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## INSIDE



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**Reports From The Field**

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# Home-grown disease management programs reap rewards for insurer

*Plan sees advantages to developing its own programs*

When ConnectiCare looked into starting disease management programs six years ago, there were few similar products on the market. So, the small regional HMO based in Farmington, CT, decided to create its own disease management programs.

ConnectiCare is an independent practices association (IPA) model HMO with 260,000 members in Connecticut and western Massachusetts. The plan established its first disease management program in 1996.

One of the first programs, BREATHE, an asthma program, achieved a 119% return on investment. **(For more information, see charts, p. 51.)**

"At the time, there weren't a lot of vendors out there because it was a new concept. We thought it was in our best interest to develop our own program. We wanted to have them in-house, and we saw it as an opportunity to learn something about the industry rather than just outsourcing

## Get on the disease management bandwagon

Whether you're an insurer, provider, or an independent case management firm, you need to be doing disease management in order to keep up with your peers. More than 90 million people in the United States suffer from at least one chronic condition. Their care makes up 60% of the nation's total health care expenditures, according to the National Center for Chronic Disease Prevention and Health Promotion. Managing chronic diseases is the most effective way to address escalating health care costs. For instance, the national chronic disease center estimates that every dollar spent on diabetes management saves $2 to $3 on hospitalization costs. In this issue, we'll show you how two organizations, an MSO and an HMO, set up and run their disease management programs. We include tips on setting up your own program. You'll learn about the Joint Commission on Accreditation of Healthcare Organization's disease-specific certification program and see how a hospital developed a clinical reminder for case managers to document patient education.

it," says **Jay Salvio**, BSN, MBA, director of ConnectiCare's health management department.

The company wanted a program with a personal touch to make it a "true ConnectiCare program," Salvio adds. ConnectiCare's philosophy was to be member-oriented and keep as many operations in-house as possible.

"We wanted our staff from Connecticut dealing with our members. We wanted a program that had a real personal touch and fit in with the case management aspect," says **Steve Delaronde**, MPH, MSW, an epidemiologist/research analyst with ConnectiCare's health management department.

In fact, the members appreciated having someone from the organization they were familiar with being part of the disease management program and welcomed the chance to form a relationship with their insurance company.

ConnectiCare's member satisfaction ratings soared after the disease management programs were implemented.

"One of the most important aspects of what we are doing is creating a personal connection with the members. This is also one of the areas where you get the greatest return. It helps distinguish your organization within the marketplace and helps you carve a niche and build your reputation," Delaronde adds.

The plan's oldest disease management program is a high-risk pregnancy program, which started as a quality improvement activity and evolved into a health management program.

"It was born out of concern about the number of pre-term deliveries we were experiencing five or six years ago. We felt that with proper education and management, we could reduce the number and improve the quality of life for members and their children," Salvio says.

The company has created additional disease management programs in asthma, diabetes, and congestive heart failure. The programs typically are staffed by two nurses and a support person.

The HeartCare program, which previously focused on members with congestive heart failure, will begin serving members with coronary artery disease in 2002. Two nurses and a support person will staff the HeartCare program, with a nurse dedicated to each.

ConnectiCare's disease management plans were developed by a committee that included a physician advisor who was a specialist in the chosen condition. Other committee members included the director of the health management program, the nurse or nurses who would be operating the program, and the plan's medical directors.

A lot of the work was done in the background and brought to the committee for approval, Salvio says.

For each diagnosis, the plan's disease management committee creates guidelines to guide the management and education of members and the physician community.

The staff at ConnectiCare recommend using established guidelines rather than developing your own.

For the asthma disease management program, ConnectiCare used the National Heart, Lung, and Blood Institute guidelines for managing asthma.

It takes ConnectiCare about four to six months to develop a disease management program and go live with it. "We started our coronary artery disease program in January and plan on having it go live in June," Salvio says.

Patients are identified by utilization — either claims for the physician office, emergency room, hospital, or pharmacy.

The plan uses pharmacy claims and lab data to identify patients who are not having problems at present but may in the future.

For instance, diabetes patients with high cholesterol or A1C hemoglobin levels are identified. The system flags asthma patients who are refilling their short-term "rescue" medications frequently and seldom refill their anti-inflammatory medication for long-term control.

They are stratified according to how they are identified. For instance, those who have been hospitalized or treated in the emergency department get the highest level of management from the case manager.

"As part of the evolution of health management, we started by identifying members once

## *COMING IN FUTURE MONTHS*

- Proving the value of case management efforts
- Get your CEUs on-line
- How other case managers are preparing for HIPAA
- Coordinating care throughout the continuum

they had experienced some event, and helped them improve their health status. Our goal is to move further upstream and try to predict who may end up in the hospital and prevent hospitalization by getting them into the program before their condition gets severe," Salvio says.

Once members are identified, the case managers personally contact those in the high-risk group. The rest are sent materials to educate them about their condition and help them manage it.

For instance, in the asthma case management program, nearly 400 of the 23,000 members with asthma are under active case management.

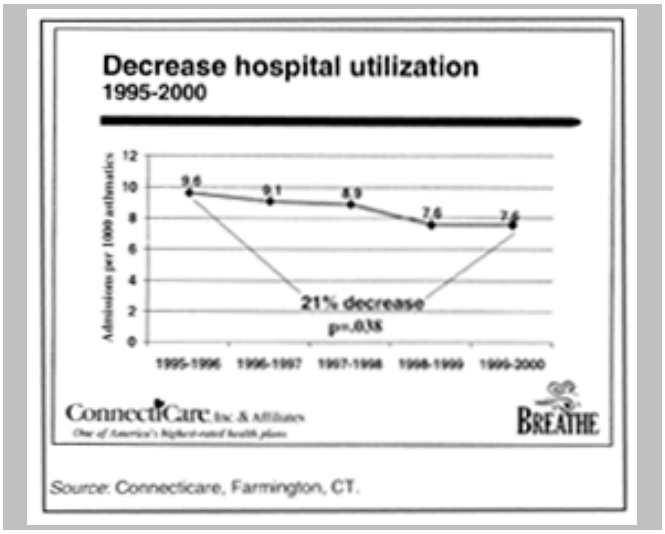
When they contact high-risk patients, the case managers assess their level of knowledge about their condition, determine what they need in terms of management help and education, and then put together a treatment plan.

The ConnectiCare disease management committees have developed standard protocols for typical situations that the case managers use unless the patient has unique comorbidities.

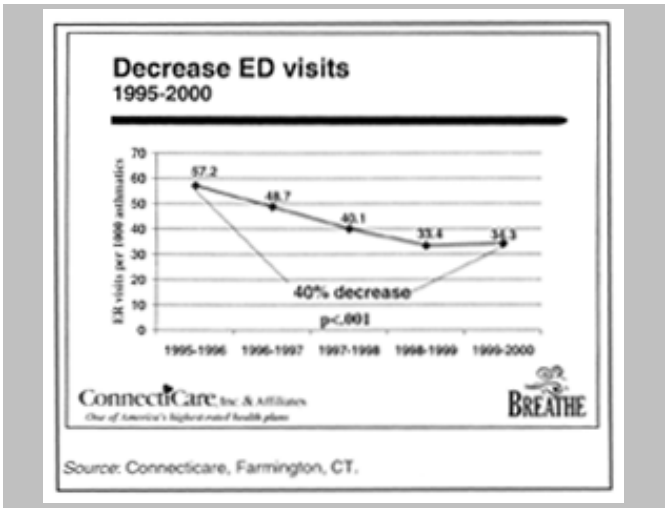
The patients receive follow-up telephone calls as needed. While the primary focus of the disease management program is the members, ConnectiCare makes sure that patients' treating physicians are in the loop.

The physicians are sent up-to-date guidelines annually, and quarterly patient utilization and drug profile reports.

"We don't operate apart from the patient's regular medical care," Delaronde adds. ■




*Source*: Connecticare, Farmington, CT.




*Source*: Connecticare, Farmington, CT.

## Select where you can have impact on cost, utilization

*Develop your DM program one step at a time*

When ConnectiCare of Farmington, CT, set up its disease management programs, the staff looked carefully at its covered populations and chose programs that were prevalent and had high emergency medical utilization.

"We looked for conditions where there was a set of nationally recognized guidelines that could guide the care, and conditions where we felt we could make an impact," says **Jay Salvio**, BSN, MBA, director of ConnectiCare's health management department.

For instance, there are 23,000 people with asthma in the ConnectiCare population. "There are nationally recognized guidelines for asthma, and we know that proper management can have a significant impact on the quality of life for people with asthma," adds **Steve Delaronde**, MPH, MSW, an epidemiologist/research analyst for the health management department.

There weren't as many members with heart failure, but there was enough utilization in the membership and ConnectiCare was adding a managed Medicare product to its line so the staff felt they could make an impact, Salvio says.

Here's how ConnectiCare selects areas where a disease management program could have an impact:

It looks at the membership for the top diagnoses and procedures, where there are the most claims, what disease and conditions are most prevalent, and what costs are associated with the conditions.

## Eight things to consider in developing a DM program

1. What population will you manage?
2. Will management be one-on-one or population based?
3. How will you contact the members?
4. What tools will you use?
5. What collateral material, such as newsletters and educational pieces, will you need?
6. How often will you contact the members?
7. How long will they stay in the program?
8. How will you determine the effectiveness of the program?

From there, it looks at which conditions a disease management program could impact the most, including reduction in hospitalization, emergency department visits, and improvement of quality of life.

Once you target a disease or condition for a disease management program, you should learn as much as you can about the condition and how it's treated. "If you're going to educate and impact your membership, you need to be knowledgeable about the condition and know how to apply the treatment protocols to your membership," Delaronde says.

You must be certain that you can identify members who will benefit from the intervention and that you can stratify them as to level of severity to determine who needs help the most.

For instance, it would take an enormous staff to contact all 20,000 of ConnectiCare's members with asthma, assess, and educate them. That's where the stratification piece comes in.

"We've identified the members whose conditions have brought them most often to the emergency room or inpatient hospital. These are the people who will benefit most from case management," Delaronde says.

These patients were offered the opportunity to enroll and participate in the program.

"Once we know we can stratify our membership, we can put together our own disease management plan that will work for our population," Delaronde says.

Then decide how you'll go about managing them and how frequent the management will be.

"What we have learned is to develop a protocol that sets out exactly how you are going to work with your members. You should know what topics the intervention is going to include and how long it is going to last. Your goal should be to cover certain topics and provide a certain number of interventions over a certain period of time," Salvio adds.

However, there is no hard and fast prescription of what interventions are needed for every patient.

"Some members need more education. Some grasp things very quickly and are dedicated to managing their disease," Salvio points out.

A good disease management program should include a management plan that specifies the intensity of contact and how the members will be contacted.

"You need to have in place a plan for how often you're going to call the members, even before you know who you are going to call," Salvio says. ■

# Measuring your success is key part of DM program

*Database helps quantify your results*

The last and perhaps most important step in designing a disease management program is to develop a way to track your members and measure your success.

ConnectiCare, based in Farmington, CT, uses a tracking database created by the company's database and design specialist John Plecan, who uses Microsoft Access, an off-the-shelf database program.

When you identify your members, your database helps you keep track of them.

For instance, ConnectiCare's database enables the plan to track interventions, including when they were called, what was discussed, what were their health perceptions, when they saw the doctor, etc. ConnectiCare tracks clinical outcomes such as hospitalization and emergency room utilization as well as performing quality of life assessment surveys and measurements.

It uses the outcomes for continuous quality improvement projects to fine-tune the programs.

A tool to measure the return on investment or the financial benefit of the programs also is useful in proving to management that the program works.

"This has been evolving since we started. It's not an easy thing to measure," says **Jay Salvio**, BSN, MBA, director of the health management department at ConnectiCare.

But remember, it takes a long time to see a return on your investment for some conditions

such as diabetes, Salvio warns. For CHF and asthma, you can tell the investment has paid off in a shorter time, he says. ■

# Community DM program pays off for MSO

*Nurses, social workers, pharmacists are on team*

A community disease management program aimed at the frail elderly has saved Physician Health Partners of Denver 50% on patient care for congestive heart failure patients within six months after patients are identified and enrolled in the program.

Nurses, social workers, and pharmacists who work closely with the patients' primary care physicians staff the multidisciplinary program.

Physician Health Partners is a management service organization (MSO) that is 90% owned by physicians. About 500 patients are enrolled in the frail elderly community case management program. About a third of them are in the congestive heart failure disease management program.

"When you look at the senior population, congestive heart failure is one opportunity where increasing compliance can dramatically reduce the global costs," points out **Jay Want**, MD, medical director. Physician Health Partners currently works with three independent practices associations (IPAs), covering about 58,000 lives.

"We provide all managed care infrastructure for each group, utilization review, looking at referrals and precertifications, and a case management program that follows patients through hospitalization and into the community," Want says.

Physician Health Partners started its disease management efforts in 1997 as a way of examining and controlling utilization in a market where providers increasingly were under global capitation. There was one case manager on staff.

"The disease management efforts grew out of a sense that there were people who repeatedly came in and out of the hospital and that it would be a good idea to manage them. At that point, there may not have been literature and data to support such an approach," Want says.

"At that point, we decided that there needed to be a lot more discipline in the frail elderly program before we could figure out whether or not we were doing anybody any good," he says.

The organization had good anecdotal data, but it was hard to prove that the success stories were typical patients rather than atypical incidents.

The management contracted with Pfizer Health Solutions for its customized Clinical Management System disease management modules. Physician Health Partners currently uses the Healthy Lifestyles and Heart Failure modules. The software is used to collect patient data; organize information from patients, case managers, and physicians; apply clinical guidelines; and produce treatment recommendations.

Physician Health Partners made the decision to contract with a vendor for the software but manage the program in house as a way to continue its personal link with the patients and physicians.

"We feel that they are more likely to respond to treatment recommendations or to call us if they have questions when there's a local presence rather than someone out of state," Want says.

When the patients are in the hospital or skilled nursing facility, the on-site nurses flag patients with congestive heart failure, chronic obstructive pulmonary disease, and diabetes and refer them to on-site case management for assessment. About a third of the patients are referred for community case management, says **Rosalind Bader**, MSW, director of case management.

Other referrals come from physicians and home care agencies. The organization also conducts a patient data review to find other patients with multiple emergency room visits, frequent readmissions, and chronic conditions that fall in the top 10% of costs.

"The data says that any single screening method is no more than 60% sensitive. That's why we use multiple screening methods," Want says.

Disease management is essential in today's health care environment because complex cases often go beyond the ability of the primary care physician to manage them well enough to keep patients out of the hospital.

"If a physician has 10 minutes of contact with a patient once a month, it's difficult to manage them well, especially if it's a patient with complex conditions such as congestive heart failure or diabetes," Want adds.

The program began with physician commitment and evolved over time as it became more data-driven.

Setting up a disease management program is always difficult, especially for physician groups who don't always have a large cash reserve, Want points out. "It's a tough call to commit the money

to hire a nurse to follow patients with a sense that you're going to recoup your investment somewhere along the line," he adds.

The MSO is focusing on congestive heart failure and is considering adding chronic pulmonary obstructive disease and diabetes.

In addition to the hard outcomes, the physicians believe that the disease management program gives their organization something above and beyond what other types of payers can provide, Bader says.

*[For more information on Pfizer Health Solutions and its disease management programs, contact the company at (866) PHS-2002 or visit www.pfizerhealthsolutions.com.]* ■

# Multidisciplinary approach is key to program's success

*Case managers rely on instincts, software prompts*

Physician Health Partners' frail elderly disease management program is multidisciplinary by necessity.

"These patients' problems are not strictly medical problems, they aren't strictly drug interaction, and not strictly psychosocial problems. That's why it makes it difficult for any single physician to manage one of these patients. It takes a team approach," says **Jay Want**, MD, medical director for the Denver management service organization (MSO).

About 500 patients are enrolled in the program. It is staffed by three RNs who manage the cases, one licensed practical nurse who does the callback program, 1.5 full-time equivalent social workers, and one pharmacist who examines the medications the patients are on and checks to make sure those medications are working.

The team works closely with the patients' primary care physicians.

"We see ourselves as an extension of the primary care physician," adds **Rosalind Bader**, MSW, director of case management.

In the Physician Health Partners model, the pharmacists, socials workers, and nurses work with the same physicians on a consistent basis.

"Our philosophy is that, in order to make changes, a physician has to trust that the information is reliable, and it's easier if they have met the person who has given it to them," Want says.

Although the community case management staff may make recommendations to the physicians, it is the physician's option to make changes in the treatment plan or keep it the same, Want adds.

Many of the patients are referred to the program by Physician Health Partners' case managers, who work onsite at local hospitals and skilled nursing facilities. They work together with the case managers in the community program.

The nurse case managers call patients 24 - 48 hours after discharge from acute care or the skilled nursing facility and make sure they have their prescriptions and that follow-up appointments have been made.

The nurses use a scripted questionnaire and use their judgment to call in community case management if needed. "In some cases, the nurses may call the primary care physician or direct the patient to emergency care," Bader says.

In the frail elderly program, the case managers follow the patients on an outpatient basis and contact them anywhere from weekly to monthly, depending on the patient.

Nurses do the initial assessment of patients using Pfizer Health Solutions' Clinical Management System software. If there are no red flags, they follow up in a month. If they think the patient needs additional services, they either call them more frequently or get with the social worker and come up with a way to meet their needs.

"The software program has prompts, but many times the nurses use their judgment and skills to decide what is appropriate for the patient," Bader says. The nurses get a list of medications the patient is taking, and the pharmacist looks at the list and makes recommendations.

"The primary care physicians are the drivers of the patients' prescriptions, but sometimes there are multispecialists, and we try to oversee the medications and make sure the primary care physician knows everything that has been prescribed," Bader says.

As they talk to the patients on the telephone, the nurse care managers often follow their instincts in deciding whether patients need a home visit or additional follow-up. If something doesn't seem quite right, they often involve the social worker, who visits the home.

"The nurses are attuned to the medical piece, and pull in social work if other things are impeding compliance," Bader says.

For instance, patients may have cognitive defects or financial problems that can prevent

them from taking proper care of themselves.

The program will provide scales for people who need to weigh themselves and can't afford to buy their own scale.

"Home visits are part of the services. We try to keep our visits down because they are a resource-intensive component. But if we're not sure what's going on, we like to take a peek and see if any interventions are needed," Bader says.

The pharmacist may accompany the nurse or social worker on home visits.

"With the frail elderly, the social work component is critical to making sure they are staying safe at home and have the resources they need," Bader says. In these cases, the social workers help the patients and their families find local resources to help. The social workers work with a local Alzheimer's project and refer patients to the program if the need it.

They work with the drug companies to get prescriptions filled for indigent people and get the patients who need it on entitlement programs such as Medicaid, Meals on Wheels, and a state energy assistance program.

"We also work with charitable organizations, like the Dominican Sisters, to provide homemaker assistance and other services not traditionally covered by insurance," Bader adds.

"We try to be really creative in hooking people up with the resources they need. The social workers are really in tune with the community agencies," she adds. ■

## Be committed, patient with new DM programs

*Results don't come overnight*

Whether you develop your own disease management program or buy one from a vendor, be prepared to wait for the results, say representatives of two organizations with locally run disease management programs.

A disease management program can be cost-effective and rewarding on a human level, says **Jay Want**, MD, medical director for Denver-based Physician Health Partners. Want says organizations developing and running disease management programs should be committed to doing the right thing as well as saving money.

"There are going to be times when you question whether the program is beneficial, especially when you don't yet have data to analyze. An organization should commit to disease management because they feel it's the right thing and the moral thing to do," Want says.

Whether you buy one or create your own, keep in mind that a disease management program requires a substantial commitment in terms of money and staff.

"You can't do it half-heartedly and hope to have success. You have to be dedicated to making the investment," says **Jay Salvio**, BS, MSN, director of the Health Management department at ConnectiCare, a Farmington, CT-based independent practices association (IPA) HMO.

Here are some other things to remember if you're considering disease management:

- **Take a long-term view**. The minimum period for calculating your investment should be two to three years. "If your expectation is to show a return in the next quarter, disease management is not a program for you," Want says.

It takes a long time to see a return on your investment for some conditions like diabetes, Salvio says. For congestive heart failure and asthma, you can tell the investment has paid off in a shorter time, he adds.

- **Track your data in a disciplined way**. Understand how much you've spent and how much return you've gotten. You may be in the red for a while, but make sure you're headed in the right direction.
- **Make sure you have software to support your program**. "It seems like we turned the corner once we got the software. IT [information technology] helped us formalize and standardize what we do," says **Rosalind Bader**, director of case management for Physician Health Partners.
- **Make sure your staff are knowledgeable and committed.** One of the reasons for the success of ConnectiCare's disease management program is low staff turnover, Salvio says. "All the nurses who were present when the programs were developed are still here. This is extremely important because of the personal relationship they have developed with the members and the continuity of care," he adds.
- **Be prepared to do a lot of continuous quality improvement**. Disease management is an evolving process. Analyze your data and see where you need to make changes.
- **Make sure you have buy-in from everyone in your organization before you begin.** "You

need support from the chief executive officer and board of directors down to the people who run the program on a daily basis," Salvio says. ■

## Reminder system prompts CMs to provide education

*Pilot program part of hospital's QI initiative*

When the Hunter Holmes McGuire Veterans Affairs Medical Center (VAMC) in Richmond, VA, participated in a national performance measures initiative for congestive heart failure (CHF) patients, the administration was not pleased with what it saw.

Although the staff were certain that the case managers were giving the patients the required educational materials, they often weren't documenting it. One of the Veterans Administration performance measures is how well a hospital provides written instructions on diet, activity, medication, and weight to congestive heart failure patients.

"We knew a lot of education was being provided, but our scores showed us to be on the lower end of the performance improvement scale when it came to documenting education to our congestive heart failure patients," says **Mary Jacobs**, RN, PhD, quality management coordinator at VAMC.

Working with the case management department, the hospital quality management team launched an interdisciplinary program aimed at changing the behavior of the hospital's case managers and improving the education of the patients at the same time.

Patient education at the VAMC has three components: a patient education brochure produced by the VA for use nationwide, a packet of supplemental information, and a class that further addresses issues that arise with congestive heart failure.

"We wanted to change the process to improve upon providing information to inpatients with a principal diagnosis of congestive heart failure," says **Mark Zunk**, RN, MS, quality management nurse.

To strengthen the program, the hospital came up with a series of strategies designed to improve education for CHF patients and their families.

The heart of the program is a clinical reminder system modeled after the VA's technique to remind physicians of preventive measures.

"If a patient meets the criteria for a preventive measure, such as needing flu vaccine, cancer screening, or mammography, a reminder to physicians pops up on the patient's electronic chart during a clinic visit," Zunk says.

The hospital's information technology service developed a similar clinical reminder to prompt the case managers to conduct patient education and to document it. When a patient is admitted with a congestive heart failure diagnosis, the case managers on the medical unit are alerted.

When they look at the patient's electronic chart, a reminder pops up prompting them to conduct congestive heart failure education with the patient and give them the required written materials.

When the case manager gives the patient the material, she clicks on the screen to satisfy the clinical reminder. "After the case manager gives the patient the educational material, he or she documents this in an education progress note, which in turn satisfies the clinical reminder for CHF education," Zunk says.

Case managers at the VAMC are assigned to each unit and frequently see patients on the floor as part of the treatment team. They work with the pharmacist and the physician on discharge information for the patients.

For instance, the case managers may work with the pharmacist to set up boards or containers to help patients keep track of a complicated regime of medicines, Jacobs says.

Since many of the patients have multidiagnoses, such as diabetes, chronic obstructive pulmonary disease, and coronary artery disease, the case managers work with the entire treatment team to educate the patients.

"If the case managers feel that patients need additional information, they can call in the dietitian, pharmacist, or another member of the interdisciplinary team," Zunk says.

For instance, the dietitian may be called in for further education on restricted sodium intake. The pharmacist can give more in-depth instruction on the medications and how they should be taken.

"If the case manager finds that a patient needs a consultation, he or she initiates the consult and coordinates the care," Jacobs says.

If patients need it, the program provides them with scales, blood pressure cuffs, and paper tape measures to take home so they can monitor their weight, girth, and blood pressure.

If the hospital's system for clinical reminders in progress notes is successful, it will be implemented in other VA hospitals nationwide.

The program now is in Phase I of the quality

improvement program. Phase II will look at utilization to determine if providing the education to CHF patients reduces utilization.

"What we have begun to do is collect data on congestive heart failure from the utilization managers. We want to be able to analyze before and after measures to determine if we are improving patient outcomes such as decreasing length of stay, reducing unplanned admissions, and decreasing emergency room visits," Zunk says. ■

# DM certification available from JCAHO

*Program assesses disease-specific care*

As consumers and referral sources look for ways to assure that the performance of the health care entities they choose is up to par, it's more important than ever for your disease management program to distinguish itself.

That's why the Joint Commission on Accreditation of Health Care Organization (JCAHO) has begun offering its Disease Specific Care Certification to recognize high-quality programs that foster better outcomes for people with chronic conditions.

The Disease Specific Care Certification program recognizes the emergence of disease management and offers programs a way to differentiate their programs from the rest.

Certification can give a disease management program a competitive edge in the marketplace by making consumers, payers, and clinicians aware that the program has demonstrated compliance with national standards developed to address the needs of chronically ill patients, says **Maureen Connors Potter**, RN, MSN, executive director of JCAHO's Disease Specific Care Certification program.

"The general public will be aware that the program has the gold seal of approval. For instance, if a family member or friend is looking for a program for someone recently diagnosed with diabetes, they can see a program of excellence and say that's where they want their family member to go," she adds.

Certification differs from JCAHO accreditation in that it demonstrates commitment to providing a comprehensive chronic care or condition-specific service. Accreditation is a comprehensive evaluation of the organization's overall services.

"Certification and accreditation can be viewed as separate, yet complimentary programs," Potter says. The Joint Commission is offering certification in any disease management program requested including common diseases such as asthma and diabetes as well as rarer conditions such as end-stage renal disease and multiple sclerosis, she says.

To meet the criteria for certification, a program must:

- Support a patient's self-management activities.
- Utilize a standardized method of delivering integrated and coordinated care based on clinical guidelines or evidence-based practice.

## JCAHO Disease Specific Care Certification Eligibility

- Organizations that provide clinical care directly to participations. Examples include hospitals, clinics, home care companies, long-term care facilities, rehabilitation centers, and physician groups.
- Organizations that provide clinical support and interact directly with participants by telephone, the Internet, or other electronic methods. Examples include disease management service companies and health plans with disease management services.

## Material Required for JCAHO Accreditation

- Demographic information
- Identification of disease-specific services to be evaluated
- A summary of clinical guidelines used for each disease state and collateral documents
- An aggregated report of disease-specific outcomes measures
- A report describing participant's perception of quality of care
- Performance improvement action plans, demonstrating how data have been used to improve practice
- Educational material provided to participants
- Mission statement, goals, and objectives
- Written code of ethical business and professional behavior
- Self-description of compliance with standards
- Marketing and other presentation materials

• Tailor treatment and intervention to individual needs.

• Promote the flow of information across settings and providers while protecting participants' rights and privacy.

• Analyze and use data to continually improve treatment plans.

• Evaluate ways to improve performance and clinical practices to improve patient care.

"We stress good communication among all care providers and with patients to ensure patients' privacy, to identify trends and track variances and problems areas so clinical quality improvement activities can take place," Potter says.

Communication is an important part of the patient safety focus since chronically ill patients often take multiple medications prescribed by specialists as well as their primary care physicians. For instance, a specialist and a primary care physician may prescribe the same medication with different names and patients may not be aware of it, she says.

The standards require that the programs use disease management guidelines from the National Clearinghouse for Guidelines.

The guidelines may be updated or adapted for local implementation following a review by a multidisciplinary team.

At present, JCAHO does not specify any particular guidelines for the disease management program.

"Disease management is a fledgling industry in its first stages. Our certification is not prescriptive about guidelines nor about performance measures. Over time, as a consensus develops, we will participate in cooperation with other accrediting bodies and organizations such as the National Quality Forum and the American Medical Association to have the same measures. This will give us a national mechanism to compare apples to apples," Potter says.

When there is a consensus on guidelines, the Joint Commission will share them with certified organizations and those who request a review and require that they utilize those particular performance measures and report on them.

Currently, the guidelines allow the disease management organizations to select four areas for performance improvement, with the requirement that one performance measure is patient perception of care and another is a clinical measure, such as monitoring retinal eye examinations for diabetics.

The other two may be other clinical measures, a health status parameter, or an administrative measure, such as reduction in emergency room visits or hospitalizations due to complications from the disease. Certification is for up to two years. The first year, JCAHO conducts an on-site review. At the beginning of the second year, it conducts an external review, based on data submitted by the disease management organization and extends the certification for the second year.

"The second year's review is off site unless there are significant changes in the data or some other indicator to warrant it. We have established a sentinel events line, and if we receive calls or complaints about a program, we may go back on site during the second year," Potter adds.

National disease management programs administered from a centralized location also are eligible for certification. The certification extends to all organizations that have purchased the services as long as the programs at each location are similar in such areas as comprehensiveness and documentation.

"We do certify disease-management programs in health plans as well as disease-management vendors who serve health plans, integrated delivery systems from hospitals, and physician groups. Certification can cross over all those settings," Potter says.

The certification program was pilot-tested in 10 locations, and several organizations have achieved certification since the first on-site review was conducted in February.

The standards were developed with input from chronic care management experts, employers, and consumers, Potter says. An advisory committee with representatives from 16 organizations and five at-large people with expertise in disease management will guide the program as it evolves. ■

# CMSA revises standards of practice

The Case Management Society of America is issuing its first revisions of its Standards of Practice for Case Management, originally developed in 1995.

The revised standards are available for public comment through May 15. The organization used key representatives of the health care industry to update the standards of practice in 2001 and 2002.

The board of directors of CMSA began a project to revise the standards in 2001 to more

accurately reflect the practice settings, process, and performance of case management in today's health care environment. The update initiative was begun in July 2001 with the first draft completed in the fall.

The full draft of the standards is available at www.cmsa.org. ■

## CE questions

17. BREATHE, an asthma program established by Farmington, CT-based ConnectiCare, achieve a return on investment of what percentage?
    A. 86%
    B. 102%
    C. 119%
    D. 150%

18. Physician Health Partners of Denver started its disease management efforts in what year?
    A. 1996
    B. 1997
    C. 1998
    D. 1999

19. Which of the following is **not** one of the three components of patient education at the Hunter Holmes McGuire Veterans Affairs Medical Center (VAMC)?
    A. a patient education brochure produced by the VA for use nationwide
    B. a packet of supplemental information
    C. a class that further addresses issues that arise with congestive heart failure
    D. a patient pathway on coronary artery disease

20. True or false: For its Disease Specific Care Certification program, the Joint Commission on Accreditation of Health Care Organizations requires that programs use disease management guidelines from the National Clearinghouse for Guidelines.
    A. true
    B. false

# New guidelines issued for arthritis pain

The American Pain Society (APS) has released clinical guidelines for treating the acute and chronic pain associated with arthritis.

The APS *Guidelines for the Management of Pain in Osteoarthritis, Rheumatoid Arthritis, and Juvenile Chronic Arthritis* is the first set of multidisciplinary evidence-based clinical guidelines for treatment of arthritis pain.

"Research shows that the undertreatment of pain in adults and children can have many serious consequences, including psychological complications — anxiety, depression, and an overall

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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. ■





decrease in the quality of life. The APS Guidelines will help practitioners and patients better understand acute and chronic pain brought on by this disease and learn when to use various treatment to manage their patients; pain," says **Michael Ashburn**, MD, APS president.

Arthritis is a generic term that refers to more than 100 conditions, the most common being osteoarthritis, a disease that occurs with aging and affects eight in 10 people older than 75.

The guidelines specify that all treatment should begin with a comprehensive assessment of pain and function and that arthritis patients should maintain an ideal body weight and adhere to a balanced diet.

The guidelines are available at the APS web site at www.ampainsoc.org. ■


## Guidelines, protocals can improve heart attack care

Following evidence-based practice guidelines and standardized treatment protocols can improve the quality of care in patients being treated for a heart attack, according to a study in the March 13 *Journal of the American Medical Association* [Eagle K, et al. Improvements Gained Through Adherence to ACC/AHA Practice Guidelines. *JAMA* 2002; 287: 1,269-1,276].

During the one-year study, the medical staff at 10 Michigan hospitals used a "tool kit" to help them follow the American College of Cardiology (ACC) Foundation's Guidelines in Applied Practice (GAP). The tool kit included a condensed version of the ACC/American Heart Association guidelines; standard order sets, a critical pathway for nurses, and take-home materials for patients.

The initiative produced impressive results, according to **Kim Eagle**, MD, principal investigator. For instance, before implementation of the program, only 65% of heart attack patients received beta-blockers, compared to 74% after the program was begun. Beta-blockers have been shown to reduce the risk of death one year after discharge by 20% to 25%.

"The GAP project provided for greater consistency of care regardless of age or gender and closed the gap of care that existed for elderly and female patients in several areas of care," Eagle says.

For more information, see the ACC web site: www.acc.org/gap/gap.htm. ▼

## Pharmaceutical expense cited in rising health care costs

A majority of health care benefits purchasers cite prescription drugs as the major driver of U.S. health care costs, according to a new study by the Blue Cross and Blue Shield Association (BCBSA).

In a survey of more than 500 business decision makers, 64% said that prescription drugs are responsible for double-digit increases in health care costs, and 62% said that direct-to-consumer advertising is the main cause for the dramatic increases in pharmaceutical costs.

The benefits managers cited consumers (33%) and hospitals (30%) as the next biggest driver of health care cost increases. The aging of baby boomers, demand for drugs, and treatment as the overall use of the health care system were reasons for inclusion of consumers as cost drivers.

"Rising hospital and pharmaceutical costs, new technology, increased utilization, and government regulations are stretching health care affordability to its limits. Add to that the changing demographics of an aging baby boomer population, and the problem, if not addressed, will worsen," says **Scott Serota**, president and chief executive officer of the Blue Cross and Blue Shield Association.

BCBSA and the 43 independently licensed Blue Plans have begun an initiative, including a series of research projects, to find ways to make health care more affordable while maintaining quality and choice, Serota says.

For more information, visit the web site www.bcbs.com. ▼

## At-risk patients aren't being screened for colorectal cancer

Fewer than 52% of people age 50 or older are being screened for colorectal cancer, according to a survey by the Cancer Research Foundation of America.

The survey also found that 90% of people who were told by their health care provider to get a colonoscopy or sigmoidoscopy to screen for pre-cancerous polyps were likely to follow the recommendation.

People older than 50 and those with a family history of the disease are at highest risk. Up to 90% of people can be cured if the disease is discovered early, according to the foundation.

More information on colorectal cancer can be found at www.preventcancer.org/colorectal. ▼

## More Americans facing blindness over next 30 years

As the baby boomers age, the number of Americans who are visually impaired is expected to double over the next 30 years, according to the National Eye Institute and Prevent Blindness America.

"Blindness and visual impairment from most eye diseases and disorders can be reduced with early detection and treatment," says **Tommy Thompson**, U.S. Secretary of Health and Human Services.

The leading causes of vision impairment and blindness are:

- Diabetic retinopathy, a common complication of diabetes affecting more than 5.3 million people. An annual eye exam is recommended for diabetics.
- Age-related macular degeneration, which affects 1.6 million people over age 60. This is the most common cause of legal blindness and rarely affects those younger than 60.
- Cataracts, or clouding of the eye's lens, affects 20.5 million Americans. Surgical treatment can eliminate vision loss.
- Glaucoma, a disease that causes gradual damage to the optic nerve and affects about 4.2 million people, only half of whom have been diagnosed. Most cases can be controlled by timely diagnosis and treatment.

"Blindness and vision impairment represent not only a significant burden to those affected by sight loss but to the national economy as well, says **Paul A. Sieving**, MD, PhD, director of the National Eye Institute. He called for increased screening and early treatment of diseases.

A copy of the report on blindness and eye disease is available at www.preventblindness.org. ▼

## Web site offers personalized information on heart diseases

Patients with coronary artery disease and heart failure can get personalized treatment information on the Internet at the Heart Profile web site, a joint project of the American Heart Association and NexCura Inc.

The Heart Profiler matches an individual patient's clinical profile, including diagnosis and test results, to peer-reviewed clinical research studies and offers treatment options, including descriptions of side effects and questions patients can discuss with their health care providers.

Patients also can read summaries of significant peer-reviewed studies that relate to their clinical condition. The tool is designed to help them make decisions about their treatment options.

The web site also includes professional tools that enable physicians to evaluate scientific literature based on patient case modeling methods.

The Heart Association plans to make the Heart Profilers available through the web sites of academic medical centers, hospitals, managed care organizations, physicians, and major health portals as well as at its web site, www.americanheart.org. ■

## Send us Resource Bank items

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

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. ■