evidence-based best practices. Klepper cites Minnesota, where all major health plans agreed on the same best practices for the top 50 conditions."The results have been a dramatic decrease in variation and improvement in quality and cost," he says. However, Klepper points out that establishing best practices wouldn't mean forcing practitioners to use them but that practitioners should be accountable for their performance.

5. Publicly available performance information on all practitioners and institutions.

6. Distinguishing between preventable and nonpreventable risks. Nonpreventable risks would include diseases, catastrophes, and genetic defects. The group called for greater individual financial responsibility for preventable risks due to unhealthy lifestyle choices and demand for services beyond protocol, or, as Klepper puts it, "holding consumers' feet to the fire for their choices."

7. Moving from a single year to multiyear health plan. "A single year doesn't give you long enough to deploy a program and get a necessary return on your investment in disease management and wellness programs. That takes three to five years," he says. ■

"If we keep the existing system, there have to be new disciplines that everybody buys into — all stakeholders, including consumers. We must say that we are all going to use the standards and be responsible for the choices we make," Klepper says. ■

UR, proactive steps keep hospital days to a minimum

Discharge planning starts upon admission

By keeping close tabs on utilization and planning ahead, case managers at Harbor Medical Associates are keeping their days in the hospital for their Medicare Risk population to between 900 and 1,000 days per thousand members per month.

Skilled nursing days typically run 1,000 - 1,200 per member per month.

"With our case management model, we have unbelievable days per thousand and run below the network average. Our success is setting up expectations and goals and working with the family and the whole health care team," says **Hilja Bilodeau**, RN, CCM, director of case management for the Southeast Massachusetts physician practice.

The case management department also keeps close tabs on utilization, using a program Bilodeau developed on an Excel spread sheet. The program graphs out days per thousand for each physician and for the entire group and allows the case managers to keep up with utilization on a daily basis.

Physicians get a monthly report on the days per thousand in acute care, skilled nursing, and visiting nurse services days. If the figures are high one month, the case managers look at the individual cases to see if there are outliers and why.

"We constantly have our pulse on our outcomes and have utilization management meetings twice a week with all physicians to discuss all the cases. We have a program in place so that we know how many people are in the hospital, how many are seen in the emergency room, and how many are getting home care services," Bilodeau says. The case managers have seven-day coverage and call in on weekends to make sure the plans of care are being followed and if any changes are indicated.

"We also have a good relationship with other providers and our vendors, and that is one of the keys to our success," says **Linda Connell**, RN, a case manager for the Medicare risk population.

For instance, if a patient is accepted at a skilled nursing facility (SNF) over the weekend, the SNF knows that the Secure Horizons case managers will approve payment from the time the patient is admitted until they can review the case on Monday. The same is true with any durable medical equipment a patient may need in order to be discharged to home over the weekend.

"There is a lot of trust on both sides. The providers and vendors know that we will pay for what the patient needs over the weekend and there is no delay in getting them discharged from the acute-care hospital," Connell adds.

The case managers start discharge planning from day one, working to get patients who are in the hospital into skilled nursing facilities quickly and facilitating the admission of patients from the emergency room.

"We are very proactive about setting goals and making plans for the patients as they move along," Bilodeau says.

As soon as a patient is admitted to the hospital, the case managers do an assessment to determine what the patient's discharge needs are likely to be. For instance, based on the patient's condition, Connell may talk to the skilled nursing facility or start to set up home care on the day of admission.

The case managers discuss the anticipated discharge plans with the family from the first day so there won't be any surprises. For instance, if the case manager believes that rehabilitation in a skilled nursing facility will be indicated, she suggests that the family visit the skilled nursing facility to make sure they are comfortable with it.

"We want everybody on board with the plan from day one, and if we need to adjust it later on, we do so," Connell says. If there are several skilled nursing facilities in the area, the family members get a chance to choose one, instead of feeling as though they're being forced to go to one place at the last minute.

If a patient is scheduled for elective surgery, such as a total hip replacement, the case managers get in touch with the patient ahead of time and discuss the plan of care.

They set up home care and have the physical therapist who will be working with the patient meet with the patient and family at home to look at potential problems, such as accessible areas.

The physical therapist starts the patient

education before surgery, teaching patients the exercises and bringing in equipment they will need after surgery.

If it is likely that the patient will be going to a rehabilitation setting after the surgery, the case managers arrange for the patient and family to tour the facility, meet with the staff, and decide if they are comfortable with that particular facility.

Having all the plans of care in place before the surgery occurs often results in a shorter recovery time.

"This option is much better than having it all thrown on the patients after they are discharged with pain medication," Bilodeau says. ■

Physician practice CMs manage through continuum

Team approach is key to success

When **Hilja Bilodeau,** RN, CCM, set up the case management department for Harbor Medical Associates five years ago, the Southeast Massachusetts-based physician practice was the first in its area to have internal case managers.

"Physician case management is still new, although it has developed within the past five years," says Bilodeau, director of case management for the 34-physician practice.

Setting up case management for a physician group was a hard sell at first, Bilodeau says. Physicians were wary about having someone come into the office and put plans of care in place, seeing it as another layer of bureaucracy to deal with, she adds.

But that's all changed.

"They have realized the benefits, and we work collaboratively as a team. They think it's great to have another person help with the difficult situations," she says.

Bilodeau attributes the success of the program to a team approach, collaborating with physicians and other case managers every step of the way.

"One of our successes is buy-in from the physicians and hospitals. The hospital case managers work closely with us, and we emphasize that it's a team approach. Patients pick up that relationship, and we are very successful in getting the patients to the best place they need to be," she says.

Bilodeau was a case manager for managed care companies for more than 25 years, having worked with major insurance companies and a large HMO before joining Secure Horizons to set up its capitated program.

"We set up our own mini-HMO and put together a process that met standards for the insurance company, as well as for the Medicare Risk population," Bilodeau says.

As a result, Secure Horizons, the Medicare Risk section of Harbor Medical Associates, was the first delegated physician group on the south shore of Massachusetts.

The physician practice will become fully delegated for a major commercial insurer early this year. "We are a physician-based case management program, employed by the physician organization," Bilodeau says. The Harbor Medical case managers often work with the hospital case manager and the home care case manager, as well as working closely with the patients and their families.

"We know their families. We don't just manage the insurance and payment aspect. We go beyond that and work with the social aspects, hooking patients up with the appropriate resources," says **Linda Connell**, RN, a case manager for the Medicare Risk population.The physician case managers make rounds daily in the hospital and form collaborative plans of care with the hospital and insurance case managers.

They see patients at the physician offices, act as advocates for the patients should they need ancillary services, and work closely with the Wellness Center, a collaborative effort at disease management between the physician group, CVS Pharmacy, and Pfizer Health Care Solutions.

For instance, when a patient was having difficulty paying for his cholesterol medicine, Connell worked with the Wellness Center to locate community resources such as the Massachusetts Advantage Pharmacy Program and contact drug representatives to take advantage of their programs to provide medicine for indigent patients.

"We focus on the patient as a whole and follow them through the continuum. We are a great resource for any of the services not covered under the insurance plan," Connell says.

Throughout the patient's hospitalization, the case manager makes sure the patient is making the expected progress and meets with the family and patient regularly to reassess the goals. "We may readjust the goals three to four times," she adds.

If the patient is being discharged with home

health services, the case manager meets with the Visiting Nurse Association, then calls the patient at home to make sure the plan of care and goals are being met and helps the family get in touch with community agencies, such as Meals on Wheels, to provide additional care for the patient.

If the patient needs long-term care beyond what Medicare covers, the case managers help them contact a social worker to help apply for Medicare. The Harbor Medical case managers are notified when patients are admitted to the emergency room and help the hospital case manager expedite getting patients to the appropriate venue of care.

"No one is slipping through the cracks. We are on-call 24 hours a day, 365 days a year," Bilodeau says.

Before Harbor Medical Associates set up its case management system, patients often had a case manager in an insurance company but the case managers were not designated for specific patients. For instance, the insurance case manager in the hospital managed acute and subacute care, but handed the patient off to another case manager that managed home care.

"There were different people managing the patient in different parts of the community. In our role, we're able to manage the patients through the continuum, including wellness services," Connell says.

Secure Horizons has 25 physicians fully delegated for the Medicare Risk population. Two case managers serve that population to meet the requirement of one case manager for every 1,500 patients.

Each of the two case managers for the Medicare Risk patient is assigned patients from specific physicians. The hospital case managers work the same way, working with patients from specific physicians. Each physician-based case manager works with a particular hospital case manager.

"After we round at the hospital, we collaborate on what needs to be done and coordinate with them and with the payer case managers during the day," Connell says.

Harbor Medical Associates' commercial population of about 9,000 patients is not fully delegated and is managed by one case manager.

However, the commercial population is much younger and does not require as much management. In fact most of the work with the younger population is educating them about their managed care policy, where insurance allows them to go, and what their coverage is, Bilodeau says.

"We do see the commercial patients in the hospital and are very involved in outpatient services, such as physical therapy," she says.

The commercial case managers see the physician case managers as a great front-line to the physicians.

"I go right to the physicians and talk to them about care. We really do collaborate on a daily basis. Before I leave the hospital, I talk to the commercial case managers and discuss the plans of care for all the patients," Bilodeau says. ■

Mediation could be key to return-to-work issues

Work-related stress might be delaying recovery

If you ask a patient who is out of work because of an illness or injury what caused his condition, he may just blame it on his boss or co-workers.

This is a clue that work-related stress and the psychological issues it can cause may affect this patient's return to work, according to **Mark Raderstorf**, MA, CRC, CCM, a licensed psychologist and president of Behavioral Management Inc., a Minneapolis, MN-based company that provides case management for employers and insurers in cases in which there is a psychological component.

"If you have a physical condition that impairs someone and it's not improving, more times than not, it's highly likely that [the patient] has psychiatric issues preventing their recovery or holding them from functioning," Raderstorf says.

Work stressors can contribute to longer medical leave, Raderstorf says.

"The patient may not be getting along with the boss or some of the co-workers. These stressors add anxiety to that individual's mental health status. They can become obsessional or very depressed about their job situation," he says.

If this issue occurs with one of your patients, it may be advisable to step in and try to mediate the problems in the work place in an effort to get patients back to work, Raderstorf says.

"One area that may be neglected is mediating those work place stressors. A case manager is in an ideal position to step in and rebuild those relationships, " Raderstorf says.

For instance, you may have an employee who has been on the job for many years and is very dedicated to the company. He doesn't want to leave but has the perception that the boss is unreasonable or unsympathetic. The stress can be manifested in physical symptoms — chest pains, gastrointestinal problems, or headaches. Or the employee may be anxious or depressed. "He could have a physical or a psychiatric scenario or a combination of both that is clearly contributing to his overall recovery," Raderstorf says.

Or, you may be seeing a patient with a back injury who is working hard on physical therapy. However, knowing that she eventually will go back to work and have to deal with her boss may cause the patient to become anxious and tense, which can lead to psychosomatic pain.

Watch for clues as to workplace stressors that may impede recovery and take steps to solve them as soon as possible, Raderstorf advises.

"Our studies have shown that the earlier we intervene, the better the results," he adds.

Whether you get to know the patients face-to-face or by telephone, ask what their understanding is of what led them to take medical leave. Sometimes patients will say right out that they feel the boss caused the condition. Other times, it may be a subtle comment here or there: "My boss wasn't that supportive," or "My co-workers make discouraging remarks."

You've got to pick up on it and follow through, Raderstorf says. For instance you could ask what a patient's plans are and what he or she hopes to see happen.

Patients may say they want to go back to the company but don't know if they want to go back to their old department. In some cases, a client already may have decided against returning to his or her former place of work.

But, if they may go back, it's important to try to shore up the relationships at work, Raderstorf says. "Sometimes they need a neutral outside party who is objective to facilitate the communication," he says.

"Some case managers may shy away from getting involved in mediating work place relationships, but they're doing a disservice to the client, the patient, and to the people who are paying for the care," Raderstorf says.

The first place to intervene is with the human resources person, the return-to-work coordinator, or the risk manager.

"We strongly recommend that case managers have some kind of interaction with the supervisor. Stress to the human relations person that you'd like to talk to the supervisor and get their take on the situation," he adds.

Raderstorf often sets up a return-to-work planning meeting to help ease the injured worker's transition back to work.

He contacts the supervisor and the human resources director and tries to bring the two parties together so they can talk out the issues.

Sometimes, he meets privately with the boss and the human resources director beforehand to get an understanding of what may be going on at the company.

Raderstorf has found in his experience that some employers are very open and cooperative and are willing to look at reasonable accommodations and a flexible work environment.

Some are very open to trying to shore up the relationship between the employee and co-worker or supervisor. "In other situations, the bad blood is so thick that no amount of mediation or return to work planning is going to overcome it," he adds.

When that happens, the employer needs to know that his decision not to take the patient back probably will prolong the claim and mean higher costs over time, he says.

Raderstorf encourages case managers to avoid what he calls "a bossectomy," a situation in which the client wants to remove the boss from his or her work environment.

Some clients want to go back to the company but don't want to report to their old boss. In that case, situation, the case manager should mediate the relationship between the employee and the boss and do what can be done to shore up the relationship and move in a positive direction, Raderstorf says. ■

Comprehensive diabetes treatment could save lives

Guidelines now lower for diabetics

A partnership of government agencies and other organizations has launched a new initiative aimed at reducing the mortality rates of people with diabetes.

The U.S. Department of Health and Human Services (HHS), the National Diabetes

CE questions

1. According to Brian Klepper, PhD, president of Healthcare Performance Inc. in Jacksonville, FL, what percentage of American hospitals are "already running in the red"?
A. 10%
B. 25%
C. 40%
D. 65%

2. Case managers at Harbor Medical Associates in Southeast MA, have managed to keep days in the hospital for their Medicare Risk population within what range per thousand members per month?
A. 900 to 1,000 days.
B. 1,100 to 1,300 days.
C. 1,300 to 1,400 days.
D. 1,400 to 1,500 days.

3. Secure Horizons, the Medicare Risk Section of Harbor Medical Associates, has how many physicians fully delegated for the Medicare Risk population?
A. 15
B. 25
C. 25
D. 45

4. According to Health and Human Services Secretary Tommy Thompson, projections indicate that the prevalence of diabetes in the U.S. will increase how much by the year 2050?
A. 85%
B. 125%
C. 165%
D. 200%

Education Program (NDEP), the American Diabetes Association, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) and the Centers for Disease Control and Prevention issued new, lower guidelines for blood pressure and LDL cholesterol in people with diabetes. The guidelines recommend blood pressure and cholesterol levels in diabetics that are lower than those for the general population and similar to those for people with heart disease.

Research shows that 75% of people with diabetes die from heart disease and stroke, and they die younger than the general population. Additional research shows that people with diabetes can live longer and healthier lives with

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Editorial Questions

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

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relative small decreases in blood glucose, blood pressure, and cholesterol.

The partners have launched a public awareness campaign to demonstrate that good diabetes care encompasses more than just managing blood glucose levels. It also should include managing blood pressure and cholesterol levels to help prevent heart disease and stroke.

"With 16 million people and counting, diabetes is growing at an alarming rate in America, says **Tommy Thompson**, HHS Secretary.

He cited statistics that shows that diabetes has increased 49% from 1990 to 2000, and projections indicate a 165% increase by the year 2050.

Diabetics are at a very high risk for heart attack and stroke, he added.

To communicate the importance of comprehensive care in simple language, the "ABCs" of diabetes have been developed:

"A" stands for A1C, or hemoglobin A1C, test that measure average blood sugar over the previous three months.

"B" is for blood pressure.

"C" is for cholesterol.

"People with diabetes know how important it is to control their blood glucose, but too little attention is paid to the role of cholesterol and blood pressure," says **Allen M. Spiegel**, MD, NDEP spokesperson and director of the NIDDK at the National Institutes of Health (NIH). "Research shows that this new approach, aggressively treating these three risk factors, can save lives, " he adds.

The new recommended targets for diabetics are:

• A1C — less than 7%. Check at least twice a year.

• Blood pressure — below 130/80. Check at every doctor's visit.

• Cholesterol (LDL) — below 100. Check at least once a year.

"The ABCs of diabetes is a clear message for both patients and health care providers that it's not just glucose that matters if you want to help prevent heart disease and stroke," says **John Buse**, MD, chair of the American Diabetes Association's Cardiovascular Initiative, titled "Make the Link."

NDEP and ADA have developed a new tool: A new brochure for people with diabetes that provides essential information and has a wallet card to help them track their ABC numbers. For more information, visit the NDEP's web site at ndep.nih.gov or the ADA web site at www.diabetes.org/makethelink. ■

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. ■

Researchers look at generic vs. name-brand drugs

Insurers, employers, and providers should have a better understanding of prescription drugs before they decide whether a generic or a name brand is better, a group of University of Michigan researchers have concluded. Many physicians prescribe generic drugs because of the cost reduction. Many times, the brand name drug would be more efficient.

"We feel there's a lack of knowledge on the part of employers, insurers, and providers regarding generic drugs and that these changes in prescription drug benefit programs should be made based upon a better understanding of the issues," said **Duane Kirking**, lead investigator on the project, of the motivation for the team's research. The Blue Cross/Blue Shield of Michigan Foundation provided $50,000 in funding toward the research.

The researchers conducted an in-depth look at the issues of brand-name medications and their generic equivalents.

While patients often ask for brand-name drugs, if they are told the generic drug is available and cheaper, they will most often decide on the one of lesser cost. Even if there are manufacturing campaigns to advertise brand name drugs, many times consumers will choose the generic drug to save money, Kirking says.

Manufacturers of brand-name pharmaceuticals trying to generate profits on the drugs they invented are loathe to give over market share to cheaper generics, but insurers trying to drive costs down often push providers to prescribe and dispense generics. They also encourage patients to take generics through higher copays on brand-name medications, the researchers point out.

Arguments that generics are not a true substitute are moot because of improvements in science that make it possible to tell whether generics are as effective as name brand drugs, they add. The researchers are publishing their findings in a seven-article series in the *Journal of the American Pharmaceutical Association* that began with the September/October 2001 issue. ▼

Free tool detects inappropriate hospital admissions

Prevention Quality Indicators, a free tool developed by the Federal Agency for Healthcare Research and Quality (AHRQ), can be used to detect inappropriate hospital admissions for diabetes and 15 other illnesses that can be treated effectively with community-based primary care.

The Prevention Quality Indicators allow users to measure and track hospital admissions using their own discharge data and will provide the information needed to improve the quality of primary care for these illnesses in a community or state.

"One way to improve the quality of America's health care is by preventing unnecessary hospitalizations that increase health risks as well as costs. To do this, we need to be able to track the outcomes of health care services that people receive," says **Tommy G. Thompson**, Secretary of the U.S. Department of Health and Human Services.

The Prevention Quality Indicators represent hospital admission rates for common conditions,

including bacterial pneumonia, pediatric gastroenteritis, urinary infections, congestive health failure, and chronic obstructive pulmonary disease.

For example, research shows that there are 7.2 hospital admissions for every 10,000 people ages 18 to 64 for uncontrolled diabetes. The Health People 2010 goal is to reduce the rate to 5.4 per 10,000 people.

The information in the Prevention Quality Indicators can be used to flag potential problems, follow trends over time, and identify disparities across communities and regions, says **John Eisenberg**, MD, AHRQ director. The Prevention Quality Indicators are part of the new AHRQ Quality Indicator modules developed by the UCSF-Stanford Evidence-based Practice Center.

To download the Prevention Quality Indicators and software, go to www.ahrq.gov/data/hcup/prevqi.htm. ▼

Web site provides information on IPF

The Coalition for Pulmonary Fibrosis (CPF) has launched a comprehensive Web site to educate health care providers, patients, and their families on idiopathic pulmonary fibrosis (IPF), a little known but ultimately fatal lung disease. The web site (www.coalitionforpf.org) offers information and resources on IPF that helps people to better understand the deadly disease.

IPF is a fatal disease characterized by eventual deterioration of the lungs for which there is no known cause or cure. Many victims of IPF die within the first five years after contracting the disease. The disease is characterized by a progressive scarring and deterioration of the lungs. Approximately 50,000 Americans suffer from IPF — nearly twice the number of cystic fibrosis patients.

The web site includes symptoms of the disease, diagnosis, treatment, and other information concerning IPF. A new booklet for physicians contains information on the disorder and highlights recent advances in its diagnosis, research and treatment.

The CPF web site includes a special section that addresses the needs of patients with information on symptoms, diagnosis, treatment options, and the value of a support network.

"Before we even announced its existence, we received nearly 4,500 visitors to the CPF web site (more than 73,000 hits)," says **David Happel**, senior director of pulmonary products at InterMune Inc. and chairman of the CPF's Strategic Advisory Board.

"There is a real need for credible and accessible information on IPF. It is our goal as a coalition to provide patients and physicians with the answers, resources, and support they require to help fight this battle against IPF," he adds. ▼

Calcium compound may prevent fractures

A new calcium compound has been shown to be effective in preventing osteoporosis-related fractures. The calcium compound, known as AdvaCal (calcium oxide/hydroxide), can prevent fractures in postmenopausal women according to research presented at the American Society for Bone and Mineral Research.

Other calcium forms have failed to show the ability to prevent fractures in peer-reviewed research.

In a study done by **Takuo Fujita**, MD, director of the Osteoporosis Foundation in Japan, calcium oxide/hydroxide proved to be more effective than any other method of preventing fractures in postmenopausal women.

After 27 months of study, a group of elderly women (with a mean age of 80) taking AdvaCAL calcium reported zero fractures per 1,000 patient years. A group taking calcium carbonate reported 357 fractures per 1,000 patient years, while the placebo group recorded 500 fractures per 1,000 patient years. ▼

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