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INSIDE

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Care management program cuts costs, improves outcomes

Patients report improvements in quality of life

A few years ago, **Catherine Beatty**, RN, MSN, faced a frustrating problem common to case management — coordinating care for just a few very sick patients was keeping her case managers tied up for days on end.

"These were complex patients with a lot of comorbidities," says Beatty, manager of medical services for BlueCross BlueShield of South Carolina, based in Columbia. "Many of them were terminally ill. They needed more intensive case management than our case managers could give them."

Then, in 1998, BlueCross BlueShield of South Carolina signed up for the Complex Care Management program offered by Franklin Health, an Upper Saddle River, NJ-based company specializing in managing the care of patients who need high-intensity case management. The American Accreditation HealthCare Commission-accredited company provides services for large insurance and employer populations.

The result has been cost savings to the insurer and an increase in efficiency for its in-house case managers. Members whose care is managed by Franklin Health's care managers have a high degree of patient satisfaction and have reported a tremendous increase in quality of life for themselves and their families.

"This program really makes a difference to the patients and their families. The savings are a bonus," Beatty says.

In fact, it's not unusual for Beatty to get a letter from a patient or family thanking BlueCross BlueShield for providing the service. "If you help a patient make decisions and coordinate care among providers, the patients truly appreciate it," she adds.

Franklin Health focuses on the complex patients, the less than 1% of the population that accounts for a significant proportion of health care costs, according to **Jeanne Clement**, RN, MPH, senior vice president of operations for Franklin Health.

About 60% of the BlueCross BlueShield of South Carolina patients in

the program have cancer, and most are terminally ill, according to **Michelle Hendershot**, account director for Franklin Health.

Other patients in the program include those with complex comorbidities such as complications from diabetes, people who are recovering from catastrophic injuries and need an intensive rehabilitation regime, and premature infants.

Franklin hires and trains local nurses for its complex care programs. The nurses are required to sit for the Certified Case Manager examination as soon as they are eligible. Their caseloads vary from 20 to 25 patients at a time, depending on the complexity of the case.

The Franklin care managers set goals that focus on issues that frequently need to be addressed in complex patients: patient knowledge and choice, case management treatment plan, family and living environment, terminal care planning, pain and symptom management, physician and provider support, and benefit plan management.

The Franklin nurse case managers make at least one on-site visit with patients (more if required) and talk to the patients and families by telephone at least once a week. They work at home, on a flexible schedule, and are available if a crisis arises.

"They are the eyes and ears of the health plan. They can see the family dynamics, the financial situation, and get a total picture that they might not get over the telephone," Clement says.

The care managers develop a plan of care and work with the patient's physicians, the family, and community resources to see that the patient receives the care and support he or she needs. **(For details on how the program works, see related article on p. 39.)**

"The key part is that we really coordinate and facilitate among different providers of care. Clear communication is the key. Patients may not know what to ask. They don't know how to link all the providers who are involved in their care," Clement says.

Patients in the middle of a medical crisis have so many decisions to make that many haven't been able to stop and consider all their options, Clement says. The Franklin care managers sit down with the patients, explain their conditions, answer questions, and help patients understand their disease and their treatment plan. They review the options and help the patients and families set realistic goals.

For instance, in the case of terminally ill patients, the care managers will educate the patient and the family about advance directives.

They work closely with the physicians making sure patients absorb what their physician is saying. "Often, the physician gives the patient information and the patient simply does not understand it. We review it with them in a less stressful environment, explaining what might happen with each option," Hendershot says.

The case managers are available by telephone and often get calls from the patients about symptoms and problems.

"Our care managers form a close relationship with the patients, which allows them to be more proactive and anticipate problems. They have the opportunity to get to know patients and devote a lot of time to them to help make sure they don't get into a crisis situation," Clement says.

For example, if a patient faces the possibility of dehydration from chemotherapy, the care manager will develop a plan of care to treat the symptoms before hospitalization is required. This may include making sure the patient has adequate medicine to treat nausea and vomiting or arranging for a home care agency to provide intravenous hydration.

"The care managers facilitate direct care in a less costly setting because the patient will call them more quickly than they'll call the physician," Beatty says.

Franklin uses a team approach to managing the patients. The care management company has practicing physicians on staff who are part of the team. The care plan for each patient is reviewed regularly by a team of nurses and physicians.

The Franklin Health physicians make it clear to the treating physicians that their role is to assist patients in getting the care they need, and not to challenge their treatment.

COMING IN FUTURE MONTHS

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- Ways to put telephonic case management to work for your members
- Convince your employer of the value of case management
- New technology and what it can do for you

"We've had a number of provider referrals for this program. The patients that Franklin Health manages are very resource-intensive in the physician's office, and the doctors are glad to have another resource to lean on," she adds.

When BlueCross BlueShield of South Carolina first began its collaboration with Franklin Health, 250,000 covered lives from its HMO and fully insured population were eligible for the program. Because of the success and the high degree of patient satisfaction, the program has grown to more than 700,000 lives with the addition of self-funded programs that purchase the program as an option.

Franklin Health gives BlueCross BlueShield of South Carolina an annual analysis of effectiveness, including cost savings, patient satisfaction, and quality of life. "They have contract requirements for patient satisfaction outcomes, and if they don't meet them, there are penalties. They have always exceeded the requirements," Beatty says.

(For more information on Franklin Health, see the firm's web site at www.franklinhealth.com.) ■

Complex care program chooses participants

Screening identifies patients who will benefit most

BlueCross BlueShield of South Carolina members who participate in the Franklin Health Complex Care Program, administered by Upper Saddle River, NJ-based Franklin Health, are chosen carefully through a process that identifies patients who will benefit most from the service.

"We look at the whole patient, the psychosocial issues, their home situation, comorbidities, history of admissions, and a lot of different things, as well as their condition and their treatment. If they are reacting well to their treatment, have a good support system, and are educated about their treatment options, they'll probably be managed through the health plan's case management system that's already in place," says **Michelle Hendershot**, account director for Franklin Health.

Here's how the program works:

BlueCross BlueShield of South Carolina identifies patients who may be eligible for the program through pre-certification. Often patients are referred by the insurer's case managers or utilization managers, or through referrals from providers.

"The local oncologists are very familiar with the program and will refer patients they know need the service," says **Catherine Beatty**, RN, MSN, manager, medical services for BlueCross BlueShield of South Carolina.

When patients are suggested for the program, BlueCross BlueShield of South Carolina does an initial screening to make sure they are eligible for the program under their insurance plan.

Then the insurer's case managers call the patients to see if they are interested in participating.

Franklin Health's care coordination team then reviews the clinical situation to make sure it's an appropriate case. If the patient is appropriate and interested, the Franklin care manager talks to him or her on the telephone to further explore whether services are needed.

For instance, patients typically are not put into the program if they have a good treatment plan in place and a good relationship with their providers, or if they are at a stage when they don't need an intervention yet. The Franklin care managers also take psychosocial needs and family dynamics into consideration and include patients who need a lot of support.

The nurse care manager goes to the patient's home, hospital room, or rehab center and conducts an initial assessment, looking at medical history, current condition, family, and living environment.

The team members (the care manager, the clinical account manager, and the physician) use the information to identify issues and set goals, then confirm the plan with the treating physician.

The Franklin care managers coordinate the care for the patients in the program, working closely with the BlueCross BlueShield case managers.

The health plan case managers work out the best way to use the benefits under the plan. The Franklin care managers may help find additional resources for things that are not covered by the health plan.

Although many of the patients in the complex care program are terminally ill, others progress to the point that they no longer need intensive care management.

In those cases, the Franklin care managers work closely with the insurance case managers as they turn the case over to them.

"Working with BlueCross BlueShield of South Carolina is a wonderful example of teamwork and collaboration. The patients are very complex and need to be managed intensely. When those

who are not terminally ill do return to a state where they can be managed by the health plan's case manager, there is a lot of collaboration in the hand-off between the case managers. They work together to make sure the members get what they need," says **Jeanne Clement**, RN, MPH, senior vice president of operations for Franklin Health. ■

Temporary case managers can ease workload

Practice fill gaps, helps avoid staff burnout

Do vacancies due to illness or vacation leave your case management staff with a caseload they simply can't handle?

Are patients falling through the cracks because of seasonal fluctuations in your business, a shortage of qualified full-time case managers, or unexpected staff vacancies?

If so, hiring a temporary case manager may be the solution to your problem, suggests **Dia Moore**, RN, director of clinical and technical services for the Compass Continuum, a case management professional staffing agency covering the Denver metropolitan area.

Moore and her partner, **Vicki Peterson**, RN, started the Compass Continuum in January 1999, because they had observed so many case managers burn out because of work overload.

In fact, Moore, a case manager herself, recalls 60-hour work weeks during which she found herself on the verge of total burnout.

Compass is an acronym for Case Management Professional Staffing Specialists.

"I've been a case manager myself, and I know that when there is a vacancy or a heavier workload, what happens is that the work either doesn't get done at all or it isn't done in a timely manner. This results in a cost to the company," Moore says.

Among the potential problems that arise when case managers are overworked:

- A patient who should have been discharged stays in the hospital, resulting in charges in excess of $1,000 a day.
- An injured employee doesn't get back to work in a timely manner.
- A patient doesn't understand his or her treatment regime, misses medication and doctor's appointments, and doesn't get any better. In a catastrophic case, no one monitors expenses closely and the costs soar, due in part to

Patient-centered complex care program

If a patient wants it, CMs try to get it

If patients in Franklin Health's Complex Care Management program want something, the care manager will make every effort to see that they get it — whether it's covered by the insurance plan or not.

"This is truly a patient-centered program. The Franklin care manager works with the patients to determine their goals and is dedicated to helping meet these goals een though the goal may not be something covered by the patient's health insurance," says **Catherine Beatty**, RN, MSN, manager, medical services for BlueCross BlueShield of South Carolina, based in Columbia.

For instance, one patient wanted to try alternative treatment, which was not covered by her policy. The Franklin Health care manager found the resources so the patient could have the treatment she wanted.

The care managers develop a customized treatment plan for each patient, but they try to help the patients reach their personal goals as well.

For instance, the care managers have gotten patients in touch with the Make-a-Wish Foundation, brought family members back from Europe in an end-of-life situation, and found money to pay for flights to treatment centers in other parts of the country for a second opinion. (The health plan pays for second opinions but often not for transportation.)

"We reach out and find resources through their insurance benefits or other sources to help the patients get what they want," Clement says.

The care managers work to find creative solutions to some of the problems they identify. For instance, if a patient needs nutritional supplements and can't afford them, the care manager can arrange for the patient to get them free through the American Cancer Society. ■

duplication of services.

"What happens when there is a work overload and no staff to cover it is two-fold. Case managers feel overworked and stressed and look for another job. Or they may stay on the job but they don't do the work as well as when they aren't stressed. Whether they stay or don't stay, there is a decrease in productivity," Moore says.

Nurses are particularly susceptible to burnout when they are overworked because they are caring people and feel dissatisfied when they can't get everything done, Moore says.

"If people are overworked, they're unhappy. They feel underappreciated . . . If nurses feel appreciated, it's amazing how productive they can be. They will happily work overtime," Moore says.

Hiring a temporary case manager doesn't just get the immediate job done. It also supports the staff who are trying to fill the gaps left by the vacancy and may make them less likely to seek greener pastures.

When people leave a company, it costs a lot to train new employees and orient them to the way your firm does business. At the same time, the remaining staff have to pick up the workload while new employees are trained.

Temporary staffing works well for companies that have seasonal fluctuations in caseload and for employees who don't want to work full time, says **Brian LeCount**, director of marketing for HPO Healthcare Staffing, a Cincinnati-based temporary staffing company. HPO fills long-term nursing vacancies throughout the company and operates local temporary staffing companies in Cincinnati, Indianapolis, Columbus, OH, Milwaukee, and Minneapolis-St. Paul. **(For tips on how to find a reliable temporary staffing agency in your city, see p. 42.)**

At the beginning of the year, when managed care companies get renewals and have an influx of insured signing up, they call on the Compass Continuum to find extra help to deal with the temporary increase in work load.

O, they may call for a temporary case manager in an area that is outside their regular working area. For instance, a workers compensation company may need a case manager in an area that is too far for their staff to drive in a day. They may call on a temporary staffing agency to find someone local to do the job.

Temporary staffing also gives employers the ability to offer a flexible schedule for employees and gives the case managers an opportunity to broaden their experience by working at a variety of jobs. "I've had several people who moved here from out of state and used temporary jobs as an opportunity to learn about the Denver market," she says.

Temporary staffing agencies typically fill jobs for periods ranging from a day to a year. They can find a temporary employee for planned absences, like planning months in advance for someone to fill in for a case manager on maternity leave, or fill a job with only a few hours notice.

"We do what we can to meet their immediate needs and their planned needs. We provide somebody with either the same skills or strong transferable skills so the learning curve is short and they can hit the ground running," Moore says.

Most staffing agencies also offer temp-to-hire staffing, which enables an employee to try out the company for a while before deciding whether to work there permanently.

"There are a lot of times when people take a job and find out it's not what they expected or when an employer hires someone and finds out they just don't fit in with the company," Moore says.

With a temp-to-hire job, the employer and employee get to evaluate each other and decide if the job will work out. ■

Seven reasons to hire a temporary case manager

1. Respond rapidly to increased caseload, caused by employee vacations, illnesses, and other employee absences.
2. Respond to fluctuation in the work force due to terminations, downsizing, or seasonal fluctuations.
3. Optimize productivity by reducing caseload to a manageable level, maintaining continuity of care, and covering scheduled time off such as maternity leave and short-term disability leave.
4. Manage expenses by decreasing recruiting, training, and benefit costs, avoiding overstaffing, and decreasing employee burnout.
5. Acquire specialized case management expertise for temporary situations, such as a catastrophic injury or a case in a rural area you don't typically cover.
6. Save time by leaving the pre-screening and interviewing to the staffing agency.
7. Evaluate employee fit and performance before you offer a full-time job.

Choose your temporary staffing agency carefully

Don't consider cost as the only factor

There are a lot of variations in the services that temporary staffing agencies offer. That is why you should shop around before finding an agency to fill your case management vacancies, says **Brian LeCount**, director of marketing for HPO Healthcare Staffing, a Cincinnati-based staffing company that offers temporary local staff in five cities and traveling nurses nationwide.

He warns against using cost alone as a basis for hiring temporary staff or when you choose a staffing agency.

"Employers should weigh the benefits of having someone to fill a gap and the costs of not having staff as well as considering the cost of a supplemental staffing solution," adds LeCount.

While you may pay temporary staff a higher hourly rate than your employees, you save the "soft costs" such as employee benefits programs, recruiting costs, and other costs.

When you're filling case management vacancies, it's particularly important to choose an agency that knows something about case management, suggests **Dia Moore**, RN, director of clinical and technical services for The Compass Continuum, a case management professional staffing agency covering the Denver metropolitan area.

She suggests choosing a company that specializes in case management placement or at least has someone on staff who is familiar with the duties of a case manager.

"It's one thing to deliver a body. It's another to deliver a qualified person in a timely manner," LeCount adds.

Here are some other tips for finding a company to fill your temporary staffing needs:

- Look for a company with a proven track record. Ask for references and check them.
- Look for a company that gives you the opportunity to look at the resume of potential temporary employees and interview them in advance.
- Start small. Give a company you are considering a few assignments at first to make sure the people they send meet your expectations.
- Ask how long it typically takes to fill a position. It might be better to pay a higher fee to a company that can fill your needs quickly. ■

Contracting for DM pays off for small insurer

Plan saves on cancer treatment, heart attacks

When the management at CHA Health realized the need for disease management services for their population, they decided to contract with outside providers rather than establish the programs themselves.

CHA Health chose to purchase disease management programs rather than creating them in-house because it is a small company with limited resources, says **Timothy D. Costich**, MD, chief health services officer.

"Disease management is very time-consuming and very resource-consuming if you do it yourself. For active intervention in an identified risk population, you have to have the resources to develop the protocols and manage the program," Costich says.

Large, national companies have the experience and the expertise and are able to spread their resources over a large population base, making their services more affordable, he adds.

CHA Health is a Lexington, KY-based managed care organization created by local medical providers with more than 140,000 members in central and eastern Kentucky. About 70,000 members are fully insured by CHA Health and are eligible for its disease management programs. The others are employees of self-insured companies.

CHA Health has a lot of members in a wide geographic area. Many live in rural areas. Their needs are different from the needs of populations in other areas, Costich says.

"Telephone disease management works in other areas or with self-insured employers with multiple sites. But we need a hands-on approach with our population. We knew that just calling people on the telephone or sending them a booklet in the mail wasn't going to work for our population," Costich says.

The insurer started with two of its costliest diagnoses: heart disease and cancer.

Healthy Horizons, a program for oncology patients undergoing active treatment, was rolled out in September 1999 and is managed by McLean, VA-based Quality Oncology, which specializes in managing care for cancer patients.

Healthy Heart, which focuses on early detection and treatment of coronary artery disease, was

launched in March 2000. Q-Med, a Laurence Harbor, NJ-based disease management company offering technology-based management for cardiovascular disease, administers the heart program.

"For reasons of mostly lifestyle choices — smoking, obesity, Type II diabetes — we see a lot of heart disease. It's the condition upon which we spend the most money," Costich says.

"When we chose our heart attack program, we were looking for a program that was preventative. We were not particularly interested in managing people who were already sick," Costich says.

In its first year, Healthy Heart achieved a dramatic reduction in heart attack incidence. Q-Med reported that the incidence of heart attack had been reduced by 35.8% for the total CHA Health membership.

"In addition to utilization numbers, we've had a big increase in our HEDIS [Health Plan Employer Data and Information Set] numbers in terms of appropriate medication and appropriate monitoring of outcomes," Costich says.

He's waiting to see if the second year's results will be as dramatic or if the gains were based on a change in population.

"If you are doing prevention and identification properly, ultimately you will have a reduction in the number of events," he adds.

The staff at CHA Health didn't just turn management of its heart and cancer patients over to the vendor — they stay involved on a regular basis, reports **Kim Lee**, director of medical management.

"It's very important to realize that none of these programs work in isolation from each other. A joint effort at communication back and forth is extremely important," she adds.

CHA Health has a liaison case manager with each disease management program. The case managers do discharge planning, coordinate benefit coverage with local resources, set up home health or other programs that the patients need, and collaborate with the disease management company case managers on challenging cases.

The staff have ongoing monthly and bi-monthly conference calls with the vendors, as well as more frequent contact to make the most of the disease management efforts, she adds.

The Healthy Horizons cancer management program focuses on applying up-to-date protocols that use evidence-based medicine, Costich says.

"If you're doing it right, you typically save money on cancer treatment," he says.

Participants are identified through claims data, referrals from case management, and from local oncologists.

Quality Oncology assigns a primary case manager to the CHA Health cancer population. The case manager looks at the chemotherapy protocols that are proposed, the lab results, the biopsy results, and does day-to-day utilization management of the cancer population.

The cancer program is available for members undergoing active treatment. The member is assigned a case manager who works with the patients and family by telephone, answering questions and helping facilitate the treatment plan.

"The case managers look at the appropriateness of the treatment plan the oncologist puts together and looks for duplication of services," Lee says.

For instance, the family physician may order a battery of tests and refer the patient to specialists who do the same tests.

Participants in the Healthy Heart Program are identified by their physician or through patient self-reporting. CHA Health puts information in the member newsletter and sends letters to primary care physicians to identify people who are at risk for coronary artery disease.

"We look at claims data many times a year," Lee adds.

When a patient is identified, Q-Med staff go to the patient's primary care physician office, take a patient history, examine the patients, and stratify

Four tips for planning a successful DM program

1. Decide what you are trying to accomplish and make sure your vendors will meet your needs.
2. Find out what type of intervention will generate the best response from your members. For instance, CHA Health in Lexington, KY, chose a program that worked with patients in person, rather than via the Internet or telephone.
3. Choose your diagnoses carefully. For example, CHA Health started with the disease that cost it the most money. "Our strategy has been to do things that save the most money and inaugurate programs that will pay for themselves," says Timothy D. Costich, MD, chief health services officer at CHA Health.
4. Keep your disease management programs to a level that you can handle. "Some companies do all their disease management programs at the same time. One disease management roll-out a year is as much as we can do," Costich says.

the patients into risk categories. The company uses a proprietary technology system to assess, stratify, and manage the patients.

The Q-Med case managers work with the physicians to make sure they follow standard protocols for patient care and work with the patients on lifestyle changes, Costich says. "We haven't had any complaints from our physicians. It's hard for them to say they aren't interested in learning the best way to treat heart disease."

The program saved money in the first year as costs for heart attack incidence declined. "It's somewhat of a moving target. Costs change every year, and our population also changes," he says. ■

UM companies focus on case management

CM fits 'high-return' model

There may be good news on the job market front for case managers, according to a new study by URAC, the American Accreditation HealthCare Commission based in Washington, DC.

The survey of companies registered to provide utilization management showed that they are increasing their use of case management and disease management to complement utilization management.

The study, "Trends and Practice in Medical Management: 2001 Industry Profile," addressed the evolution of utilization management and how it relates to case management and disease management.

The companies surveyed reported that they are looking for better ways to do business. Their strategies include cutting down on pre-certifications, concentrating on procedures most likely to be overused or abused, or identifying groups or individual providers who typically fall outside of utilization norms.

They're taking the staff and financial resources previously used for pre-certification and using them for case management and disease management for patients with the need for intensive interventions.

"They're using utilization management as an early warning system to get patients who need it into case management. There's still the age-old challenge of proving the return in outcomes for case management. But a lot of companies are demonstrating that they believe that case management can deliver better outcomes by coordinating services and helping providers stick with evidence-based practices," says **Liza Greenberg**, RN, MPH, vice president of research at URAC.

Although utilization management is changing, it's not likely to be eliminated completely in the near future, the researchers concluded. Instead, companies view utilization management as having an important role in containing costs.

However, medical management organizations see the need to focus on patients who need a higher intensity of care and those who have difficulty navigating the complex health care system. They are looking at predictive modeling as a way to identify future high-use patients.

The companies are using case management and disease management to improve compliance with evidence-based care recommendations and to improve patient outcomes says **Michael Harwick**, MD, a consultant to the study.

"They are building a high-return model by increasing case management and discharge planning and reducing emphasis on prior authorizations. An intentional byproduct of this strategy is reduced administrative burden for physicians and, the companies hope, better relationships with physicians," Harwick adds.

Staffing needs are changing as the companies shift their emphasis from direct utilization management to case management.

"Our study shows that companies still view utilization management as an important tool for evaluating medical necessity. However, companies are now using utilization management as a gateway. They are reviewing fewer procedures but looking more closely at each encounter to identify opportunities to improve and coordinate care more effectively," says **Garry Carneal**, JD, MA, president and chief executive officer of URAC.

The study may indicate an increase in demand for the services of case managers, but other factors could affect the job market in the immediate future, Greenberg points out.

"One sort of confounding factor is that the economy is affecting people covered by health care plans. Although companies are increasingly using case management, if their enrollment goes down, there still may be employment contractions," she adds.

The real implication for case managers in the study is recognizing trends in the industry,

Greenberg says. For instance, the URAC investigators heard repeatedly that companies are converting to electronic ways of communicating because of the increase in efficiency.

Health education and health information through the telephone or Internet are increasing as components of utilization management, case management, and disease management programs, or as independent components.

For instance, many health care organizations have nurses who answer telephone questions about nonlife-threatening conditions 24 hours a day. Many companies offer health education on the Internet, including health risk assessment.

The companies are focusing on evidence-based practices as the most effective and efficient way to treat patients.

Patients are able to make more decisions about their benefits and their providers and to share in the financial risk.

Researchers surveyed companies registered to provide utilization management in the state of Illinois. "There is no comprehensive list of utilization management companies. We used Illinois because the companies are required to register," Greenberg says.

The study included an Internet-based questionnaire, focus groups, and interviews of medical management leaders, site visits to several companies, and a search of peer-reviewed literature for industry trends and practices.

Participants included 120 different companies representing a cross section of companies providing medical management services. Survey respondents included HMOs (23%), PPOs (36%), standalone medical management companies (39%), insurance carriers (20%), and others.

"URAC's findings suggest that medical management has the potential to influence cost and quality within the health care system. The success of medical management's evolution may be dependent upon the ability of companies to capture and use data to develop targeted, integrated programs and to influence providers in a collaborative, educational manner," the researchers wrote. ■

Key components of URAC's medical management study

- Companies are looking for more efficient approaches to utilization management, such as reducing the number of procedures certified, identifying groups or individual providers outside of utilization norms, and concentrating on procedures most likely to be utilized.
- Companies are linking medical management programs such as utilization management and case management or case management and disease management, and are enhancing referral and information-sharing among the programs. Standalone medical management organizations are most likely to link all three programs in a unified approach.
- Staffing for medical management is changing as companies shift their emphasis to case management rather than direct utilization management.
- Medical management companies rely heavily on external criteria and guidelines to assist in medical management decision making.
- Companies are working toward integrated electronic systems for medical management and quality management.
- Health care organizations are working to develop more collaborative relationships with providers, including expansion of physician-to-physician interactions, data sharing, and medical management support.

URAC standards broaden eligibility for accreditation

Independent CM companies may apply

If you're an independent case management company or a case management department within a large organization, you now will be able seek accreditation under URAC's revised Accreditation Standards for Case Management Organization.

URAC, the American Accreditation HealthCare Commission, located in Washington, DC, has revised all its accreditation standards to include Core Standards, which any organization seeking accreditation must meet, and specific standards for each type of program seeking accreditation.

For instance, case management programs must meet the Core Standards and the Case Management Organization Standards. The case management organization standards cover standards that apply uniquely to case management.

In the past, case management organizations could become accredited only if their parent organization went through the accreditation process.

Organizations that have gone through the accreditation process have found that it helps them identify areas of improvement, says **Guy D'Andrea**, senior vice president of URAC.

"Most of the organizations we've talked to feel like they are better for having done so," he adds.

Accreditation is useful for case management organizations when they develop partnerships and build business relationships, he adds.

"Trust and mutual confidence is always part of the relationship. It helps to have a third-party seal of approval. Case management organizations aren't a bricks-and-mortar kind of business. They don't have a lot of physical things to show. Accreditation shows that they are a substantial organization," he adds.

The new standards make it possible for independent case management organizations and for case management organizations within a larger organization to seek accreditation, according to D'Andrea.

"The revisions bring our standards up to date, improve the scoring process, and integrate our standards into the modular concept," he says.

The new case management organization standards may result in more case management organizations seeking accreditation, D'Andrea says.

"Even without revisions to our case management standards, our case management accreditation program has been our fastest-growing program over the past 18 months," he adds.

Case management organizations that previously have been through the accreditation process shouldn't see any major changes under the new standards, D'Andrea says.

"The biggest change is in the quality management section. They will find that the standards have become more refined and more specific than in the first generation of case management standards," he adds.

The case management organization standards were released in late December 2001 for public comment through Feb. 20, 2002. They are expected to be approved by the URAC Board of Trustees this month and go into effect in October.

Organizations that already have started to apply will be able to seek accreditation under the old standards.

The case management standards apply to companies providing telephonic or on-site case management services in conjunction with a privately or publicly funded benefits program.

Among the categories the case management standards cover are policies and procedures, staff structure and qualifications, staff management and development, information management, organizational ethics, case management process, disclosure and consent, access, complaints, and definitions.

Core standards address issues such as consumer protection, confidentiality of health information, oversight of delegated functions, staff qualification and management, and quality management.

The new standards integrate the Interpretive Guide, which covers the intent of the standards, into the body of the standards.

Instead of using "shall" and "should" to indicate the importance of standards, the new version assigns each standard a weight of 1 to 5 to indicate its relative importance. Applications are

Materials to include with application

- Application cover sheet
- Billing worksheet and payment
- Signed representations by the applicant
- Corporate information, including attestation of compliance with applicable state and federal laws
- Site-specific information
- Signed multi- or mega-site representations if applicable
- Documentation as evidence of compliance with each URAC standard
- Articles of incorporation, including organizational charts.

Material you may need during the accreditation site visit

- A copy of the application for accreditation
- Copies of other information provided to URAC
- Committee minutes for each committee relevant to the standards
- Files that may be selected for examination, including complaints, appeals, credentialing, and employee quality initiatives
- Policies, procedures, and guidelines available to staff
- Training materials for new employees
- Analyses, reports, and data from quality assessments
- Delegated contracts and reports between delegated entities and the program

scored on a scale of 0 to 4, with "0" indicating noncompliance.

The standards include primary and secondary elements. The primary element is something the standards committee believes will have a direct impact on patients or consumers. Secondary elements are features that indicate a high-quality program.

Applicants must meet all primary elements of standards that are weighted with at "5."

CE questions

13. What is the typical caseload of case managers in the complex care management program offered by Franklin Health, based in Upper Saddle River, NJ?
    A. 10 to 15
    B. 15 to 20
    C. 20 to 25
    D. 25 to 30

14 What percentage of BlueCross Blue Shield of South Carolina patients in the complex care management program are terminally ill, according to Michelle Hendershot, account director for Franklin Health?
    A. about 60%
    B. about 70%
    C. about 80%
    D. all of them

15. What type of patients are served by the Healthy Horizons program at CHA Health in Lexington, KY?
    A. cardiac patients
    B. oncology patients
    C. COPD patients
    D. asthma patients

16. True or false: URAC, The American Accreditation HealthCare Commission in Washington, DC, has revised its accreditation standards to include Core Standards, which any organization seeking accreditation must meet, and specific standards for each type of program seeking accreditation.
    A. true
    B. false

The accreditation process involves submitting a detailed application that includes documentation for each of the standards and a site visit conducted by URAC's full-time accreditation review staff. Certified case managers conduct the case management reviews. During the site visit, the reviewer discusses specific areas of the case management program, based on his or her review of the application. Applicants receive an agenda before the visit.

The length of time it takes to submit an application depends on the organization's operations — how close they are to the standards, the number of changes they have to make, and the level of resources they want to devote to the process, D'Andrea says. Once the application is submitted, it takes three or four months to go through

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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. ■

the accreditation process.

URAC offers accreditation to a variety of organizations in the managed care industry. Among their accreditation programs: health utilization management, clinical triage and health information, claims processing, health networks, health utilization management, workers' compensation networks, credential verification organizations, disease management, and health web sites. ■

Public opinion of health care based on many factors

Report suggests reasons for changes in concerns

Satisfaction about the health care system, services, and providers change frequently based on a number of forces, according to a report by Harris Interactive, a marketing research firm based in Rochester, NY.

The report suggests that all the forces sometimes have made a difference at one time or another in public priorities and support for legislation or new health care initiatives. But the magnitude of the effect varies greatly from event to event. The report is available at www.harrisinteractive.com.

The factors that affect public concerns and priorities include:

- experiences;
- media coverage;
- advertising and advocacy;
- events;
- physicians;
- election campaigns;
- costs;
- aging of the population;
- the gap between expectations and reality. ■

Diabetics not aware of heart disease risk, study says

A survey of people with diabetes showed that 68% are unaware they are at increased risk for heart disease and stroke and also are unaware of ways to reduce their risk for serious complications.

Three-fourths of those surveyed reported having risk factors for cardiovascular disease such as high cholesterol or hypertension, but they did not relate the problems to their diabetes. More than half said they did not feel at risk for a heart condition or stroke, and nearly two-thirds did not feel at risk for high blood pressure or high cholesterol.

About half said that their health care provider had never discussed ways they could reduce their risks for heart disease and stroke, such as lowering their blood pressure or cholesterol or quitting smoking.

"This research clearly illustrates the gap between perception and reality. The harsh reality is if you have diabetes, you have a two to four times greater likelihood of having a heart attack than if you do not have diabetes. People with diabetes need to know that good diabetes management is more than just lowering blood glucose," says **Christopher D. Saudek**, MD, president of the American Diabetes Association.

The study was part of the Make the Link! Initiative, a joint project of the American College of Cardiology and the American Diabetes Association. The initiative focuses on education and outreach to health care professionals.

For more information, visit the American Diabetes Association web site at www.diabetes.org/makethelink. ■

Foot and ankle surgery relieves pain, arthritics say

Surgery to treat arthritis in the foot and ankle significantly relieves pain and helps patients increase their physical activity, according to a patient survey from the American College of Foot and Ankle Surgeons (ACFAS).

About two-thirds of the patients reported pain relief, while more than half said they increased their physical activity after surgery.

Patients who were surveyed had foot or ankle surgery in the past two years to treat conditions in which arthritis was the underlying cause. Procedures include ankle arthroscopy, joint replacement, joint removal, fusion, and remodeling to clean out the joints.

Patient quality of life can be significantly improved by surgery to relieve arthritic pain and restore lost motion, says **Robert W. Mendicino**, DPM, FACFAS, president of the ACFAS.

For more information see the organization's web site at www.acfas.org. ■

Glaucoma treatment best for those at greatest risk

A new drug, Travatan Opthalmic Solution works well on all groups of patients with glaucoma but provides even greater effect for African-Americans who are hardest hit by the disease, a year-long study has concluded.

The study, published in the *American Journal of Ophthalmology* late last year, compared the

effectiveness of three different treatments for glaucoma, a leading cause of blindness in the United States.

Investigators concluded that Travatan worked as well or better than Xalatan, was superior to Timpotic, and that it worked significantly better in African-American patients.

"Given that glaucoma takes a different course in black patients than in others, understanding the variations in treatment responses will enable doctors to provide optimal treatment to their African-American patients," says **Mildred Olivier**, MD, a member of the National Eye Advisory Council of the National Institutes of Health.

Glaucoma affects about 3 million Americans, is the second leading cause of blindness among Americans, and is the number one cause of blindness in African-Americans. Vision loss from glaucoma is irreversible, but with early detection and treatment, vision usually can be preserved.

People at greatest risk include those over 40, people of African-American descent, people with a family history of the disease, people with diabetes, and people with high blood pressure. ■

Young women at greater risk after bypass surgery

Women are at as much as a three times greater risk than men of dying during or shortly after coronary artery bypass surgery, researchers report.

The report, in the Feb. 19, 2002, issue of *Circulation: the Journal of the American Heart Association*, concludes that women younger than 50 face an even greater risk than men.

"Although the percentage of bypass surgery patients who died was relatively small, the differences in both overall mortality and the death rate for patients under age 60 was significant between the two sexes," says **Viola Vaccarino**, MD, PhD, associate professor at Emory University's School of Medicine in Atlanta and co-author of the study.

The researchers were unable to determine why the death rates were different between men and women, Vaccarino says. The researchers reviewed the records of 51,186 patients in the National Cardiovascular Network database who underwent bypass surgery at 23 medical centers. Of the patients, 29.7% were women.

Overall, 5.3% of the women died in the hospital compared with 2.9% of the men. In addition, 3.4% of women younger than 50 died compared with 1.1% of the men. In the 50-59 age group, 2.6% of women and 1.1% of men died.

"Women tended to have more pre-existing illness and risk factors in their medical history but they had less extensive coronary atherosclerosis and their hearts had better pump functions as detected by cardiac catheterization. It seems paradoxical, but that's what the data show," Vaccarino says. ■

Vitamin E reduces hypertension in case of kidney failure

High doses of vitamin E significantly reduced high blood pressure in rats with chronic kidney failure, a University of California at Irvine College of Medicine study has found.

The study shows how vitamin E and other antioxidants may provide new ways to treat high blood pressure, the researchers say.

"The study confirms earlier work showing that kidney failure results in accelerated production of free radicals and demonstrates the beneficial effect of antioxidants. We hope that future tests on humans will show how much antioxidants can be used to help ease high blood pressure and free radical production in kidney disease," says **Nick Vaziri**, MD, professor of medicine and chief of nephrology.

More than 300,000 people are treated for severe kidney failure in the United States each year, a number that is expected to double by 2010 according to the U. S. Public Health Service. ■

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. ■