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## INSIDE



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**Reports From The Field**

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# Individual case management of chronically ill pays off for insurer

*Employers contract for special case management services*

Under a unique arrangement with employer groups, case managers at Regence BlueCross BlueShield of Oregon (BCBSO) in Portland provide individual case management for people with chronic or catastrophic illnesses who require long-term care, or have psychological and social needs that require coordination of or access to multiple levels of care.

Recognizing the potential benefit of a program to address the serious needs of the chronically ill, Regence BCBSO created Individua, a program that assigns case managers to each employer who purchases the Individua program.

Members who need care management services deal with the same case manager who coordinates their care throughout the continuum. The plan has received high praise from employees who have only one person to call about their health care needs, and employers, who receive regular reports on their employees in the Individua program. **(For details on the reports, see related story on p. 15.)**

"To my knowledge, we are the only insurer-based case management department that provides this type of service for specific employer groups," says **Annie French**, RN, case manager and manager for health care management.The case management program currently serves 32 employers with more than 200,000 members. Regence BCBSO's Individua program has 37 case managers who deal with 40-60 acute interventions at a time.

"We can have up to 100 or more cases because some are in the monitoring phase, where we watch the claims and evaluate what is happening with the care," French says.

The company has specialty case management programs that work only with certain types of cases. For instance, two case managers deal only with transplant patients, French says.

The case managers provide individual care management for members

at the employee group to which they are assigned. "In a world where people so often feel like a number, Individua focuses on the individual's needs," French says. Having in-house case management for patients who need it is particularly effective for an insurer because the case managers have access to all aspects of information regarding the members, French points out.

"Our program sets us apart from independent case managers because we know the provider contracts, the member contracts, what the employer has purchased. We get the clinical picture, make contact with the members, and learn their psychological and social needs. Because we have access to all their claims information, we are able to take a look at all the information that is available," French says.

The case managers often follow the patients from the time they are born. For instance, **Olivia Warfield**, RN, BS, CCM, is managing the care of one child who is autistic, another who has cerebral palsy, and another who has a genetic disorder.

"It really is a wonderful way to stay involved with a patient. When you work with them just in the hospital, you never know what happens after discharge," Warfield says. She's worked for years with one patient who has major physical defects and has needed a variety of adaptive equipment.

"I worked with the mother for many years, and in May the grandmother called to say the mother had died, so I moved on to the next generation of caregivers. It made me feel better to know that the family was aware of how I can help," Warfield says. When a patient is not healing, the care manager consults with a team in suggesting treatment for the patient. If the patient's primary care physician accepts the plan for additional treatment, the case manager guides the patient through an alternative treatment plan.

Often the case managers go far beyond meeting just the medical needs of the patients. For instance, Warfield worked with an elderly patient who was very sick and had no family in Oregon. She was able to help the patient's sisters in California find local resources to help care for the patient after she was discharged from the skilled nursing facility.

Another patient, with cancer, an immune deficiency disorder, and hemophilia, couldn't afford to pay for his medications at the time of purchase and wait to be reimbursed. Warfield stepped in and made special arrangements with the pharmacy to save out-of-pocket expenses for the patient.

Regence BCBSO started its case management program in 1984, working with a single employer group with about 3,500 employees to help patients navigate the health care system.

Early on, the program focused on patients in skilled nursing facilities, inpatient rehabilitation, or those who required multiple layers of care, such as home health. "We knew that there were some patients who needed more help than we were giving with just preauthorization. The single-employer-specific case management program was the foundation for the program we have today," French says.

In 1991, the company began marketing to employer groups with more than 200 employees. When employers purchase the program, the company dedicates case management staff specifically to their employees, depending on the size of the company and the members' needs. For instance, only one case manager is assigned to smaller groups. Larger groups may have as many as three case managers servicing them.

The case managers also act as benefit managers to help the patients find the best options for them. For instance, a person is qualified for a skilled level of care in a nursing home, but the family prefers to keep him or her at home. The patient doesn't have benefits for hourly skilled care, so the case managers take what the company would have been paid on skilled nursing facilities benefits and convert it to money that will pay for care at home.

"Our responsibility is to help families come up with plans of care for their loved ones. We work with the family as well as the patients," Warfield says. The Individua case managers also manage care for a high-risk pool of patients who are denied insurance because of their medical conditions. The Oregon Attorney General's office coordinates a program in which a group of insurance companies underwrites care for these patients. ■

## *COMING IN FUTURE MONTHS*

- What credentials do case managers need?
- The latest technology and how you should use it
- The best ways to move patients through the continuum
- Putting patient satisfaction surveys to work for you

# Collaboration is key to success of CM program

*Referrals come from a variety of sources*

The beauty of Regence BlueCross BlueShield of Oregon's (BCBSO) Individua program is that the case managers work closely with both employers and internal departments to make sure all eligible patients get the care they need, says **Annie French**, RN, manager for health care management at the Portland insurer.

The case managers get referrals from the precertification staff, employer groups, the customer service department, claims department, and underwriting. "What's unique about our program is that it is totally integrated with the preauthorization department, and we receive many referrals from them," French says.

Rather than preauthorize every hospitalization or service for members, Regence BCBSO has targeted its preauthorization efforts at the services that could benefit from case management or whose treatment might be a contract exclusion, or an experimental or investigational treatment.

The process allows the case managers to let members know ahead of time if a particular treatment is not covered under their policy and to help them make decisions about their care, French says.

"We have so many ways we come in contact with and find out about patients who need help. It's more effective to do it this way than just having contact with patients when they are discharged from the hospital," adds case manager **Olivia Warfield**, RN, BS, CCM.

The case management department at Regence BCBSO has educated its customer services, claims, underwriting, and marketing departments to call if they have questions about case management. "Employers, employees, brokers, and marketing people at the companies know to call their case manager if they have any issues or questions about clinical issues," French says.

In addition, the Individua case managers work with each company's health promotion and prevention department to provide special educational programs for employees depending on what they need.

They collaborate with the employer groups' nurse practitioner clinics to identify and treat employees with specific conditions. For instance, the care managers collaborated with the nurse practitioner at one employee clinic on an educational program for diabetics and sent a letter to all employees with diabetes instructing them to contact the nurse practitioner to receive additional education on diabetes.

Regence BCBSO's health promotions and its prevention and disease management program intervenes with the population as a whole and manages low- to moderate-risk clients. "We work with them and provide high-end case management if the disease has progressed to the point that they need more care," French says. ■

# Reports include info on what case managers do

*Financial savings, utilization data are included*

**Olivia Warfield**, RN, BS, CCM, loves to tell employers how much money she saved them by managing the care of their members.

"I am thinking about it all the time. Aside from taking care of our people, we make sure we can save money for the employer and the patient," says Warfield, a case manager for the Portland, Oregon-based Regence BlueCross BlueShield's (BCBSO) Individua case management program.

For instance, Warfield has saved one patient more than $100,000 a year by shopping and negotiating the price for his medicine for hemophilia.

When she was looking for a wheelchair for another patient, the first quote she got was $27,000. She asked other providers and found that she could save $6,700 on the same wheelchair.

"Even with a contract to provide equipment, it's up to me to look around and do shopping for the patient. They don't know where to look. And I can report to the company that I saved it more than $6,000 for one patient," she says. The case managers look hard for ways to save money for their clients. For instance, they look for the least costly level of care in which the patient can be treated.

Information on actual savings is included in regular reports to the employers that contract with Regence BCBSO for the Individua case management services. "We are really very conservative in how we report our cost savings. It's all hard-dollar savings rather than soft dollar or conjecture. The groups really do hold your feet to the fire," says **Annie French**, RN, manager for health

care management.

Regence BCBSO tells employers up front that signing up for the Individua program may not always save them money but has other benefits. "We set expectations at the beginning that we may not always save the employers money. We've been very good at telling our story and explaining the benefits of the program," French says.

The case management department reports to the employer group about how they have helped their employers. The report includes the aggregate number of times they have talked to the physician, made family contact, provided education for the family and patient, and helped the patient locate community resources.

"We provide this information in addition to the cost savings so they get some idea about what case management really does," French says.

Employers receive information about case management actions and cost saving as well as general utilization data.

Because of Regence BCBSO's efforts to meet requirements under the Health Insurance Portability and Accountability Act, the company does not provide any individualized information to the employers. The company works with underwriting to examine claims data for specific periods of time and provides regular reports to the employers. Among the information are the top 10 diagnostic categories of employees and the percent of generic drugs being used by their particular employee group. ■

# Disease management program saves money

*Technology boosts achievements*

A comprehensive disease-management program that combines technology and case management has generated savings of between $450 and $1,700 a year for participating members in the Denver-based One Health Plan.

"The health of One Health Plan's participating members has significantly improved, while the incidences of costly acute care events for members with specific chronic illnesses have decreased," says **Wally Gomaa**, MBA, MHA, president of One Health Plan, a subsidiary of Great West Life & Annuity Insurance Co.

For instance, medical services for asthmatics participating in the program has been $450 per year less than for nonparticipants. The diabetes program generated savings of $660 per year among participants. In the cardiac program, medical care cost $1,700 a year less for participants vs. nonparticipants. "It's been a tremendously successful program. We're not stopping here. We're looking at other programs in the future," Gomaa says.

With more than 100,000 members enrolled, One Health's CareResults program is the largest population-based disease management program of its kind," Gomaa says. "We are not the largest health plan, but we have the largest program in terms of participation," Gomaa says.

The program focuses on making the members more accountable for self-management of their conditions by educating them on lifestyle changes they need to make in order to stay healthy, Gomaa says. The program is available to the HMO, PPO, point of service, and indemnity population with no restriction on the ability to participate in the program.

"We have found that we can use low-cost interventions and achieve remarkable returns on investment as opposed to more traditional, very costly interventions," he says. The program was launched Feb. 1, 2000, and provides disease management services for people with four conditions: asthma, diabetes, pulmonary artery disease, and congestive heart failure.

The program uses technology to assign risks to patients with the four diseases, based on an interactive computer-based questionnaire. The majority of patients receive literature and test kits dependent on their condition, and are asked to take regular lab tests and do quarterly follow-ups. They receive training on "the language of care" so they can better communicate with their physicians about their conditions.

Higher-risk patients also receive interventions from the company's nurse care managers who help coordinate their care. The information collected by the CareResults program is available on-line to the One Health Team nurse care management team. They use the information in their case management and support efforts.

"The bottom line is to balance resources with benefits. I would love to have every one of our 100,000 members interacting with the nurse, but we have to be able to generate positive returns," Gomaa says.

The program cuts down on nurse interventions by having them concentrate on the patients who

need the most interventions, he adds.

Because of the diverse population the program serves, some nurses focus primarily on diabetes, others on cardiac problems or asthma. "These are our most highly trained nurses. They feel comfortable interacting with individuals with chronic conditions," Gomaa says.

One Health started off with a pilot program designed to achieve the accreditation goals of the National Committee on Quality Assurance, based in Washington, DC. In the pilot program, 85% of participants reported that they had learned new ways to manage their asthma and diabetes because of the program.

"The results were amazing. We found signification improvement in utilization of care, patient satisfaction, and incredible savings," Gomaa says. "We decided we would almost be negligent if we didn't offer the program to our entire population."

One Health looked at 21 different vendors and chose Atlanta-based Landacorp for its disease management programs. Gomaa liked the Landacorp program because the company did not require One Health to delegate the utilization management function to them. "All interaction with members is done with our nurses, and there is no overlap with their nurses doing things one way and ours doing them a different way," Gomaa says.

Because the program is technology-based, One Health was able to reach its entire population of three million members and screen them for the four conditions. To identify potential participants in the program, One Health Plan and Landacorp developed a proprietary algorithm that looks at both pharmaceutical and medical claims. The data are based on ICD-9, CPT-4, and National Drug Council Codes.

About 12%-15% of the company's total population was identified as potential participants. The program is run every month to identify other targeted candidates and people who did not respond. The health plan sends candidates a letter inviting them to participate in the CareResults program to help them manage their chronic condition. They are told that the program is free and that participation or nonparticipation will have no impact on their benefits.

If members agree to enroll, they receive a telephone calling card with two hours of free long distance. As they stay in the program, additional time is automatically added to the card. If people do not respond, One Health Plan's call center staff calls them, offering to enroll them on the telephone.

Participants fill out a 20-minute health risk assessment either over the telephone through an integrated voice response system or over the Internet. The decision tree-based survey assessment measures how knowledgeable participants are about managing their condition, how receptive they will be to information on self-managing their condition, and self-reported severity of condition.

Patients who are determined to be at high or moderate risk receive follow-up. For instance, a participant with diabetes who understands what a hemoglobin A1c level is, knows his or her test results, and knows when he or she should be tested is given a low-risk factor and is not scheduled for follow-up during the year. **(For details on the follow-up plan, see related story, below.)**

The results of the survey are sent to the patients' primary care physician or to the patient to be shared with his or her physician. ■

## Customized plan helps learn self-management

*Kit is geared to member's condition, education level*

If participants in Denver-based One Health Plan's CareResults disease management program are at moderate or high risk, they receive an individualized boxed kit that includes literature, videos, and cassette tapes from national organizations like the American Diabetes Association and the American Heart Association and a customized booklet, usually 20-25 pages long, based on their replies to survey questions.

"We're not giving them a big book that they throw on the shelf because it has a bunch of information they don't need. The book is written at their reading level, based on their level of education, and contains only the information they need," says **Wally Gomaa**, MBA, MHA, president of One Health Plan.

For instance, patients with cardiac conditions are told to get the right medication and take it as prescribed, stop smoking, use low-dose aspiring every day, manage their blood pressure, manage their blood lipid levels, exercise, and eat the right foods.

A separate smoking-cessation kit is distributed as needed. The kit also contains home testing kits, depending on the condition. For instance, diabetics receive a hemoglobin A1c kit, asthmatics get a peak flow kit, and those in the cardiac programs receive

a lipid home test kit.

The program provides training on how to use the peak flow meter and the importance of the hemoglobin A1c testing.

The participants are asked to mail the test kits back to the lab, postage paid. The lab sends the results to One Health Plan, which forwards the information on to the members and their physicians. Members in the program are asked to take quarterly surveys and regular lab tests. Each time they re-take the survey, they receive a personalized report with feedback and recommendations for action. After 12 months, they re-enroll in the program.

"The real goal is to move the high-risk individuals to the lower-risk categories," Gomaa says. ■

## Program stratifies patients into severity-based zones

*Results after interventions are dramatic*

By concentrating on patients who need interventions and gearing the individual interventions to their specific needs, Denver-based One Health Plan's CareResults disease management program in Denver has achieved dramatic results.

For instance, about 70% of diabetics who joined the program were not testing their hemoglobin A1c levels when the program began. Now more than 50% are being tested, a 21% improvement in the number of diabetics being tested on a regular basis.

At the beginning of the program, 42% of the total respondents did not know their potential asthma triggers. Of the high- and medium-risk patients who completed the three-month follow-up survey, only 24% did not know their triggers.

Among participants who completed the baseline and three-month surveys, there was a 96% increase in the use of peak flow meters.

"It helps them identify when they need to go to the doctor," says **Wally Gomaa**, MBA, MHA, president of One Health Plan. Gomaa attributes savings in the cardiac care program ($1,700 a year for participants vs. nonparticipants) to the use of low-dose aspirin. Participants reported a 27% increase in the use of low-dose aspirin. Members who participate are stratified into Red, Yellow, and Green Zone cases based on their answers to an interactive questionnaire. "What we have done is identify those people where we can make a difference in their lives. They have the greatest risk for costly care," Gomaa says.

Red Zone members are those who are not knowledgeable about their condition, who have high self-reported severity issues, are not performing adequate self-management, and are likely to become patients who need high-cost interventions. Yellow Zone members are at moderate risk and receive literature, test kits, and are asked to take follow-up questionnaires.

Green Zone members are at low risk and do not receive any active follow-up during the initial year, but are re-targeted the next year.

The program concentrates on patients whose risk factors can be improved, not just those with severe cases of their disease. "For instance, in diabetes management, we don't target individuals who have serious cases of diabetes and are eating right and exercising. There is nothing more we can do for them. We target those whose diseases could become serious," Gomaa says.

At the beginning of the program, 6% of participants were in the Red Zone category. After 12 months, the percentage had dropped to 0.25%. "This means the members have more knowledge about managing their disease because they have made lifestyle changes, and we are seeing that they know what they should do to manage their conditions. Their risk for high cost care has dropped," Gomaa says. ■

## Get involved with disease management efforts

*Coordination is the key to success*

Your company has contracted for disease management with an outside vendor. That puts you out of the loop, right? Wrong, says **Derek Newell**, vice president of marketing for LifeMasters, a San Francisco-based disease management company.

"Disease management should be tightly integrated with case management. Working together can add a lot of value to the relationship. There will be lost opportunities if case management and disease management work separately," he adds.

LifeMasters provides population-based disease management to health plans, managed care firms, and indemnity preferred provider organizations

(PPOs). The company offers disease management for asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, and hypertension.

A few years ago, disease management vendors and case managers tended to view each other as competition and went their separate ways. But, in the last year, there has been a tremendous increase in the number of case managers who are involved in the disease management process, Newell says.

Case managers are becoming more involved in the disease management vendor selection process because payers are realizing that disease management efforts are not as successful if they aren't integrated with case management, Newell says.

The winners in the long run are the patients, who get better care and better management of their chronic diseases, he says.

"We're seeing a high degree of involvement with case managers or supervisors of case management in the selection process and in the referral process. Working together with our partners is a key success factor in any disease management program, and that needs to occur at the case management level," Newell says.

In the past 18 months, Newell has noticed that many insurers looking for disease management vendors are including case managers or heads of case management departments on their selection committees. In the past, it was a rare occurrence. Case managers at the 16 major health plans with LifeMasters contracts are sending about 12 referrals a day to disease management programs, and the number is increasing rapidly, he says.

"Last year at this time, we probably got one referral a day from case managers," he adds.

Referrals from case management are particularly important to the success of a disease management program because they usually are highly qualified referrals — patients who are appropriate for the program, need the program, and are predisposed to participate. "These are key component for success in disease management," Newell points out.

More importantly, patients referred directly by case management get into the program early on, rather than when they are selected by retrospective review of their claims data, he points out.

"Case managers find people in real time. Claims are always delayed. Case managers refer to us if they feel that our program is appropriate for a patient who has just been diagnosed with a condition or who has just gone into the hospital," Newell says.

Patients who are referred by case managers tend to be more compliant because their trust in their case manager and insurer is transferred to LifeMasters, Newell says. Newell urges case managers to get involved in the disease management process, making sure the vendor will work closely with case managers to integrate the two functions. "Really, both are part of the continuum of care. There is no way without us that case managers can manage an entire population," Newell says.

A partnership between a company's internal case managers and a disease management vendor can benefit both groups, Newell says.

### *Advantages of a DM program*

Disease management can be an extension of the case management department by dealing with a population that case management simply can't reach, freeing the internal case managers to spend their time working with the most severely ill patients who need high-intensity coordination.

"Disease management is not a replacement for case management at all," Newell says. "We have the technology and solutions and scale that allows us to handle more patients and leave the case managers free to take care of the more severe cases." When patients have an acute episode of care and need more personalized interventions, the disease management company will hand them over to the internal case manager until the situation is stabilized, Newell says.

"With the most critically ill patients, we work closely with case management at the insurance company and hand them over for a while. When they become more stable or have gotten through the benefits maze, they may need to move the patient to a lower level intensity," Newell says.

Each plan that contracts with LifeMasters has an internal set of protocols for referring patients between internal case management and the disease management program.Case managers often can be helpful to the patient when a clinical intervention needs to take place, Newell says.

"We make clinical suggestions but not clinical judgments. Case managers can be more aggressive about how they think the case should be handled," he says. About 75% of the time, the patients' physicians respond to suggestions for changing medication and bringing the patient to the office, Newell says.

LifeMasters uses a claims-based analysis to identify participants. The company calls participants, urging them to enroll and assesses their

severity. Depending on their answers to the assessment questions, they may be selected to participate in the program.

Patients with severe conditions transmit their vital signs daily to LifeMasters's web site, where they are monitored by registered nurses.

"If a patient is having a clinical event, as defined by their physician, the LifeMasters nurse is alerted, and she alerts the physician to the situations," Newell says. The more seriously ill patients receive regular telephone calls from the LifeMasters nurses. ■

# Insurer's stop-smoking program attracts 12,000

*TV ads encourage people to join the program*

Blue Cross Blue Shield of Minnesota is using television ads to recruit smokers into its innovative stop smoking program.

The efforts have paid off. So far, 12,000 smokers (out of an estimated 150,000 covered by the health plan) have signed up for the BluePrint for Health Stop Smoking Program, a telephone counseling program, since it started in 2000.

"We're getting close to having results. We're still collecting data and follow-up surveys. We strongly believe that reducing smoking rates is an excellent long-term investment, but it is a long-term investment," says **Marc Manley**, MD, executive director of the Blue Cross Center for Tobacco Reduction and Health Improvement.

The St. Paul, MN-based insurer conducted a survey of 10,000 members to get information about their beliefs, needs, and concerns about tobacco use. "We found that more than 70% said they would like to quit and that almost 50% had tried to quit in the past year but hadn't been successful," Manley says.

The insurer has about two million members, some outside the state of Minnesota. According to results of the survey, about 150,000 of them are cigarette smokers. "We're making a sizeable dent. We're not dealing with smokers in the hundreds, but in the thousands," Manley says.

The Blue Cross Blue Shield of Minnesota program is different from many stop smoking programs because it is geared to all smokers.

"The program differs from a lot of other telephone-based programs in that we encourage people to call even if they aren't sure they want to quit smoking. We tell them we'll work with them when they are ready to quit," Manley says.

To enroll, a smoker calls a toll-free number and talks with a smoking cessation counselor. The smoker takes a questionnaire geared to determine their concerns, motivations, and interest in the questions. The computerized system guides the counselor to discuss a specific topic based on the answers the caller gives to the questionnaire.

The counselors give the smokers individualized advice over the telephone, including strategies to help them quit smoking. The smoker receives a printed guide in the mail and periodic follow-up calls over the next year. They are encouraged to call any time they have questions or need support. The telephone counselors strongly urge the smokers to see their doctors to talk about nicotine replacement options.

The stop smoking program is available to all Blue Cross Blue Shield of Minnesota members at no additional cost. "Our telephone counseling program is a lot like case management over the phone," Manley says. The company is recruiting members to the stop smoking program through ads on Duluth and Twin Cities television stations. The television advertising has generated a much bigger volume of calls than other methods of recruiting, such as mailing letters directly to the members, Manley says.

"The message of the TV ad is simple: We will work with each person without nagging so they can confidently take that difficult step toward quitting and ultimately succeed," Manley says.

In the past, members have used nicotine patches and other methods to quit smoking, but only a small percentage have been successful, Manley says. "Many have not used the resources available to them because they don't know about them. Research has shown that telephone cessation counseling is a convenient and effective way to quit smoking. This also gives physicians another tool to help their patients who smoke quit," he says.

Blue Cross Blue Shield of Minnesota purchased the system from New York-based Behavioral Solutions. The counselors are provided by Behavioral Solutions. The company has won numerous awards for its stop smoking program, including the Best of Blue award for health services research for its survey, the first place award for adult tobacco control from the American Association of Health Plans, and a local award from the American Cancer Society. ■

# Patient involvement most effective on compliance

*Study shows phone, mail reminders not as effective*

A study by researchers at the Ohio State University College of Medicine and Public Health in Columbus suggests that early telephone and postal reminders do not improve compliance with drug treatment or prompt patients to adopt risk-reducing behaviors. The study measured compliance with prescribed medication and lifestyle changes in 13,100 patients who were prescribed prevastatin to reduce their risk of a heart attack.

At the end of the study, there was no measurable difference in medication compliance between patients who received telephone and mailed reminders and those who did not, the researchers said. However, the researchers concluded, patients who reported taking the medication as prescribed also were more likely to make the recommended behavioral modifications, such as exercising, making dietary changes, and quitting smoking.

The study and other literature on the topic leads to the conclusion that efforts to enhance the physician-patient relationship and patient involvement in care are the most effective ways to improve medication compliance, says **Robert Guthrie**, MD, author of the study.[1] "This study mounts a strong case that early telephone and postal reminders do not improve medication adherence or compliance with recommended risk-reducing behaviors. This result should be of particular interest to heath care providers, third-party payers, and health care policymakers," Guthrie says.

The nationwide study involved 13,100 primary care patients who were prescribed pravastatin therapy because they were at risk for a first myocardial infarction. An elevated total cholesterol level despite dietary interventions was one criterion for inclusion. Patients who agreed to participate were divided into two groups: Both groups were given a two-week supply of pravastatin at no charge, prescriptions for additional prevastatin, and recommendations about modifying lifestyle and complying with their medication regime from their physician.

The group that received the interventions received telephone reminders after two weeks and eight weeks, and reminder postcards at week four, reinforcing the message about coronary risk. The reminder cards stressed the importance of following physician instructions and taking medication as prescribed. Both groups received reminder postcards at four and five months and then filled out questionnaires about compliance at three months and six months. Questionnaires included information about use of prevastatin and lifestyle modifications, such as changing eating habits, losing weight, increasing physical activity, and quitting smoking.

Compliance also was assessed by the patients' physicians. Of the 13,100 participants enrolled, 4,548 returned their six-month patient survey — 35% of patients in intervention group and 33% of those receiving usual care. After six months, 79.7% of patients receiving interventions reported taking their medication as prescribed, compared to 77.4% of patients who received the usual care. Approximately equal percentages reported that they had missed no doses in the previous seven days.

Baseline characteristics such as age, race, employment status, educational attainment, and comorbidity did not seem to be associated with self- reported compliance with prevastatin, Guthrie says. Medication adherence was associated with the adoption of other coronary risk-reducing behavior. Of those taking pravastatin as prescribed, 97.5% reported that they visited their physicians as scheduled, compared with 82% who were not compliant with prevastatin regimes. Better than 62% of the compliant group reported modifying their eating habits, compared with more than 51% in the noncompliant group.

### *Reference*

1. Guthrie, R. The effects of postal and telephone reminders on compliance with pravastatin therapy in a national registry: Results of the rirst myocardial infarction risk reduction Program." *Clinical Therapeutics*, Vol. 23, No.2, pp 970-979. ■

# Many elderly patients take inappropriate medicines

*Patient safety outside the nursing home cited*

An alarming number of elderly patients are taking medications that aren't appropriate for them, according to a new study by the Agency for Health Care Research.

About one-fifth of the approximately 32 million elderly Americans not living in nursing homes in 1996 used one or more of 33 prescription medicines considered potentially inappropriate,

the report says. Nearly one million elderly used at least one of 11 medications that a panel of geriatric medicine and pharmacy experts advising the researchers agreed should always be avoided in the elderly. These 11 medications include long-acting benzodiazapines, sedative or hypnotic agents, long-acting oral hypoglycemics, analgesics, antiemetics, and gastrointestinal antispasmodics.

"This important research indicates that patient safety issues can occur outside hospitals, nursing homes, and institutional settings, and among any patient population. This study highlights the need to develop evidence-based programs and ways to improve prescribing practices in the United States," says **John M. Eisenberg**, MD, director of the Agency for Healthcare Research and Quality.

The study also suggests that elderly women and elderly people who are in poor health and who use more prescriptions are more likely than others to receive inappropriate drugs.

The list of potentially inappropriate medications reflects the consensus of the expert panel. Not all physicians agree about the appropriateness of specific drugs for the elderly. This lack of consensus stems in part from the limited amount of evidence of risks and benefits for some medications because older patients often are excluded from drug clinical trials due to their age and other medical problems.

The actual extent of inappropriate medication being prescribed may be much higher because of the conservative criteria the researchers used and because of the rapid rate that new pharmaceutical agents are being introduced into the marketplace, says **Chunliu Zhan**, MD, PhD, lead author of the study. The problem is compounded by suboptimal prescribing, including underuse of effective medications, inappropriate dosages, inappropriate combination of drugs, and other errors, Zhan says.

The study, "Potentially Inappropriate Medication Use in the Community-Dwelling Elderly: Findings from the 1996 Medical Expenditure Panel Survey," was published in the Dec. 12, 2001 issue of the *Journal of the American Medical Association.* ■

## URAC releases DM accreditation standards

*Aim is to address accountability, performance*

Organizations providing disease management will be able to seek accreditation for their programs when the American Accreditation Healthcare Commission's (URAC's) "Disease Management Standards" are completed in the spring. Washington, DC-based URAC, a leading health care accreditation organization, released the standards for public review and comment in December.

Accreditation will be open to stand-alone disease management organizations, disease management programs offered by integrated medical management organizations, and programs offered by health plans. The standards build on URAC's core standards and include accountability for disease management interventions and performance reporting. "The health care system is constantly looking for more effective approaches to improving health care outcomes for chronically ill patients. Disease management holds tremendous promise as a strategy that can be used by HMOs, PPOs, or any other type of health care organization. Accreditation is the first step to assuring that disease management programs are credible and accountable for the services they provide," says **Robert L. Crocker**, MD, senior vice president and corporate medical director for WellPoint Health Networks Inc. of Thousand Oaks, CA, and chairperson of the URAC Disease Management Advisory Committee.

URAC's standards emphasize evidence-based practices, collaborative relationships with providers, and consumer education. They address key areas of accountability such as the scope and interventions offered by the disease management program; types of performance measures used; rights and responsibilities of participants; and methods for population management, including stratification, engagement, and program design, including assessment and education. They are built on URAC's core standard modules.

"Under this approach, all organizations that seek accreditation are reviewed under the core standards plus an accreditation module specific to that company's lines of business. We are excited to add disease management to our array of modules that already include utilization management, case management, and claims management accreditation programs," says **Gary Carneal**, URAC president and chief executive officer.

The public comment period for the standards ends Feb. 14, 2002. The standards are available on URAC's web site: www.urac.org. ■

# Web accreditation program promotes accountability

*URAC accredits 13 e-health sites*

Do you know where to turn when your clients ask you to suggest a health care web site about their condition?

When they bring up information they've found on an Internet site, do you know whether it's reliable or not? Finding the right Internet site for your clients may be easier now that Washington, DC-based American Accreditation Healthcare Commission (URAC), a leader in accreditation of health and managed care organizations, has issued accreditation for 13 medical web sites.

The web sites, which include some of the nation's largest and busiest, received accreditation under a program that measured them against rigorous standards for quality and accountability. URAC also announced another 15 web sites have begun the process of seeking accreditation, or have committed to doing so. The accreditation program is a major step forward for consumers, says **Garry Carneal**, URAC president and CEO.


5. List the number of employers currently served by the Individua case management program at Portland-based Regence Blue Cross Blue Shield of Oregon.
   A. 6
   B. 32
   C. 40
   D. 60

6. At One Health Plan in Denver, the diabetes disease management program has generated savings of what amount per year among participants?
   A. $125
   B. $350
   C. $660
   D. None of the above.

7. About 70% of diabetics who joined One Health Plan's CareResults disease management program were not testing their hemoglobin A1c levels when the program began.
   A. True
   B. False

8. List one of the initial 13 e-health web sites accredited by Washington, DC-based URAC.
   A. Joint Commission on Accreditation of Healthcare Organizations (www.jcaho.org)
   B. National Committee for Quality Assurance (www.ncqa.org)
   C. American Health Consultants (www.ahcpub.com)
   D. Healthwise Inc. (www.healthwise.org)

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## Editorial Questions

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

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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.

Please save your monthly issues with the CE/CME questions in order to take the two semester tests in June and December. A Scantron form will be inserted in those issues, but the questions will not be repeated. ■

"URAC accreditation provides them with an important tool to identify health web sites that meet tough standards for quality," Carneal adds. He cites a study by Pew Internet, which shows that 48% of all Internet users who have gone online for medical information believe the advice they found on the web improved the way they take care of themselves. About 41% of respondents in the same survey say that the information they found on-line influenced a major medical decision.

The URAC Health Web Site Accreditation Program Standards, released on July 30, are based in part on a 14-point set of principles by Hi-Ethics, a coalition of the most widely used Internet health sites and content providers. Standards include consumer protection, including privacy, security, quality of information, fairness of transactions, and professional conduct.

Other issues covered by the standards include the health content editorial process, disclosure of financial relationships, links to other web sites, and mechanisms for consumer complaints.

"By building on the efforts of Internet quality leaders, the URAC Accreditation Program is undoubtedly the best and clearest way for health web sites to demonstrate their compliance with ethical standards," says **Michael Rozen**, MD, president of Hi-Ethics.

The standards were developed through a process that encouraged broad-based input from numerous stakeholder groups, including consumers, regulators, health care providers, health care organizations, and insurers. ■



## URAC Accredited Web Sites

- **A.D.A.M. Inc.** — www.adam.com
- **American Specialty Health Networks (ASHN)** — www.healthyroads.com
- **Group Health Inc.** — www.GHI.com
- **HAYES Inc.** — www.hayesonhealth.com
- **Health Insurance Association of America** — www.hiaa.org
- **Health International** — www.health-intl.com
- **HealthHelp** — www.hhni.com
- **Healthwise Inc.** — www.healthwise.org
- **InteliHealth** — www.intelihealth.com
- **Veritas Medicine** — www.veritasmedicine.com
- **VHA Inc.** — www.LaurusHealth.com
- **WellMed Inc.** — www.wellmed.com
- **WebMD** — www.webmd.com


## Out-of-pocket expenses burden those with chronic conditions

People with chronic conditions spend up to five times more out-of-pocket for health care than people without chronic conditions, according to a study supported by the Partnership for Solutions project.

The Partnership for Solutions project, led by Johns Hopkins University and the Robert Wood Johnson Foundation, is an initiative to improve the care and quality of life for the more than 125 million Americans with chronic health conditions.

Coinsurance payments and gaps in health insurance coverage are the main reasons for higher out-of-pocket expenditures.

"It is no surprise that people who are sicker tend to pay more for health care, but just how much more out of their own pocket is quite significant. The magnitude of out-of-pocket expenditures is staggering," says **Gerald Anderson**, PhD, national program director of Partnership for Solutions and professor at the Johns Hopkins Bloomberg School of Public Health in Baltimore.

The study reveals that there are significant consequences for the 108 million Americans with chronic conditions such as diabetes, heart disease, hypertension, and arthritis. Many have to pay a considerable portion of their income on medical services. Large out-of-pocket expenditures for medical services have been shown to impede access to care, affect health status and quality-of-life, and leave insufficient income for other necessities, Anderson says.

Out-of-pocket spending increased with age and varied by insurance coverage. Individuals in the oldest age category (older than 80 years) spent more than five times more out-of-pocket than persons in the youngest age category (0-19 years) and more than twice as much as those in the middle age category (45-64 years).

Out-of-pocket expenditures were highest for nonelderly persons with no insurance and for elderly persons covered only by Medicare. Both elderly and nonelderly Medicaid beneficiaries had the lowest out-of-pocket expenditures. Medications made up the largest portion of the out-of-pocket expenses.

The purpose of the study was to raise awareness of challenges faced by individuals with chronic conditions and to help policy-makers identify possible solutions. The study revealed that nonelderly individuals with chronic conditions and no health insurance were less likely to use health care, with 15% reporting never receiving health services in 1996, compared to 3% with private insurance. ▼

## Lipoprotein count can predict heart attack risk

The size and number of lipoproteins in the body can predict an individual's risk of a heart attack, particularly in women, a University of Pittsburgh study has found.

"The higher the number of small LDL particles, the greater the woman's chance of a heart attack," says **Lewis Kuller**, MD, professor and chair, department of epidemiology, University of Pittsburgh Graduate School of Public Health.

Researchers found that the heart attack risk

was as much as 2.45 times greater for women who had the largest number of small LDL particles compared to women with fewer particles.

The association is much stronger for women than for men, he adds. Physicians may be in a better position to initiate therapy to reduce the risk of heart attack by assessing this new marker, Kuller says.

Lipoprotein size and distribution can be improved by diet and exercise as well as drug therapy, he adds.

Kuller presented his findings from a study of 1,849 participants in the university's Cardiovascular Health Study at the American Heart Association meeting in November. ▼

## Support is a factor in how diabetics manage their disease

Family and emotional support are key factors in how well diabetics manage their disease, a new international study has shown.

The DAWN (Diabetes Attitudes, Wishes, and Needs) study looked at the perceptions, motivations and need for information of more than 5,000 diabetes patients in 13 countries, including the United States.

The first results of the study indicate that diabetes patients consider a supportive network of family, colleagues, and friends to be at least as important as the medication they take in helping them manage their disease.

Final results will be available early this year.

The interim results also indicate that people who do not have access to a community of support, especially the young and elderly living alone, may be less likely to comply with their medical regimens, putting them at risk of inadequate control of their diabetes. Patients responding to the survey also indicated that family or social networks sometimes can put too much pressure on them about taking care of their diabetes, increasing their anxiety.

"This study adds to the growing body of evidence that psychosocial issues play a critical role in how people manage their diabetes and in their long-term health and quality of life. The DAWN study is unique because it considers these issues from the perspective of people with diabetes and health care providers in many countries of the world," says **Richard Rubin**, MD, Associate Professor of Medicine and Pediatrics at Johns Hopkins University School of Medicine and a member of the International DAWN Advisory Panel. ▼

## Booklets offer support for Parkison's patients, families

The National Parkinson Foundation, Orange County chapter, has produced two booklets designed to support Parkinson's Disease patients and their families, friends, and caregivers.

One booklet, "Dear Friends and Family" was written from the point of view of a recently diagnosed Parkinson's patient. It provides information on how a patient's life may change, and the effect of the disease on their personal interactions.

"We Are There," written for caregivers, provides details of the impact of Parkinson's on topics such as activities of daily living, medications and health care, speaking, reading and writing, mobility and transportation, finances, economics, and insurance

Both books are available in Acrobat Reader (PDF) format and can be downloaded free of charge at www.npfocc.org.

For more information, contact: the National Parkinson Foundation, Orange County Chapter, 355 Placentia Ave., Suite 302, Newport Beach, CA 92663. Telephone: (949) 574-6338. ■

## 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 items for 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 news about conferences and seminars at least 12 weeks prior to the event to meet our publication deadlines. ■