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Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

INSIDE

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Member-driven care management yields high satisfaction scores

Case managers are freed up to manage care

In an effort to better serve its chronically ill and catastrophically injured members, Phoenix-based Blue Cross Blue Shield of Arizona (BCBSA) has switched its case management from a service-driven model to a proactive, population-based, member-driven program.

The move shifted utilization management functions away from the case managers and onto the utilization management nurses. The result is that the case managers' time is freed up to actually devote to care management activities.

Now, instead of waiting for the provider to file a claim or call for case management services, the company takes a proactive approach, seeking referrals from providers, internal staff, and the members themselves and examining laboratory and pharmacy data to determine if a member is receiving tests or drugs that indicate a chronic problem.

The case managers work with members on goal setting and long-term care planning.

CE testing process simplified

Beginning this semester, *Case Management Advisor* is simplifying its continuing education program by no longer requiring you to return a test form. Instead of completing a Scantron form as you have in the past, all you will need to do is complete a CE evaluation, which will be enclosed in your December issue. Upon receipt of your evaluation, your CE certificate will be mailed to you. It's that simple.

CE questions will continue to be included in every issue. Answers to those questions will be printed in the issue as well, giving you the opportunity to reinforce the learning activity by immediately reviewing any missed questions. This process has been shown to be an effective adult education method and fits well with our commitment to provide you with quality continuing education activities that are designed to meet your needs. If you have any questions about this process, please call our customer service department at (800) 688-2421. ■

Members are happy with the change. In fact, 97% of members who responded to a satisfaction survey report being "very satisfied" or "somewhat satisfied" with case management services. The survey was conducted by an independent research company.

Before the switch, a request for benefits triggered case management.

"We knew we were missing some people with chronic diseases who were not yet using the resources or who had catastrophic events and were well into care before the insurance company got involved," says **Barbara Guerriero**, RN, MA, vice president of medical services.

There were no pre-certification requirements for emergency services, so the company had no way of knowing that a member had been seriously injured until the hospital bills started coming in.

Now, although there still is no pre-certification for emergency admissions, the company may be notified when a member is hospitalized and the case managers get involved with discharge planning and helping the members understand their benefits. **(For details on ways case managers work with members to best use their benefits, see related story, p. 75.)**

The program was revised in August 2001. The goal is to involve 1% to 3% of the member population in the care management process. "We're still getting our internal infrastructure finalized to make sure that all referral processes are working," she says.

Referrals come from claims data, from providers that include physicians, skilled nursing facilities and rehabilitation facilities, from the utilization management staff at hospitals, and from internal staff.

The company has a case management referral form available to all employees.

"If people in other departments are aware of a member who would be a candidate for case management, they can send a referral form on the computer. It has been a good resource for us," Guerriero says.

The utilization management team and case management worked together to develop an integrated approach so that when the utilization management staff encounter a patient with a chronic disease or a multiple trauma, they alert case management. "Utilization management has ended up being a strong resource for us, and we're not tying up the case managers' time handling utilization management activities," Guerriero says.

To assess the results of its new case management approach, the insurer contracted with an independent research company, which sent out two sets of satisfaction surveys — one to members and one to providers.

The insurer originally planned to send out an annual survey, but the results of the first survey showed that people who had been in case management for a short period of time were unable to give meaningful data when the services were received months earlier.

Now BCBSA sends out satisfaction surveys 30 days after members are discharged from case management.

The insurer sent its first satisfaction surveys to hospitals, skilled nursing facilities, and inpatient rehabilitation facilities — "wherever we send a lot of our members," Guerriero says.

The results indicated that there was some confusion about who to contact on which of the insurer's multiple insurance products. As a result, the insurer came up with a frequently asked questions (FAQ) document based on the feedback received from the surveys. The FAQ was distributed to case management or utilization management at all facilities.

A follow-up survey is planned for late summer to see how the FAQ document was received.

BCBSA has received accreditation for its case management services from URAC, the American Accreditation HealthCare Commission, based in Washington, DC.

"URAC accreditation is a significant achievement for the organization because it validates our dedication to providing the best possible service to our customers, says **Gary Smethers**, MD, senior vice president and chief medical officer. ■

COMING IN FUTURE MONTHS

- Everything you wanted to know about asthma management
- How to get your workers' comp patients back to work
- Identifying members with the potential for high-cost health problems
- A team approach to case management

Evaluate to determine who will benefit from CM

Examine claims data, current situation

When a member is referred into the case management program at Blue Cross Blue Shield of Arizona, the case managers do a triage evaluation to determine which members are likely to benefit from case management interventions.

They examine the historical claims data and the current situation, and decide whether case management can have an impact.

"This is a critical issue. Sometimes, you can't have an impact because of the significance of the disease. If this is the case, and a member is using their benefits appropriately, our interventions would not have an impact," says **Barbara Guerriero**, RN, MA, vice president of medical services.

If the members are appropriate for the case management program and consent to participate, the case manager does a full assessment that includes physical, psychosocial, and behavioral evaluations.

The case managers develop the care plan with the provider, the member and/or family, and come up with long-term and short-term goals based on the findings in the assessment.

"We work within the benefits structure to meet the goals and adjust the plan when it's necessary," Guerriero says. They look for psychosocial issues, cultural diversity impact, need for family support, long-term care planning, and the various venues of care in case of a patient with traumatic injuries.

There are two Spanish-speaking case managers on staff who work with the Hispanic population.

"We know that multiple trauma patients often need active rehabilitation, then skilled nursing care, and then home health. We want to make sure we are part of the process to guide the member through it," she says.

The care managers update the care plan regularly and set criteria for discharging patients from case management as their goals are met.

Chronically ill members are referred to the insurer's disease management program, depending on their individual needs. For instance, patients with diabetes who are at the lowest risk levels receive ongoing educational materials. Those with the highest risk level are assessed for entry into the case management program.

At present, members in the case management system are assigned alphabetically by name to a case manager. The company set up a case manager "buddy system" so each case manager has a specific backup person to cover for them. There is a centralized database for all documentation, making it easy for the "buddy" to fill in for an absent case manager. ■

Managing benefits key to keeping members happy

Case managers help them negotiate health care maze

Families facing a serious disease or catastrophic injury often need help getting through the complex maze of medical care, and the case managers at Blue Cross Blue Shield of Arizona are there to lend a hand.

"Medical care is so complex today. One of the big advantages of having a care manager is to help you work through the maze," says **Barbara Guerriero**, RN, MA, vice president of medical services at the Phoenix-based insurer. "A lot of times, people are not aware of their benefits until they need them and they're trying to sort through them in time of crisis."

The care managers work with the patients and families to determine the benefit limits and how best to utilize the benefits they have purchased. The members get assistance finding community resources that can help them make the best use of their benefits. "We work as an advocate for the patients. We try to work with them to make management of their condition as successful as possible," Guerriero says.

For instance, a person with multiple trauma is likely to need rehabilitation when he or she is discharged from the hospital, but benefits may be limited to 60 days. If the patient is being discharged from the hospital and is too sick to actively participate in rehab, the case manager may suggest that the patient go to a skilled nursing facility until he or she can fully benefit from rehab.

"We are helping them manage the benefits they've purchased to help them get well. Members may not understand their benefits in the context of their own condition. We want to help them find the best way to gain functionality," Guerriero says.

The case managers work with the families proactively to help preserve the benefits for when they are needed most. ■

Prenatal program slashes premature birth rate

Members are rewarded for participating

Strategies such as rewarding pregnant women for keeping their appointments with physicians, and making it easier for physicians to file claims, have paid off for Horizon / Mercy's Mom's GEMS (Getting Early Maternity Services) prenatal program.

Horizon / Mercy, headquartered in Trenton, NJ, covers 273,021 members, representing 42% of the state's total managed care market for the publicly insured. The health plan members have approximately 6,000 deliveries a year.

The Mom's GEMS program was begun as a response to an increase in pre-term births in New Jersey and a high African-American infant mortality rate.

"We needed a way to get our moms into care and keep them in care. The Medicaid world is very different from the commercial insurance world. Our moms need someone they can reach out to, someone who can answer questions and help them advocate for themselves," says **Pamela Persichilli**, RNC, director of clinical operations for Horizon / Mercy.

The company's efforts to provide high-quality services to the publicly insured was recognized in a best practices report on Medicaid managed care called *Innovations in Medicaid Managed Care: Health Plan Programs to Improve the Health and Well-being of Medicaid Beneficiaries by the American Association of Health Plans (AAHP).* Five Horizon / Mercy programs, including the Mom's GEMS program, were profiled in the national report.

Members in the Mom's GEMS program receive frequent contact from case managers throughout their pregnancy. The medical case managers work with Horizon / Mercy's social work case managers and community agencies to help the women find housing, food, and transportation to and from the physician's office.

The program has reduced the number of premature babies among members while achieving cost savings.

From August 1999 through January 2000, only 5% of the Mom's GEMS program members had premature babies, compared to 13% of the plan's non-GEMS members. The GEMS program babies spent a total of 394 days in the neonatal intensive care program, compared to 529 for the babies of mothers not in the program.

The improvement has continued, Persichilli adds. For moms in the Mom's GEMS program, the low first weight for the first quarter of 2002 was 2.06 per thousand deliveries. Very low birth-weight babies made up only 0.44 per thousand deliveries.

The Horizon / Mercy staff hit on the incentive program as a way to ensure that the expectant mothers receive proper prenatal care. "We were looking for ways to make everybody happy with this program — to get the moms to participate, and to recognize the provider needs," Persichilli says.

Physicians who enroll their Medicaid patients covered by Horizon / Mercy into the Mom's GEMS program are assigned an authorization number that covers all claims for prenatal care, delivery, and postpartum care. There is no need for the physician to get further authorization to treat the patient.

When a member keeps an appointment with her physician, she receives an incentive gift. Among the gifts she receives are a diaper bag, a hooded baby towel, a "mom's pack" filled with lotions and toiletries, and a baby camera.

"After each visit, something comes in the mail for their diaper bag we sent at the beginning. It's a really nice way of reminding them that they did great by keeping their appointment," Persichilli says.

The case managers work with the social workers and local agencies to make sure that the pregnant women have everything they need during the pregnancy and that all barriers to good care are eliminated.

For instance, if a member doesn't have access to a telephone in her home, Horizon / Mercy provides her with a pre-programmed cell phone that she can use to call the case managers, the provider, the hospital, and a family member, such as a mother or a sister. The phone is programmed so it can be used only for calls to and from telephone numbers of people the member may need to contact.

The case managers arrange transportation for the members to keep their medical appointments and may work with local agencies to see that the mother-to-be gets food stamps.

"Transportation is often a major barrier for the pregnant moms, and if a mom can't put food on the table, she's not likely to worry about herself. We work to reduce any barriers to a healthy pregnancy," Persichilli adds.

The members also receive informational packets each trimester. The packets are geared toward the

members' risk factors and may include information on smoking cessation, the danger of using drugs or alcohol during pregnancy, tips for staying healthy during pregnancy, breastfeeding, postpartum care, and information about pediatric care.

All of the mailings are geared to the educational level of the recipients.

Case managers also may help mothers with high-risk pregnancies negotiate the health care maze. For instance, if a woman is referred to a perinatologist, the case manager makes sure she goes to one that is near her home. If mothers need more intense work-ups, the case manager works with local centers of excellence for maternal and child care to meet their needs.

The members frequently call their case managers to report on their office visit and with questions.

After delivery, the mothers continue to participate in the Children's Health Assessment and Preventative Services (CHAMPS) program, an offshoot of Mom's GEMS that covers children from birth through age 2.

After a year, the CHAMPS program has increased well-child visits by 16%.

The program is so popular with the members that they often refer their sisters or friends to the case managers for help, giving the program another referral source.

Horizon/Mercy's marketing and communications departments educates providers and people in the community to get word to all eligible mothers to be that the program is available. ■

One-to-one contact key to success of program

Case managers guide women through pregnancy

When pregnant Medicaid recipients find out about the Mom's GEMS program offered by Horizon/Mercy, they're often relieved that they have help negotiating the complicated health care system.

"The case managers tell about the sigh of relief that comes over the telephone when the members hear about the program. That's worth everything. They are so thankful because they didn't know where to go," says **Pamela Persichilli**, RNC, director of clinical operations for the Trenton, NJ-based managed care organization.

Members are recruited for the program through public agencies, referrals from other members, and physicians who notify Horizon/Mercy when one of their Medicaid patients comes in for prenatal care.

The physician fills out the Mom's GEMS enrollment form and sends it to the insurer. Horizon/Mercy uses the enrollment form for risk assessment. The data are entered into a database that stratifies pregnant members into risk categories.

The members are assigned to a case manager by the county in which they live, and the same case manager manages each member throughout the pregnancy.

"You need continuity between the case managers and members. If there are problems, the members know who to call," Persichilli says. Depending on the member's risk factors, the case manager creates a plan of care for the pregnancy.

For instance, high-risk moms are those who have previous pre-term deliveries, gestational diabetes, adult onset diabetes, or who are expecting multiple births. The case manager is likely to contact them weekly or even daily to make sure they are getting the care they need.

Moderate risk factors include smoking and being on their feet all day.

Participants who are deemed "social risks" are those who have family or social barriers that could keep them from getting prenatal care. In these cases, the GEMS case manager works with the social work case manager to link the member to community programs that can help.

The case managers call members as often as necessary to establish rapport and make sure they are taking care of themselves.

If the members are high risk, the case managers are likely to call them daily until they understand what they need to do to coordinate their care, then weekly after that.

The case managers also conduct patient education over the telephone and in person when necessary, rather than relying on a set of printed documents that the member may not read.

If the members don't show up for an appointment, they get a call from the case manager. The case managers help with whatever is necessary to get medical care for the members. In some cases, the social worker may arrange a home visit to work with the members. If a member is homeless, the social worker visits her at the hospital or in the physician's office.

Communication isn't limited to the members. "We talk to the doctors' offices once or twice a week to make sure we're meeting their needs," Persichilli says. ■

Accreditation is next step for insurer's DM programs

Members receive preventive health guidelines

When officials at Blue Care Network of Michigan heard about the National Committee for Quality Assurance (NCQA) disease management accreditation program, they were among the first to sign up.

In fact, the Southfield, MI-based insurer is one of 18 organizations and just one of two HMOs nationwide who are participating in the new program. Other participants include pharmaceutical manufacturers, a hospital system, and specialty disease management vendors.

"We pursued the first opportunity to make certain our programs are in line with national standards and expectations in the industry.

Participating in the accreditation process demonstrates we want to be recognized as one of the top disease management programs in the country. The endorsement of NCQA is the industry seal of approval. It will help us better promote our programs within our marketplace to our purchasers and consumers," says **Janie Flemming**, vice president of quality improvement programs.

The company began its comprehensive disease management program in early 1999 when the Blue Care Network was formed by four independently licensed HMOs. It is the HMO affiliate of Blue Cross Blue Shield of Michigan.

"Each of the regions had some disease management programs when we integrated. When we became one statewide organization, we took the best of all the regional programs and added to them," says **Pam Reinert**, MSN, director of quality management for Blue Care Network of Michigan.

The disease management programs for diabetes, asthma, and congestive heart failure are the longest running. The insurer added pregnancy management in 2000 and a depression management program in 2001.

There are about 40,000 members in all five programs out of a total of 530,000 members covered by the HMO.

The insurer is seeking accreditation for its asthma, congestive heart failure, and diabetes disease management programs.

NCQA released its final disease management program standards late last year. Blue Care Network of Michigan's survey will be complete by the end of August.

"We have a top-notch disease management program. It supports the promise we have made in our vision and mission statement to maintain, improve, and promote health," Flemming says.

In addition to disease management programs for the at-risk population and case management for high-risk members, Blue Care Network offers a variety of programs to help members stay healthy. Among them are men's and women's health fairs that include screenings for cholesterol, bone density, glaucoma and vision acuity, and blood pressure as well as educational seminars and materials about exercise, diet, cancer, high blood pressure, and cholesterol.

Members receive preventive health guidelines as well as self-help guides for common health problems and discounts to community-based programs for smoking cessation, stress management, exercise and fitness, pregnancy, parenting, and CPR and first aid.

Blue Care Network of Michigan identifies members eligible for their disease management program through medical claims data, from medications prescribed for diseases covered in the program. Physicians refer members, and some choose to self-enroll. **(For more details on how the program works, see related story on p. 79.)**

When members enroll in a disease management program by Blue Care Network of Michigan, they receive a Personal Health Card that helps them take control of their health. The cards, which fit into a wallet, include the member's identification number and spaces for health information such as medications they are taking, blood pressure readings and other vital signs, when they had their last screening examination, and a hotline number to call for information on their condition.

"We encourage the members to use the cards to help them better manage themselves. We encourage them to take them to the physicians so the physician can help them keep track of their health information," Reinert says.

The insurer began using the cards in late 2001.

The cards have been well received by members because they are easy to use, she adds. The members are given instructions on how to fill in the pre-printed card.

"We use similar cards in our health promotion programs to help our female population keep track of mammograms and pap smears, and we just moved the concepts onto our disease management program," Flemming says.

The company tracks its progress through clinical

outcomes, a functional well-being survey, and an annual member and physician satisfaction survey.

Here are some tips from Flemming and Reinert on how to develop disease management programs in your company:

• Get early support from physicians and work to get physician buy-in, Reinert suggests.

"Without physician support, you lose a major link with the programs. Their involvement and their interventions are key to success," Flemming says.

• Look at the NCQA standards as a place to start, Reinert suggests.

• Take a team approach to managing chronic conditions.

"Disease management is an area that requires a lot of people working together as a team. This includes the case manager, the disease manager, the physician, pharmacy representatives, provider services, medical informatics staff, quality management staff, and customer service. All of these areas come together and work to improve the health of people with chronic diseases," Flemming adds.

• Be cautious about some of the claims disease management programs give you for a quick return on investment. Look carefully to see what is being measured and what the results show, Reinert cautions.

"If you have unrealistic expectations based on a literature review, you could be very disappointed in your results or question the value of the program," she adds. ■

DM programs help to reduce hospitilizations

Programs continue to be refined, enhanced

A team approach to managing chronic diseases and conditions has proved beneficial for Blue Care Network of Michigan.

Blue Care Network developed its five disease management programs in-house with the assistance of outside resources and continues to refine and enhance the programs.

For instance, this year, the company contracted with Alere Medical, a Reno, NV-based medical technology and services program for its congestive heart failure monitoring program.

Members in the program receive electronic scales that hook into a telephone line and transmit the patient's weight and answers to a series of questions to a nurse from Alere who takes action in contacting the primary care physician if warranted.

"So far, the results have been very positive. We started in late 2001, and we have already shown improvement in reducing hospitalization and maintaining patients' weight and health status in the home," says **Pam Reinert**, MSN, director of quality management for Blue Care Network of Michigan.

All of Blue Care Network's disease management programs have the same basic framework and design and include member education components, data, and tools for the physician to use in managing members with chronic illness, monitoring the medication and treatment plan, and measuring the clinical, utilization, and cost outcomes of interventions taken.

The insurer strives for early identification of members in a number of ways, including claims analysis, physician referral, and member self-enrollment. New members age 50 and older are asked to fill out a health risk assessment as a way to identify people who may be eligible for disease management early on.

When a member is identified, the company sends the member an introductory package and notifies the primary care physician that the member has been identified for the program. Members are given the opportunity to choose not to participate in the program.

"If someone opts out of the program, we take them out and notify their physician they will not be receiving the information. Otherwise, everyone receives the same interventions and the same educational information as designed in our programs," Reinert says.

All participants in the disease management programs are asked to fill out a well-being survey, tailored to their disease and condition, at the time they enter the program and at the end of six months.

Among the questions on the survey are: Do you feel better now than six months ago? Do you have more energy than six months ago? How many days of work or school did you miss because of your condition? The insurer sends physicians information from their patient data registry and sends them regular reminders of the need for preventive screening.

The disease management team mails reminder notices to the members periodically. For instance, near the holidays, the members in the diabetes disease management program may receive a

reminder about dietary cautions during the holidays. When it's time for flu shots, all members get a notice. Smokers receive information on smoking cessation programs.

"We try to interweave all of the programs to make them relevant," says **Janie Flemming**, vice president of quality improvement programs.

Members in the highest-risk populations, those who are admitted to the hospital or visit the emergency room, are turned over to case management for more comprehensive and intensive case management. The case managers work with the physicians and contact the patients regularly to check on their progress and see if they have additional needs for home health care or other services.

Blue Care Network has documented consistent improvement on the outcome measures for each program since their existence. In 2002, new programs scheduled for implementation are Migraine Headache Management, Low Back Pain Management, and Diabetic Management for Children. ■

How to choose the right CM software

Make it a group effort, work closely with vendor

If your organization is looking for software for your case management department, keep one thing in mind — there's no one-size-fits-all product on the market.

You're going to have to spend a lot of time deciding what you want in a product and working to find a vendor who can help design software that will do what you want it to do, says **Marcia Diane Ward**, RN, CCM, project manager for IBM Global Services.

"It's a myth to believe that there is a case management software program that can do everything for everybody," Ward says.

Your special needs will depend on your practice setting, the other organizations with which you share information, the number of clients you handle, the people with whom you communicate, and many other factors.

It's likely you'll have to buy a basic system and add features and functions that will work in your environment. Plan on working closely with vendors to design a specific system to meet your requirements, she says.

There's no quick solution to your software needs, Ward says. In fact, she recommends that organizations take several months to define their requirements before they even look at vendors.

With a lot of strategic planning on the front end, you can get the system that will meet the needs of everyone in your organization who uses it, she adds.

A search for case management software should be organized as an official project of the organization, with team members from every department that will use the system or be affected by it, Ward advises. "It's not something you can do in a hurry. Finding the right software application is a project that can take several months, and team members need to be able to commit their time to the project," Ward says.

That's why it's important to make sure your organization is committed to allowing people to participate on the team and to dedicate the time needed to come up with a workable solution to your technology needs.

Once you're under way, communicate with everyone on the team and the organization's management. "Communication within the project is the lifeline. Keeping everybody involved and informed is the primary part of any project," Ward says.

The most time-consuming part of the process is likely to be refining your requirements, Ward says. "Software vendors cannot define an organization's requirements. They can make suggestions, but every organization has a unique way of doing things and unique needs," Ward says.

Start by doing an analysis of whatever systems you have or don't have and what software applications you are using.

Include an analysis of what your case managers do on a daily basis and define what the case managers need the software to do.

Look for the gaps. Look at what computer systems you already have in-house and decide how you want to integrate case management software into the system.

In addition to looking at what you need today, focus on your business strategies, objectives and mission of your organization and where you expect to be in two or three years. "Organizations should plan on purchasing software that will meet their needs in the future, rather than just what they need for this year," Ward advises.

When your team refines its requirements for software, it's time to look at vendors.

Ward suggests the Case Management Resource

Guide Online (www.cmrg.com) as a good source for identifying vendors.

Start with 10 or 15 vendors and gradually narrow down the field based on the information you receive. **(For tips on how to choose the vendors best suited for your needs, see related story, below.)**

Send out a request for information (RFI) to the group of vendors that looks the most promising, and use the information you receive to cull the list. When you have come up with about five favorite vendors, send them each a request for proposal, a detailed document with information about your applications, functions, and technical requirements.

Include an RFI on the implementation process, support services available, and other details to help you determine the stability of the vendor.

When you have narrowed your choices down to two vendors, it's time for the negotiation strategy to begin.

Document very carefully an outline of what the business partnership will be like between the vendor and the purchaser. Include the whole project team in the process of developing a negotiation strategy.

Remember that you're probably going to have to give up something to get something else you want. Be prepared by finding out where everybody on your team is willing to give.

When you plan the implementation, make sure that everybody in your organization is in agreement with the implementation strategy and time frame.

Be sure to develop times for post-implementation assessment so you can have access to the vendor for a certain number of hours a month after the software is installed to review or refine the system. ■

Screen vendors carefully before making a selection

Make sure the firm will be in business

It's everyone's technology nightmare. Your software system isn't working right, and you find that the vendor has gone out of business. Or the system you buy doesn't deliver what you think it should, and you're stuck with a product that isn't what you wanted.

That's why you should screen your vendors carefully, check references, and do everything you can to protect your organization from computer problems in the future.

Start by creating a vendor profile analysis for each vendor you are considering, suggests **Marcia Diane Ward**, RN, CCM, project manager for IBM Global Services, in Dublin, OH.

Include company history, size, and any recent or projected growth.

Find out if the vendor has acquired or merged with other companies or if it is planning a merger or acquisition.

Find out as much as you can about the company's financial condition.

Consider looking at placing the software code in escrow so you will still have access to it if the company shuts down.

Ask the companies you are considering for their client base and get their permission to call and visit their customers.

Ask about their development cycle — how long it takes for them to turn around a new feature or a new release.

Find out how long it will take from the time you purchase the software until you can use it. Make sure the vendor devotes full-time people to installing your software.

Production demonstrations will be a key step in your selection process, Ward says.

Four Criteria to Include in a Vendor Contract

1. **Implementation details with specific dates and time frames.** For instance, you might specify that the vendor will give you dedicated staff for eight hours a day for 10 days during the implementation period. Include assurances that the staff will be dedicated to your company and not called off your job for an emergency elsewhere.
2. **Vendor roles and responsibility and your roles and responsibility.** Specific time frames in which the software will be installed.
3. **Training and education services provided.** Training and education after the system is rolled out is critical. If your staff aren't thoroughly trained, they may have a bad experience and refuse to use the software.
4. **Follow-up and technical support criteria.** Spell out that support people will be available to your staff after installation to help with the problems that may occur.

Tips for Choosing Case Management Software

- Make sure that everyone who will use the new software or be affected by it has a chance to participate in the selection process.
- Get buy-in from your management team and keep them involved and informed along the way.
- Refine your requirements for the system in specific detail before you start looking at vendors.
- Screen your vendors carefully. Make sure the vendor you select is someone with whom you want a longstanding relationship.
- Carefully scrutinize the company, its history, and its financial stability.
- Check references. Make site visits and talk to the end-users. Ask them if they would buy the software again.
- Make sure your contact spells out that the company will have dedicated staff to install your system in a short time frame.
- Be sure you have technical support available whenever your staff needs it after the installation.

Basic Features for Case Management Software

- The ability to support customized patient care protocols and guidelines.
- The ability to support rule-based criteria for identifying patients who would benefit from proactive interventions.
- Compliance with emerging and current industry standards for interfacing with other systems.
- Compliance with the Health Information Portability and Accountability Act (HIPAA) is a necessity if your company falls under HIPAA regulations.
- Adequate security, authentication, and encryption capabilities to meet federal and confidentiality regulations.
- The ability to accept data from other systems and to interface with the other information systems you use. For instance, you may need data from a patient information system or a scheduling system.
- The ability to assign cases based on configurable rules.
- A calendar function that will allow you to set up a file of to-do lists or appointment schedules.
- The ability to generate letters.
- Web-based capability so you can access information posted on the Internet, such as patient education information.
- Ease of navigation with minimal steps required to complete a task.

Before the demonstration, develop a checklist that includes the requirements you spelled out in your request for information and request for proposal.

Make sure the vendor is demonstrating only the product that you can buy today and not something it is planning to have ready in the future. "Tell them you don't want them to demonstrate anything you couldn't run with now," Ward advises

Ask what changes they are planning in the future, but be clear that you want the main product demonstration to include only products that are ready to use now.

The first demonstration should be a remote demonstration through a telephone modem that lets you see firsthand how the software looks. Remote demonstrations enable you to find out if the software will fit your needs without the vendor spending travel money.

Provide the company with a demonstration script that includes all the things you want the software to do in your particular practice setting.

Get the script to the vendor as soon as possible to give it time to set up a demonstration that will include your specific needs. For instance, if you're a case manager in a payer setting, your script might be for a patient with diabetes. You'll want the software to demonstrate how you access claims information, patient history, utilization review information, and how you track your interventions.

The vendor representative can help you fine-tune your demonstration script. When you're planning the remote demonstration, allow the vendor to ask as many questions as possible.

After the remote product demonstrations, you're ready to narrow your choice of vendors down to two or three and it's time for a visit to the vendors' corporate headquarters.

Ward recommends sending at least two people from your company on the site visit — a nurse case manager who will be using the software and an information system person who will be working with the software after it's installed.

Visit some of the customers who are using the software you are considering.

A nurse case manager should visit the user sites and talk to the user and an information systems person should talk to the technology people at the user site.

Ask questions that include: Would you buy the software again? How has it helped you? What problems have you had with it? ■

New alliance provides multiple DM programs

Manage the whole patient, not just the condition

The best way to get good outcomes from a disease management program is to manage the patient and not the single disease, says **David Plocher**, MD, vice president for health solutions of Cap Gemini Ernst & Young (CGE&Y).

Plocher is working with a new division of CGE&Y's existing health practice to address the need for improved medical outcomes in the health insurance and managed care industry.

Through a strategic relationship with American Healthways, CGE&Y is offering a comprehensive disease management program for more than 20 different chronic conditions. The practice is concentrating on organizations that bear full financial risk for patients, Plocher says.

In addition to commonly managed diseases such as diabetes and congestive heart failure, the organization offers disease management for 15 to 20 other conditions such as arthritis, low back pain, and acid peptic disease. "Our program is based on discovering the most prevalent chronic conditions and finding out the cost of care," he says.

There's no one solution to managing chronic conditions for all patients, Plocher asserts. "To

CE questions

1. According to a satisfaction survey, what percentage of members are very satisfied or somewhat satisfied with the case management services provided by Phoenix-based Blue Cross Blue Shield of Arizona.
   A. 93%
   B. 95%
   C. 97%
   D. 99%

2. From August 1999 through January 2000, what percentage of mothers in Horizon Mercy's Mom's GEMS program had premature babies?
   A. 5%
   B. 8%
   C. 13%
   D. 20%

3. How many HMOs nationwide are participating in the National Committee for Quality Assurance's disease management accreditation program?
   A. None
   B. 2
   C. 5
   D. 17

4. According to David Plocher, MD, vice president for health solutions at Cap Gemini Ernst & Young, the best way to get good outcomes from a disease management program is to manage the single disease rather than the patient.
   A. true
   B. false

Answers: 1) C, 2) A, 3) B, 4) B

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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.

The testing procedures have been changed. See box on cover for more information ■

manage patients who are chronically ill, providers and case managers need to understand the individual patient, how well they understand their disease, and how they learn. The solution requires dealing with the whole person and not just the disease," he adds.

For instance, many patients fail to take their prescription medicine as it is prescribed because they don't understand what they are supposed to do despite the provider's and case manager's efforts to teach them, he says.

"Our attention needs to be devoted toward how people learn, how people change their behavior, and how to improve their adherence to their medical regimes. We have to teach them, then retest how much they learned and customize the plan for each individual patient depending on who they are and how they learn," he says.

For instance, some people learn better by reading. For some, face-to-face dialogue works best. Others prefer to learn through videotapes.

"It doesn't work to have just one method of teaching people. We have to customize our learning methods and take it one patient at a time," he says.

The CGE&Y-American Healthways Alliance has a unique predictive model that can be used on an entire patient population to identify members who are about to become costly.

"We don't wait for someone to get diabetes of heart failure. We identify people at risk early on when we can make a difference," he says.

The program stratifies patients into risk categories and sets priorities for outreach according to the risk.

For instance, patients who are really sick may be telephoned every day for several weeks until their condition stabilizes. Those who are at high risk may be visited in their homes by a nurse case manager. Patients who are catastrophically ill are managed by traditional case managers.

All people selected for disease management receive educational materials.

"Our educational process includes alerting patients to watch for various symptoms and signs that should prompt them to call the nurse instead of waiting for the nurse to call them," he says.

The program is staffed by American Healthways nurses in the field. As part of their care management strategy, the nurses select the physicians with the highest-cost patient visits and visit them to explain the program. ■

Updated guidelines available for treating unstable angina

The American College of Cardiology (ACC) and the American Heart Association (AHA) have updated the practice guidelines on management of unstable angina and a related form of heart attack known as non-ST-segment elevation myocardial infarction (NSTEMI).

The two conditions account for 1.4 million hospitalizations a year. The guidelines are an update to a previous version released a little over a year ago and include the latest information from research into the two common and dangerous conditions.

"We've learned more in a year about unstable angina and NSTEMI than we did in the previous 20 years. The clinical landscape has changed substantially," says **Eugene Braunwald**, MD, who chaired the panel that developed the guidelines.

The updated guidelines strongly recommend that high-risk patients have cardiac catheterization shortly after their admission and rule out the use of glycoprotienIIb/IIIA inhibitors except for patients having an invasive procedure such as a balloon angioplasty or stenting.

The guidelines are available at the ACC web site at www.acc.org and the AHA web site at www.americanheart.org. ▼

Outpatient treatment for PID as effective as inpatient treatment

Women with mild-to-moderate pelvic inflammatory disease (PID) who are treated as outpatients have recovery and reproductive outcomes similar to those for women treated in hospitals, the Agency for Healthcare Research and Quality (AHRQ)[1] has concluded.

The PID Evaluation and Clinical Health study was a randomized clinical trial to compare the effectiveness of outpatient and inpatient strategies in preserving fertility and preventing PID recurrence, chronic pain, and ectopic pregnancy. Women treated in a hospital were given multiple intravenous doses of cefoxitin and doxycycline during an inpatient stay of 48 hours or longer. Those who were treated as outpatients received a single injection of cefoxitin, an oral dose of probenecid, and a 14-day supply of oral doxycycline.

The short-term clinical improvements were similar for women in both groups, and after 35 months, the pregnancy rates were nearly equal. There was no statistical significance between the proportion of women with ectopic pregnancy, chronic pelvic pain, or PID recurrence.

"Treating women with PID in an outpatient setting means receiving care won't disrupt their daily lives and those of their families. This study provides the first evidence of the comparable effectiveness of outpatient treatment," says **Carolyn Clancy**, MD, acting director of AHRQ.

Reference

1. Ness R et al Effectiveness of inpatient and outpatient treatment strategies for women with pelvic inflammatory disease: Results from the PID Evaluation and Clinical Health (PEACH) Randomized Trial. *Am J Obstet Gynecol* 2002: 186; 929-37. ▼

HAART therapy cuts hospital days for HIV/AIDS patients

Highly active antiretroviral therapy (HAART) reduces the amount of time HIV-positive patients spend in the hospital, data from a nationwide network of HIV clinic show.

The report, by the HIV Research Network, was published in the May issue of *JAIDS: The Journal of Acquired Immune Deficiency Syndromes*.[1]

The study includes data on 5,255 patients treated at nine HIV primary and specialty care clinics during 1999. Patients receiving HAART averaged 265 days per 100 patients compared with 320 days per 100 patients for those on a different type of drug therapy. Patients receiving HAART made more clinic visits for outpatient care.

Patients with lower CD4 cell counts, an indicator of immune system function, experienced more hospital days and more clinical visits. Other factors affecting the patterns of HIV care included race, with African American patients spending more time in the hospital than whites and making fewer clinic visits, and gender, with women making more clinic visits than men.

The monthly cost for patient averaged $423 for hospital care and $168 for outpatient care. This suggest that the cost of HIV care may have leveled off since the advent of HAART in the late 1990s, the researchers concluded, adding that more data will be needed to confirm the conclusion.

Reference

1. Lange, C et al. Impact of suppression of viral replication by highly active antiretroviral therapy on immune function and phenotype in chronic HIV-1 infection. *J Aquir Immune Defic Syndr* 2002: 1:30, 33-40. ▼

Lack of communication increases cardiovascular risk

Medicaid recipients with high blood pressure who live in the southeast, minorities, and low-income people are at an increased risk of developing cardiovascular disease according to data presented at the 17th Annual Scientific Meeting of the American Society of Hypertension.

Many of these patients in high-risk categories do not efficiently communicate with their health care providers, leading to a reduction in favorable health outcomes, says **Brian Egan**, MD, of the Medical University of South Carolina in Charleston.

The majority of Medicaid patients studied did not fill prescriptions for medicine after they were discharged from the hospital, the researchers concluded.

"The data confirm the impressions that hypertensive Medicaid patients are at higher risk for major cardiovascular disease leading to hospital admissions. The high admission and readmission rates are associated with suboptimal use of prescribed medications," Egan says.

Research suggests that the majority of Medicaid patients do not get proper guidance about prescriptions and the importance of maintaining medical therapy, he adds.

The researchers obtained data from billing records on hospitalization and prescription medication after hospital discharge. They found that hospital readmission rates for hypertensive Medicaid patients were relatively high over the two-year observation period following hospital discharge. Many of the patients have diabetes in addition to hypertension. ■

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.

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