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Covering Case Management Across The Entire Care Continuum

INSIDE

Inserted in this issue:
Resource Bank
1998 salary survey results
1998 *CMA* index
Resources for continuing education, accreditation

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Professional development

Accreditation spotlight moves from case managers to CM programs

Here's what's happening and how it may affect you

The era of case management accountability dawned at the beginning of this decade with increased demand for case managers who were bachelor's-prepared and had proven their professional standards by obtaining appropriate case management certification. The 1990s saw the development of several nationally recognized certification programs for individual case managers and the Case Management Society of America's Standards of Practice. Now it looks as if two new accreditations designed not for individual case managers but for case management programs will be available before the decade ends.

Both the Commission on Accreditation for Rehabilitation Facilities (CARF) in Tucson and the American Accreditation HealthCare Commission / URAC (Commission / URAC) in Washington, DC, are developing accreditation programs for case management programs that will be available in 1999. "Certification helped us establish a benchmark for individual practice," says **Jeanne Boling**, MSN, CRRN, CDMS, CCM, executive director of CMSA in Little Rock. "But we've still faced the problem of certified individuals practicing in a system that doesn't always understand what they do. The accreditation of case management organizations will help shape the system to help individual case managers reach the full extent of their practice capability."

Accreditation is "a quality seal of approval."

"There are certainly benefits to having accreditation," says **Guy D'Andrea**, vice president of policy for the Commission / URAC. "It's a quality seal of approval. It gives the entire industry credibility and accountability. It made sense for us to develop the case management program at this time."

Yet case management industry sources tell *Case Management Advisor* they have several main concerns about the proposed CARF standards. Those concerns include the following:

• Standards in the field review apply to internal medical rehabilitation case managers and external medical rehabilitation case managers who may work for or contract with payers and employers.

"Case management programs have a right to choose whether or not they wish to be accredited by us."

• Many of the proposed standards would be nearly impossible for smaller external case management companies and independent rehabilitation case managers to meet.

• Case management clients soon may look for and even require that case managers work as part of an accredited case management program in addition to obtaining appropriate individual accreditation.

• Case managers work for many different populations. If specialty program credentials are developed for each different population they served, it would become difficult for case management programs to become accredited, especially if there were significant differences in the accreditation criteria.

• Requirements for accreditation may find their way into legislation.

However, **Don Galvin**, PhD, president and chief executive officer of CARF, notes that accreditation is a voluntary process. "Case management programs have a right to choose whether or not they wish to be accredited by us. We are simply offering a choice in response to our constituency — medical rehabilitation case managers — who want recognition for what they do."

Both CARF and the Commission / URAC say they are keeping the lines of communication open to avoid situations that would require case management programs to be accredited by both organizations. "We have some appropriate concerns about duplicating each other. Neither of us wants that to happen. We want to reassure the industry that we are in communication," says Galvin.

"We're satisfied that there's no significant overlap between the two accreditation programs," agrees D'Andrea. "CARF is primarily targeting facility-based case management programs, and we're leaning toward payer-based programs."

CMSA also has kept a close watch on both accreditation standards. "Of course, we want to see the two accreditation programs as streamlined as possible," notes Boling. "We are working with both groups in their efforts to make these two programs complementary with no onerous duplication of efforts placed on case management programs."

As for the potential for accreditation to be mandated by legislation, D'Andrea says accreditation actually may benefit case managers. "The decision to pursue health care legislation occurs independently of accreditation," he notes. "Accreditation provides a common basis for legislation. The states will do a better job regulating case management if they base legislation on a common set of standards."

What's ahead

The CARF standards have been approved by the organization's board of trustees and will be available to the public in January. Those who have seen drafts of them say they are more than 50 pages long and very detailed.

Christine MacDonnell, national director of CARF's medical rehabilitation and adult day services divisions, says the standards were developed by an international advisory committee of health care professionals in the United States, Canada, and Europe.

The standards address the following:

• **Leadership.** This section addresses who is responsible for managing and directing medical rehabilitation case management. This section

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also outlines which leadership would be responsible for various areas of case management activity, such as fiscal management, ethics, strategy, health, safety, and transportation.

• **Information and outcomes management.** This section addresses how information is gathered at both the level of the individual and the program to determine the outcomes of work completed by case managers. It also discusses public disclosure of information gathered.

• **Rehabilitation process for persons served.** This section addresses the rights of the client and how case managers interact with the client and the rehabilitation team.

Beta testing will begin next spring

Other key concepts addressed in the CARF standards include:

• Full participation of the case manager in decision making related to the services, equipment, and supplies provided to the persons served, community resources used, and efficient movement of the client through the continuum of care.

• The role of the case manager in the continuum of care and use of the continuum of care.

• Coordination with all stakeholders.

• Advocacy for clients.

The CARF case management standards will be published in the organization's accreditation manual in January. Field-testing will begin in July.

The Commission / URAC standards will be available for public comment later this month. "We are also posting the standards on our Web site so we can get broad input," D'Andrea says. "After public comment, which will be a two-month process, we will beta-test the standards in real-world settings beginning in March or April 1999. Organizations interested in serving as beta testing sites are still welcome to contact us."

The standards focus on six broad categories, says **Kathleen Ward Douglas**, RN, MPA, CCM, assistant vice president for disease management of Health International, a Scottsdale, AZ-based medical management company, and chair of Commission / URAC's case management advisory committee. Those categories are:

• case management program characteristics and scope;

• staff qualifications;

• accessibility requirements;

• documentation and information systems;

• patient protection;

• quality management structure and staffing.

"The purpose of these standards is to set realistic goals for managed care organizations regarding these concepts," she says. "The committee is large and diverse. We have committee members from a variety of professional disciplines and practice settings. The committee has worked hard to keep the standards and principles flexible yet meaningful. These new standards will provide additional accountability for case management. The process will acknowledge that case management is a major health care strategy.

"I really believe that this process will advance the evolution of case management as a health care concept into the year 2000," Ward Douglas says. "It will solidify the significance of the practice of case management. Accreditation will be a mark of distinction for purchasers — a guarantee for consumers that there is a level of excellence."

[Editor's note: To review the public comment draft of the Commission/URAC standards, visit the Web at www.urac.org or call (202) 216-9010. CARF can be contacted at (520) 325-1044 or on the Web at www.carf.org.] ■

Will the millennium bug bite you?

The countdown has begun. You have exactly one year to check all your systems for Year 2000 (Y2K) compliance. President Clinton recently signed into law a bill that will make it easier to trade information about Y2K problems without running afoul of federal antitrust laws.

Earlier this year, a Senate panel sent notices to all medical equipment manufacturers asking for information about their systems. At that time, many manufacturers refused to answer the survey, citing antitrust concerns, according to a recent report in *Modern Healthcare.*

Some analysts and legal experts predict that small businesses will be hardest hit by Y2K problems. But whether you work for a large payer or for yourself, it's not too late to run a Y2K check of all your systems, providers, and vendors.

In the next issue of *Case Management Advisor,* we will provide you with the information you need to reach Y2K compliance before the stroke of midnight on Jan. 1, 2000. ■

Team helps brain adapt to damage

Program manipulates brain to achieve outcomes

Their success stories are heartwarming and at times just short of miraculous. A patient learns to walk 10 years after a stroke left him in a wheelchair. Another patient regains the use of his left arm and is able to enjoy boating again. The secret lies in neural plasticity, or tapping into the brain's ability to adapt to damage and manipulating it to achieve improved outcomes, and the Emory Program in Restorative Neurology (PROREN) in Atlanta is pioneering new techniques that do just that.

While some of PROREN's techniques are being used elsewhere, few, if any, centers bring them together under one roof and use them in quite the same way, say team members. Those techniques include:

• **Forced use.** "We basically immobilize the good limb, and force the patient to use the involved limb," says **Krish Sathian**, MD, PhD, medical director of PROREN and assistant professor in the department of neurology at Emory University School of Medicine. "When the brain is first injured, it goes into a state of shock," explains Sathian. "Patients learn not to use the involved limb. The shock wears off and the brain's circuits come back to normal, but in the meantime, the patient has learned not to use the involved limb."

Sometimes, forced use is combined with mirroring techniques, adds **Arlene Greenspan**, DrPH, PT, assistant professor in the departments of neurology and rehabilitation medicine at Emory.

"We use the mirror to trick patients into thinking they are using their involved extremity when they are actually used their unaffected extremity," she explains. "Sometimes, we get patients who are sensory impaired. They can't feel their arm. The mirror tricks them into believing they are using their involved arm."

• **Biofeedback.** "Biofeedback has been around for a long time but not widely used in rehabilitation," notes **Steven L. Wolf**, PhD, FAPTA, PT, director of PROREN and a professor in Emory's department of rehabilitation medicine.

"We use computer visualization to show patients the amount of force their muscles are exerting," he explains. "Patients see a line moving across the screen. The line spikes higher with more activity. We can place targets on the screen for the patient to meet."

• **Balance retraining.** The computer is also used to provide visual feedback of forces exerted through the body under stationary and moving standing platforms, says Wolf.

Careful selection

Fewer than 200 patients have completed PROREN since it opened its doors in 1996. That relatively small number is due in part to PROREN's use as the program of last resort — the place patients go when they don't achieve optimum outcomes in other rehabilitation programs, say team members. The other reason the numbers are so small is that the PROREN team carefully selects patients for participation. "We don't take them if we don't think we can help," Sathian says.

PROREN is designed for patients with neurological disorders that have a motor component. He notes that three groups of patients benefit most from PROREN's unique approach:

• Patients with chronic neurologic conditions and movement disorders, such as Parkinson's disease. "Many patients with chronic neurologic conditions never enter rehabilitation. There is not a lot of awareness among neurologists that rehabilitation could be helpful for these patients," Sathian says.

• Patients who suffered a brain injury some years ago, completed rehabilitation, and then recently experienced declines in function for no obvious reason.

• Patients who recently suffered a stroke and completed both inpatient and outpatient rehabilitation without achieving their rehabilitation goals.

Patients referred to the program undergo a comprehensive, multidisciplinary, objective evaluation, say team members. After patients have been evaluated by team members, the team holds a case conference to share findings and discuss the patient's appropriateness for PROREN.

Team members use standardized evaluation tools that provide a quantifiable scores for

muscle activity, range of motion, and joint function. Those scores are entered into the program's database and referred to at each team conference to track the patient's progress, Wolf adds. "The fact that we use so many objective, quantifiable measures of function sets us apart from other programs, he says.

The initial evaluation can cost as much as $1,500. The neurological evaluation costs roughly $350. The physical therapy evaluation costs about $150. If the patient needs a neuropsychological evaluation to assess cognitive or memory problems, it costs about $248 an hour with evaluations lasting an average of four hours.

According to Wolf, an excellent candidate for PROREN has the following characteristics:

- some ability to open the hands and move the fingers away from each other;
- some ability to straighten the elbows;
- ability to begin to bend the knees toward the rear end in standing position;
- some ability to raise the bottoms of the feet from the floor.

"We look for minimal motor criteria — something we can build on," says Wolf.

Send me in, coach

Patients with cognitive or memory problems are evaluated by **Felicia C. Goldstein**, PhD, associate professor in Emory's department of neurology. "I probably see about 75% of the patients referred to the program," she notes. "The most important thing we have to determine is whether the patient will be able to understand and remember instructions. I am also able to detect conditions such as depression that may impact the progress of the patient's rehabilitation."

Characteristics Goldstein looks for include the following:

- motivation;
- eagerness to participate;
- willingness to work hard;
- ability to comprehend, even if patient is unable to speak;
- ability to follow through with instructions.

"Patients can have memory problems, especially after stroke or head injury, and still participate in and benefit from the program," she notes. "I help identify cues that therapists can use to help patients remember what they learn. For example, a patient may need to have a note or diagram taped to his wheelchair to help him remember the steps involved in transferring from his wheelchair to his bed."

The patient evaluation sometimes identifies issues that members must address before effective therapy can begin, notes Greenspan. "I might note that the patient has a spasticity problem that is too great for me to have an impact. I might recommend holding off treatment and trying a neural block to control the spasticity before therapy begins."

Looking at outcomes

Once a patient is accepted into PROREN, the team develops a treatment plan and coordinates all of the patients appointments. "I coordinate all of the patient's appointments, including appointments with outside specialists," says **Alvatine Smith**, PROREN coordinator. "For example, if the patient has some eye involvement, the team may refer him to a neuro-ophthalmologist," she notes.

Team members meet frequently to discuss patient progress. "We have a philosophy that if a patient doesn't improve over three or four consecutive treatments, we have to reevaluate the treatment plan," says Wolf. "If the patient is progressing well, we discuss the case every month to two months. If the patient does not progress as expected, we discuss the case after every three to four sessions."

Even when the PROREN team feels a patient is not suitable for the program, it makes recommendations to the referring physician. "We may recommend that the patient undergo standard gait and balance training at an outpatient rehabilitation center. We may recommend vocational support services or social programs to help enhance the patient's life," says Sathian.

Greenspan works with the program's database. "We're tracking data to get a better sense of what is working. We're using our outcomes to modify treatments and get a better feel for what works best for which patients," she says. "At this time, our numbers aren't large enough to look at statistical significance, but we're still using the data internally to improve our outcomes and also to report progress back to referring physicians."

In addition to functional measures, PROREN is tracking quality of life outcomes. "Quality of life is not measured enough in rehabilitation," Greenspan notes. "Our perception of a patient's progress is not meaningful if the patient also does not feel his life has improved." ■

Senior fitness program builds member loyalty

Physicians say it improves health, too

Gaining member loyalty is a challenge. It's also essential to the success of Medicare risk and cost plans. Sometimes, the best way to gain that loyalty is to offer seniors programs that set your health plan a step above your competition.

That's what health plan administrators say the Silver Sneakers senior fitness program developed by Health Care Dimensions in Tempe, AZ, has done for them. "We were looking for a benefit that would help assist in maintaining the health of our members and improve retention for us. Silver Sneakers seems to be doing both," says **George Renaudin**, vice president of government programs for Ochsner Health Plans in Metairie, LA.

Most of the data on the impact of the Silver Sneakers program is still filtering in because most plans only have offered the program for two years or less. However, some of the preliminary news has health plans very excited. In fact, the program has caught the eye of the Health Care Financing Administration (HCFA) in Baltimore as well. Health Care Dimensions is on the conference circuit, and it will share results of its SF-36 scores with HCFA in upcoming months.

Some of the results that have caught the attention of both health plans and HCFA include:

- 75% of Silver Sneakers participants are more likely to recommend their health plan to others than they were before participating.
- 64% of participants report that Silver Sneakers is a reason to stay with their health plan.
- 20% of participants say that the program is their main reason for staying with the health plan.
- Roughly 50% of Silver Sneakers participants have moved from an elevated risk category to low risk due to changes in their exercise patterns.
- 53% of participants improved their functionality, and 33% improved their clinical outcomes.

Kaiser Permanente Northwest in Portland, OR, recently received a grant from the Centers for Disease Control and Prevention in Atlanta to conduct a three-year study of health status improvement in Silver Sneakers participants and link those improvements to reductions in claims costs, says Swanson. But what pleases health plans most are the success stories they hear from members and their physicians.

"I went to watch one exercise class," says Renaudin, "and a member walked up to me and asked if I had noticed what he just did. I told him I was sorry, but I had missed it. The member turned to me and said, 'No, you didn't miss it. You saw it. I walked over here to you. Six months ago I couldn't have done that without a walker.' He was so excited by his progress."

Physicians whose patients participate in the Silver Sneakers program notice marked improvements in overall and emotional health, adds **Tom Janisse**, MD, assistant regional medical director and liaison to health plans for Kaiser Permanente Northwest. "We have patients who tell us that since starting the Silver Sneakers program they experience less dizziness, they can walk up the stairs again, and their blood pressure has come down," he says.

"The comment I'd make as a physician is that those three improvements translate into fewer clinic visits, medications, and lab tests," he explains. "If a patient presented at the clinic with those three complaints, the series of tests and evaluations it would prompt would add up to significant health care expenditures. These patients start to take responsibility for their own health and that's good for them and the health plan. Our physicians also report that patients who participate in the program are less depressed."

Keep 'em smiling

Health Care Dimensions contracts with local health clubs and then trains qualified exercise instructors to deliver the Silver Sneakers program. "We download the health plan's membership information into a software tracking system and select clubs according to density of plan population," says **Mary K. Swanson**, BS, president and chief executive officer of Health Care Dimensions, a trained speech pathologist who founded the company. "We select clubs that provide access within five miles of home for 90% of the health plans members."

Health Care Dimensions evaluates about three times as many clubs as it adds to its network, she

(Continued on page 207)

(Continued from page 202)

adds. "We look for health and safety standards but also the club's willingness to serve the senior population. We try to select clubs with a good array of services that appeal to seniors, such as water exercise classes."

The Silver Sneakers program itself includes free health club membership and three levels of exercise classes designed especially for seniors. The seniors stay seated for most of the class, and exercises focus on improving balance, posture, strength, and range of motion — issues that are important for maintaining independence.

"I went on a tour of senior centers and asked seniors what they wanted," says **Deborah Redder**, BS, ACE, national director for instructor training for Health Care Dimensions, who designed the exercise program with oversight by physician consultants. "Most seniors told me that they weren't as interested in improving their cardiovascular health as they were in living alone as long as possible. I heard comments like, 'Help me keep my driver's license and stay in my house.' To help seniors maintain an independent lifestyle requires we improve coordination and agility."

Before participating in the program, seniors must complete an activity readiness questionnaire and an SF-36 health risk assessment. "We work with the medical directors of each health plan. Some are more stringent than others and ask us to add an additional question or two to our readiness questionnaire," says Swanson. "If any risk factors are identified, seniors must receive approval from their physician to participate." For example, if a health plan member had experienced a major heart event in the past year, they would need physician clearance to participate.

"Instructors attend an eight-hour workshop. We want to make sure the program is delivered in a consistent and safe manner," she says.

Health Care Dimensions trains instructors to deliver the program. Training covers a wide range of issues in addition to teaching the instructors the exercises themselves, Redder says:

- helping seniors recognize perceived exertion;
- medications that may be contraindicated in terms of exercise;
- consistent and articulate range of exercises designed to improve ability to perform activities of daily living;
- maintaining a fun atmosphere.

"The element of fun is what keeps these seniors coming back. These seniors become a social club," says Renaudin. "We have one class that begins and ends each [session] with a song performed by four members who formed a barbershop quartet."

In addition to training program instructors, Health Care Dimensions trains a senior advisor for each health club facility. "These advisors are the link between the program and the health plan. They are there to respond to questions the seniors have about exercise, or any concerns seniors have about the classes. They are a component of our quality assurance efforts," says Swanson.

Quality control

Health Care Dimensions has local service representatives in each area it serves who visit clubs regularly. In addition, each Silver Sneakers instructor is audited on a quarterly basis, note Swanson and Redder. "The instructor evaluations are very objective and mechanical," says Redder, who called on her experience as an Olympics judge to design the instructor evaluation tool. "There are certain standards instructors must meet for each class — seven baseline competencies we measure." Those include:

- measure member heart rate intensity a minimum of three times per class;
- instruct members on postural alignment a minimum of three times per class.

In addition, Health Care Dimensions representatives evaluate the safety and quality of the health club, Redder says. "If any irregularities are noted, a report is filled out. One copy comes to me for filing, and the other goes to the instructor and the health club."

There are three levels of risk identified in health club evaluations. Those are:

- **No. 1: caution notice.** "This might include inappropriate lighting in a hallway or wet floor areas in a locker room," Redder says.
- **No. 2: health and safety risk.** A No. 2 risk might include a lack of handicap access or elevators, if there is a second floor.
- **No. 3: immediate attention.** "This might include extremely worn equipment or an instructor encouraging contraindicated exercises," she says. "I still occasionally see instructors leading members in exercises long deemed unsafe by the fitness industry," she adds.

Health Care Dimensions also tracks the number of participants in each class, the ratio of men to women, and the average age of class participants.

Of course, health plans are still looking for bottom-line evidence that the program helps them retain members while improving the health status of their senior population. "We track the utilization of every health plan member who participates in the program," notes Swanson. "Most of our health plan partners are surprised by how operationally intense this program is," she says. "We feel that the Kaiser Permanente Northwest study will provide quantitative proof that this program combines marketing acquisition and retention with a clinical benefit that can stand on its own."

[Editor's note: A Silver Sneakers home video is available for $14.95. For more information, contact: Health Care Dimensions, 401 W. Baseline, Ste. 204, Tempe, AZ 85283. Telephone: (888) 958-4336.] ■

Disease management

Stick to basic four to manage CHF

Simplify for patients with low literacy

To understand the challenge of heading the heart failure management program at MetroHealth Medical Center in Cleveland, you have to go on rounds with **Glynis J. Laing**, PhD, RN, CNAA, disease manager for heart failure at the large county medical facility.

"Only 40% of my patients fit the typical profile for congestive heart failure [CHF] patients — adults over 65 with hypertension and CHF. The other 60% are as young as 20. Many have substance abuse issues. I didn't realize that crack cocaine will push you into CHF until I worked here," she says. In addition to their youth and substance abuse history, many of Laing's patients are indigent and have low literacy skills.

"These people are frequent flyers. They come through the emergency room and get admitted to the intensive care unit [ICU]," she says. And that's where she first meets with patients and starts working on patient education.

Laing makes rounds daily in the ICU with the social worker, case manager, and the charge nurse. "Occasionally, patients are admitted to a general medical floor instead of the ICU, and the case manager or resident on the floor calls me, and that's how I find my people."

The first step in her CHF management approach is to review the patient's chart. "I check to make sure they are on appropriate meds. If they aren't on an ACE inhibitor, I check with the resident to see why not." After a review of the chart, Laing talks with the patient. "For many of these patients, it's the first time anyone has told them they have a heart problem. They don't know what CHF is; it's a new diagnosis for them."

If the patient is one of Laing's "frequent flyers," she asks them what caused their current admission. "A lot of times with this population, it's a financial problem. The patient ran out of their prescription and it's a week before they get their next Welfare check." At that point, she starts looking for solutions. "I hook the patient up with our case manager to get them Medicaid or disability. I beg drug samples."

She's learned through trial and error that everything from performing a psychosocial assessment to patient education must be kept simple with this population. To assess the patient's environment, Laing asks the following:

- Who does your grocery shopping?
- Who cooks your meals?
- How do you come to the doctor?

"Many times patients tell me they come to the doctor by dialing 911," she says. "I try to explain that perhaps a better option would be to schedule an appointment."

Many of her patients eat most of their meals at homeless shelters. "The personnel at the shelters have been very cooperative about working with me on low-salt diets. The shelters have been very receptive about not adding salt to the food and simply putting salt on the tables instead," she says. "I used to also ask patients who did the chores around their house until I realized that if you live in a rooming house, dusting and vacuuming are not high on your list of priorities," she adds.

Once Laing establishes a fairly good rapport with patients, she assesses their literacy skills before beginning any patient education. "I ask them how many years of school they've completed," she says. "If they are older and graduated from high school, I assume they can read at a fairly good level. If they're younger and they graduated from a Cleveland public high school, I assume nothing. I had no idea how many people cannot read well enough to follow commercial patient

education materials." She uses a standard literacy assessment tool called the Rapid Estimate of Adult Literacy in Medicine (REALM).[1] "You must tailor your materials to the literacy level of your patient. It seems so basic. We say it so often. But until you know their literacy level, you don't know where to aim."

The lowest reading level on the REALM scale is a third-grade level and the highest is 12th grade. "My patients average about a fifth-grade reading level. Most commercial education materials are written at an eighth-grade level. There are too many words on a page. The type font is too small. It's way over their heads."

In addition to their low literacy skills, most of Laing's patients have an external locus of control. "They don't believe they can be proactive," she says. "They are very short-term focused. Their attitude is, 'Tell me what I need to know so that I can get out of here.'"

Laing soon realized that the best way to deliver important CHF management information to her patients was to talk in bullets. "I skip the elaborate explanations about the circulatory system," she notes. "I tell them that their hearts simply aren't pumping right, and then I give them the four main components of CHF management."

The components are as follows:

❑ **Medication compliance.** "I simply tell patients they must take their medication every day just the way the doctor told them to take it." **(See box at right for a sample of her instruction sheet for ACE inhibitor use.)**

To help her patients take their medications even when they can't read the labels, Laing shows them their pills and counts them out into an egg carton. "To show them when they should take which pills, I draw a full sun to indicate morning doses, and a sun setting for evening," Laing says. "One patient used a paper plate with three sections for morning, noon, and night. He knew the pills by how they looked."

"Unfortunately, pharmacies sometimes switch brands of generic pills without telling patients," says Laing. "One month their morning pill may be blue, and the next month it might be red. That can really confuse them."

❑ **Low-salt diet.** "We don't get really nervous about salt since the patients are on diuretics. I don't expect them to count milligrams. I just tell them to put the salt shaker away and use frozen or fresh foods more often than canned or boxed foods."

❑ **Exercise as tolerated.** "I look at the patient to judge how conditioned I think they are. If they're in a wheelchair, I just urge them to lift cans. If they can walk, I tell them to start walking around their house. Once they feel comfortable walking around the house, I tell them to start walking around the yard, then eventually around the block."

❑ **Daily weights.** "I used to give patients a weight range. I'd say if your weight is below 160 or above 165, call your doctor. That didn't work," notes Laing. "Now, I skip the ranges. I tell them if your weight is 167, call your doctor. They simply could not grasp the concept of a weight range."

A small number of Laing's patients cannot read numbers. "For those patients, I teach them how to do an ankle assessment instead of relying on daily weights. I tell them, this is how your ankles look when they're OK. If they look different than this, call your doctor." In addition, Laing helps patients figure out how their body feels when they are putting on fluid. "I tell them to think about whether they're having trouble lying flat.

"These people are survivors. If you talk to them in bullets, if you say, 'This is what you need to know,' you can make a difference," she says.

Reference

1. Davis TC, Long SW, Jackson RH. Rapid Estimate of Adult Literacy in medicine: A shortened screening instrument. *Family Med* 1993; 25:391-395. ■

ACE Inhibitor Instruction Sheet

To get vital information about ACE inhibitor use across to low literacy patients at MetroHealth Medical Center in Cleveland, **Glynis J. Laing**, PhD, RN, CNAA, disease manager for heart failure, uses 14-point type, lots of white space, and few words in a bullet format.

ACE Inhibitors (Lisinopril)

What they do: ACE inhibitors make it easier for the heart to pump.

Things to remember:

Be careful when you take the first dose, especially if you are taking a water pill. You may faint or become dizzy.

Get up slowly to avoid becoming dizzy.

Keep taking this medicine if you feel well. It will help you keep your blood pressure down.

If you miss a dose of this medicine, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose. Do not double doses.

Do not drive, do dangerous jobs, or drink alcohol if this medicine makes you dizzy or causes you to faint.

What to watch for: Call your doctor if you have: dizziness, skin rash, dry cough.

Big health plans opt out of Medicare risk

Some of the largest health plans in the United States recently opted out of the Medicare risk market in certain cities, citing unprofitable operations as the reason, according to Arthur Andersen's health care consulting group in Atlanta. This exodus forces seniors to find an alternative to their Medicare health maintenance organizations by Jan. 1, 1999. At least one consultant says health plans still can turn a profit with Medicare risk using a 10-step plan that includes geriatric care management.

Charles A. Peck, MD, a consultant with Arthur Andersen's health care consulting group, says the secret to operating a Medicare risk plan successfully is a program he calls "Ten Steps for Medicare Risk Viability." Following are the steps:

1. **Risk assessment methodology.** Because 20% of the Medicare population generates 80% of the medical costs, it is vital to identify those at risk.

2. **Geriatric care managers and a geriatric assessment team.** Seniors require special services and increased attention as they age. Careful assessment and care management help prevent or minimize functional status decline.

3. **Disease management programs.** Providers benefit from managing diagnoses common to the elderly, such as congestive heart failure and diabetes.

4. **Risk sharing.** Financial incentives across all providers of care is a prerequisite for any risk program.

5. **Strong physician leadership.** Physician leaders must be capable of making tough decisions about performance and accountability.

6. **Strong hospital leadership.** Appointing a physician as chief operating officer of hospitals in the plan helps assist administration build stronger physician relationships.

7. **Development of physician- and manager-friendly reporting tools.** Real-time information transfer to people running the business must be flexible, accessible, readily available, and relevant.

8. **Willingness of physicians to hold themselves accountable for outcomes and cost.** Mutually agreed upon practice benchmarks must be followed by all clinicians.

9. **Willingness to change.** Networks implementing a risk program should seriously consider change-management skills building with all key employees.

10. **Development of a clearly communicated vision and mission.**

"Many believe that medical costs are the problem, but management of these costs is the issue. The real root of these losses lies with medical management processes and the need for investment in the systems of care necessary to support these patients," says Peck. ▼

Survey finds HMO members happy

The most recent member satisfaction survey released by the California Public Employees' Retirement System (CalPERS) in Sacramento, CA, found managed care members were as satisfied with their health plans as members in traditional fee-for-service preferred provider plans.

CalPERS, the nation's second-largest public purchaser of employee health benefits, second only to the federal government, used the standard satisfaction survey developed by the Washington, DC-based National Committee for Quality Assurance.

Results of the survey include the following:

- 79% of managed care members were satisfied with their health maintenance organizations (HMOs).
- 79% of traditional fee-for-service members were satisfied with their health plans.
- 81% of HMO members say they would recommend their plan to their friends.
- 83% of fee-for-service members say they would recommend their plan to friends.
- 58% of HMO members were happy with the

process of getting a referral to a specialist, compared with 73% of fee-for-service members.

CalPERS purchases health benefits for more than 1 million active and retired employees and their families at more than 1,000 state and local agencies throughout California. The survey was mailed to a random sample of 26,000 CalPERS health program members. There was a 48% response rate for the basic health plans and a 82% response rate for members of Medicare-related plans. ▼

HMOs thrive on Eastern seaboard

Enrollment in New England Medicare managed care plans grew by 90% in the last 18 months, according to a recent market analysis by Mark Farrah Associates in Kennebunk, ME. Findings of the market analysis include:

• As of March, the region's health maintenance organizations (HMOs) enrolled more than 360,000 members in either a Medicare risk or Medicare cost plan, vs. fewer than 200,000 in Sept. 1996.

• As of July, the Health Care Financing Administration in Washington, DC, reported 27 Medicare risk contracts and three Medicare cost contracts in the six-state region.

• Only 15% of the more than 2 million Medicare beneficiaries in the region had enrolled in a managed care plan as of December 1997.

The report, *New England HMO Monitor,* is available for $175. For more information, contact Mark Farrah Associates at (207) 985-8484. E-mail: mfa@ime.net. ▼

Study finds seniors unhappy with choices

In a study of more than 200 Medicare health maintenance organizations (HMOs) and more than 1,200 Medicare supplemental insurance policies in 19 cities nationwide, *Consumer Reports* magazine found that seniors are facing higher out-of-pocket expenses for health care, cutbacks in HMO benefits such as prescription drugs and vision care, and a burdensome array of Medicare choices.

The study's key findings include:

• Premiums are up 35% on average since 1994 for Medicare supplemental insurance, which offers seniors the greatest flexibility of doctors and hospitals.

• Premiums for Medicare Part B will more than double over the next eight years, from $526 this year to $1,172 in 2006.

• Premiums for Plan C, the most popular of the 10 standard Medicare supplemental plans, are up 41% since 1994.

• Many seniors who signed up with a Medicare HMO because it paid for prescription drugs are finding their plans now limit or have begun to charge for this benefit.

A worksheet that helps consumers evaluate the prescription drug benefits offered by different HMOs is available in the September *Consumer Reports* as part of the magazine's special report, "Medicare: New choices, new worries." An interactive version is available on the magazine's Web site at www.ConsumerReports.org. ■

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Don't give up on difficult clients

Clients with behavioral problems often are expelled from substance abuse treatment programs because counselors assume they're incapable of rehabilitation. But a new study shows clients diagnosed with antisocial personality disorder (APD) are just as likely to complete the programs successfully as those without the disorder.

"Our findings were not consistent with other studies in the literature," says **Nena Messina**, MA, research associate at the Center for Substance Abuse Research in College Park, MD, who conducted the study. "Most previous research has found that clients with APD don't finish treatment, or if they do, don't have successful outcomes. We found there was little or no difference in outcomes between clients with APD and those without."

The study was funded by the Substance Abuse and Mental Health Services Administration in Rockville, MD. Clients participating in the District of Columbia Treatment Initiative underwent diagnostic testing. Of 338 clients tested, 166 were diagnosed with APD, and 172 were not. Clients were assigned randomly to a program of 10 months of inpatient treatment then two months of outpatient, or a program of six months of inpatient treatment and six months of outpatient. Self-reports and objective measures of criminal activity and substance abuse were collected at pre- and post-treatment interviews. "Our first finding was that there was no difference in outcome between the standard program and the abbreviated inpatient program," Messina says. "Our second finding was that there was no difference in outcome between clients with APD and clients without APD."

For instance, the post-treatment arrest rate for APD clients who didn't complete treatment was 63%, vs. 61% for non-APD clients. The rate was higher for non-APD clients who completed treatment (32%) than for APD clients (25%). Messina says the data should encourage case managers and substance abuse treatment providers to accept and retain APD clients.

The study has been accepted for publication in *The Journal for Substance Abuse Treatment*. For more details, visit the Web at www.cesar.umd.edu. ■

CE objectives

After reading this issue of *Case Management Advisor,* continuing education participants will be able to:

1. List components of new case management standards developed by accreditation commissions.
2. Explain the mechanics of new therapies designed to harness the brain's adaptive ability.
3. List methods for selecting a qualified contractor for accessibility modifications.
4. Design a disease management program for patients with low literacy skills.