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Covering Case Management Across The Entire Care Continuum

INSIDE

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Nurses in integrated program follow clients through continuum

The same person handles case management, disease management

When First Health Group Corp. began looking at disease management programs in the mid-1990s, the preferred provider organization (PPO) decided to develop a fully integrated system, rather than setting up disease management programs for each diagnosis.

As a result, one nurse case manager follows a patient throughout the continuum and manages his or her disease or diseases.

For instance, if a patient has congestive heart failure and diabetes, then is hospitalized for cancer surgery, the same nurse case manager follows the patient throughout the continuum.

"We call it a fully integrated program. We feel that you need to look at it from a member's perspective. When patients are handed off back and forth among programs, information can be lost," says **Scott P. Smith**, MD, MPH, national medical director for First Health, the nation's largest directly contracted PPO organization, based in Downers Grove, IL.

At First Health, the nurse case managers follow patients throughout the continuum, regardless of what happens.

For instance if a diabetes patient is diagnosed with cancer and needs individual case management for that disease, the nurse assigned to manage the patient's diabetes follows him or her all the way through hospitalization and treatment.

"We didn't want to carve out the management of these patients. We thought it would be counterproductive to have three different nurses work with a single patient on three different diseases," Smith says.

The Care Support Program is overseen by 25 medical directors and supported by 21 case managers and coordinators who manage members with 10 chronic conditions — diabetes, congestive heart failure, asthma, depression, atrial fibrillation, heart attack, hepatitis C, organ transplant, high-risk maternity, and HIV.

About 40% of the members are in more than one program.

First Health rolled out its Care Support Program in January 2000 after

a team of in-house physicians designed the program and created the protocols for handling patients referred to case management.

The physician team took externally developed guidelines for management of the diseases and processed them into clinical tools for the nurse case managers. Each protocol has a set of interventions and outcomes measures.

"The disease management concept rang a bell for us. In this organization, we've always believe that the most fruitful ground for quality and cost management is with chronic diseases," Smith says.

The program works well because there is physician support that the nurse case managers can call on for assistance, he says.

"If you have a totally nurse-driven system, there may be value in hiring an outside vendor or an expert. The nurses have physician backup, and this works out better for the member and for us, too," Smith says.

When a patient is assigned to a case manager, she reviews the information and contacts the member. In the case of members who are already in the system but have a new condition to be managed, the nurse re-contacts them.

The program is voluntary, but the case managers assume that the patient wants to be involved unless the patient tells them otherwise, Smith says.

Patients are divided into four categories: High risk, high need; high risk, low need; low risk, low need; and low risk, high need.

Those with low risk and low need receive educational materials and a telephone call every six months unless they have an incident that triggers a higher level of care. Those with high risk and high need may need to be monitored every week.

The information the nurse enters into the computer program during the initial assessment triggers the next step the nurse takes. For instance, if the patient has congestive heart failure and is not on ACE inhibitors, the nurse may notify the medical director to call the physician about the issue.

"We don't put the patient in the middle by suggesting that the doctor isn't doing the right things. We know that doctors tend not to respond well to nurses who question their care. When we have an intervention that requires direct contact with the physician, unless it's just to give them information, we involve our medical staff, who call the physician to discuss it," he adds.

Generally, one nurse is assigned to a population of about 9,000 members. These all may be employees of one client, or one nurse may be assigned to cover members from several small employers.

"A nurse may be following 50-100 cases but only a few patients who need really intensive care. We don't have set numbers or productivity requirements," Smith says.

The nurses may have several cases that need full case management and a number of disease management clients who need only occasional care.

The case management services are handled out of company call centers in Downers Grove, IL, and Scottsdale, AZ. The call centers are staffed 24 hours a day so the case managers can reach members who travel or work odd hours.

"Staffing the call centers is everybody's responsibility. We let it be known up front that case managers may be working nights and weekends," Smith reports.

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Editorial Questions

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

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The program has received rave reviews from the members.

"Our members have told us in satisfaction surveys that having one nurse to call on is the best part of the program. The health care system is so complicated that they welcome having one person to help them with it," Smith says.

Financial outcomes show an increase in pharmacy costs and decrease in medical costs for patients in the disease management programs.

Patients are reporting less time off work and increased use of beta-blockers, inhalers, and other medications and procedures connected with chronic disease management.

"The key to our ability to do this is that we have the physician backup. The nurses are not out there on their own. If they've got an unusual situation, they can consult with the physician," Smith says. ■

Personal Nurses help navigate care system

Humana's program creates 'health care concierge'

When Humana members have questions about their benefits, their condition, their upcoming hospitalization, or just need help navigating the health care system, they can call their "Personal Nurse."

Humana, a health benefits company with headquarters in Louisville, KY, began its Personal Nurse service after doing extensive research to find out member satisfaction with the health plans and health care in general, as well as what services Humana's members would like to have.

"We knew we had a significant number of people who were really sick and needed high-touch resources, and we wanted to find a way to better serve them," says **Jackie Willmot**, RN, MSN, MBA, director of clinical interventions at Humana.

Focus groups and other research showed that members would find it helpful if they had one person they could call on for help in finding their way through the health care maze.

"We have moved from the paternalistic approach of feeling we know what people need and to a more personal approach in which we sat down and listened to our members and molded a program around that," Willmot says.

Humana serves about 6.6 million members in 18 states. Humana rolled out its Personal Nurse program in January 2001, and by the end of the year, about 30,000 members in all 17 geographic locations the company covers were enrolled.

"We spent a significant portion of this year refining the model and listening to members tell us how we can better serve them," she says.

Willmot explains the Personal Nurse as a "health care concierge" or a "health care navigator."

Personal Nurses call members prior to and after hospitalization. They also may identify others with specific chronic conditions and call to engage them in the service. The Personal Nurse assesses the level of interaction needed to get members armed with the tools they need to begin to make a difference in their health status.

Nurses who previously were employed by Humana in other capacities such as case management, utilization management, and concurrent review, staff the service.

"Nurses are key to this role; they are best suited to listen to and clinically understand what resources the member might benefit from. Culturally, we knew we had to make a huge change in order to migrate these nurses from their current role where they performed review, oversight, and member management activities to one where they were focused on relationship, service, and support," Willmot adds.

Personal Nurses go through a 40-hour training course at Humana's Personal Nurse Academy and take an additional 20 hours of re-certification courses yearly.

The Personal Nurses are distinguished from case managers because they are not managing a case (a member), but they are getting members to information and resources so that *they* can manage their condition. "We have moved from a more paternalistic approach where we might have told a member what they should do [or do it for them] to one where we assess the member's situation and get them to tools and resources where they are able to make informed decisions and act on them," Willmot says.

For instance, instead of asking them what their blood glucose A_{1C} level is, the Personal Nurse would explain to the member why it is important to monitor their diabetes and point them to the tools they can use to track their blood glucose levels and help them figure out why their glucose levels are high every Monday morning.

This begins a process where members participate in their own health care activities and can see where they are having problems and act on them.

The nursing population at Humana is attached to

the member population. One Personal Nurse may support a group of 5,000 members but have only 50-100 members they actively are engaged with. In addition to nurses, six full-time pharmacists who are available to help members understand their pharmacy benefits, review members' prescriptions, and provide information to members, physicians, or the Personal Nurse support the service.

"If members are on prescriptions from multiple providers, the danger is that they may be prescribed two drugs for the same symptom or condition, one being generic and the other being brand," Willmot says. "Because two different physicians prescribe them, and the medication has different names, the member doesn't realize the problem. We have numerous examples of the pharmacist catching problems of that kind, and by the member checking back with their physician and getting their medication regime changed, they are able to eliminate the risks associated with duplicate therapy."

The Personal Nurses are available during business hours and many flex their hours to accommodate member needs. Humana also has a 24/7 line where a member can call at any time of the day to speak with a nurse. Humana has a connection between the Personal Nurse and the triage line where member call in need of assistance. ■

Targeting members for 'high-touch' interactions

Personal nurses work with chronically ill

In a typical day, a Personal Nurse at Humana may guide a diabetes patient to the health benefit company's web site for tips on managing his or her disease, explain the plan's pharmacy benefit to another member, help a member facing orthopedic surgery come up with a plan for getting around at home after discharge, and explain the discharge instructions to a patient who is just home from the hospital.

"We feel that our members should have access to information, support in understanding the information, and the confidence to act on that information to best meet their individual needs. Personal Nurses interact with our sickest members, facilitating their ability to better understand and use the health care system," says **Jackie Willmot**, RN, MSN, MBA, director of clinical interventions at Humana. Here are some examples of how the system works:

• If a provider calls Humana for authorization for surgery, the information comes up on the Personal Nurse workstation.

• The nurse calls the member and helps him or her understand what to expect from the surgery and prepare for discharge.

For instance, in the case of orthopedic surgery, the nurse will ask if there are stairs in the home, and if the member has someone to prepare his or her meals after discharge.

"In addition to the pre-hospitalization call, our Personal Nurses may call members 24-48 hours after their discharge from the hospital," Willmot says.

• The nurses make sure the patient understands the discharge instructions and medication regime. If the patient had surgery, they assess whether the patient can verbalize the discharge instructions regarding how to take care of and assess the wound.

"People often are so anxious when they're in the hospital that they forget their discharge instructions. If they have questions, they may feel they're not important enough to call the physician. We connect with them in a time period when they may be entering a danger zone and let them know that there is someone they can call to help them sort through what they're going through," Willmot says.

• In the case of people with chronic diseases who are referred to the Personal Nurse, the Personal Nurse identifies whether there are programs to meet the members' needs and gets referrals to external specialty programs in the case of chronic diseases.

"We are building tools and services to support everybody, but we are focusing on high-tech services, such as the Internet site for low-risk members and high-touch services such as Personal Nurse for those at-risk who require some guidance," Willmot explains.

• The nurses help the members learn to navigate Humana's Internet site in order to self-manage their conditions and to find out information to discuss with their physicians.

"We are available to support them and to help them traverse the system," Willmot says.

• The nurses soon will have the capability of getting on-line with the members, with their permission, and helping them navigate the site.

For instance, if a member has a question about something in the asthma management tool kit, the nurses can see what he or she is looking at on the screen and walk him or her through it. ■

Seamless system refers members to services

Referrals come from a variety of sources

Referrals to Humana's Personal Nurse program come from surgical authorizations, hospital authorization or claims data, customer service, providers, and the members themselves.

One of the key components of the program is creating an integrated system that appears seamless to the members, says **Jackie Willmot**, RN, MSN, MBA, director of clinical interventions at Humana.

When a member calls Humana through its triage line or through the new member specialist line, if the need for a personal nurse is identified, that member is transferred directly to a personal nurse.

"In addition," Willmot says, "we are building electronic bridges for our information so that when we gather information on the first call it is transferred with the call so that the Personal Nurse has that information immediately and the member doesn't have to walk through and repeat all the information again with another individual.

"Before we had this service, members might call trying to understand their benefits or identify community resources and may have contacted several departments for information. Then when they got off the telephone, they felt like they didn't have an answer. With Personal Nurse, when we identify a member with a complex clinical need, we give them one place to call," she concludes.

If members have a question about explanation of benefits, the Personal Nurse can help them understand and can walk them through learning to look up their benefits on the Internet site.

If it's a complex issue, the nurses can refer the member to the right person in the benefits or claims departments.

"The goal of the personal nurse is not to show them the way but to help them find the way," Willmot says.

The Personal Nurses are notified when a member is approved for hospitalization as well as when they are actually admitted to the hospital. Some of the referrals come from the providers even when hospitalization is not needed, such as members who have a chronic illness and need some assistance.

"We have a close relationship with the provider community in all our markets. They know about the Personal Nurse service and can refer members if needed," Willmot says. ■

Diabetes management pays off for HMO

Hospitalizations decrease 50%; ER visits 40%

A program to help members with diabetes manage their disease has paid off for ConnectiCare, a small regional HMO based in Farmington, CT.

Members in the DiabetiCare program for adults with diabetes had a 53% decrease in hospitalizations and a 44% decrease in emergency room visits for 12 months after they received case management from a DiabetiCare nurse case manager compared to 12 months before their first contact, reports **Steve Delaronde**, MPH, MSW, an epidemiologist and research analyst with ConnectiCare's Health Management Programs.

The DiabetiCare program was started in 1998 because of the prevalence of the disease among ConnectiCare's population.

"We had about 8,000 members with diabetes. It was a prevalent diagnosis in our membership as well as being a high-utilization and high-cost diagnosis," says **Jay Salvio**, BSN, MBA, director of ConnectiCare's Health Management department.

A multidisciplinary team including physicians, medical directors, and case managers put the program together.

The program started in 1998 with one case manager, **Ginette Levesque**, RN. **Gina Dulak**, RN, joined ConnectiCare as the second DiabetiCare case manager in January 2001.

There are about 10,000 members in the program, most of whom were identified by a computer algorithm developed by ConnectiCare. The rest come from self-referrals or referrals from case managers, physicians, or diabetes educators.

Regular computer scans of claims data identify members who have at least two medical claims for diabetes or have filled a prescription for a diabetes-related drug.

The majority of the members with diabetes are managed on a population-base level. They receive educational material on subjects such as how to test blood sugar, how to manage diabetes, and the importance of getting regular eye examinations.

When they get the names of members with a diagnosis of diabetes, the case managers assess them to determine if they need case management or if mailed educational materials will suffice.

"We try to get the new ones into the program before their disease gets to the point that they need a lot of care," Levesque says.

ConnectiCare uses the laboratory test results of members who have A_{1C} or cholesterol tests to identify those who are at the greatest risk of developing complications according guidelines established by the American Diabetes Association (ADA), Delaronde says.

Those with an A_{1C} level of 7% or higher or an LDL cholesterol level that exceeds 100 mg/dl are identified as the highest-risk members.

The case manager begins making the telephone assessments for those with the highest A_{1C} results.

During the first telephone call, the case managers assess the members and their knowledge of diabetes and their willingness to change their lifestyle in order to get their disease under control.

Other topics for discussion include their individual treatment plan, ADA goals and guidelines, and the importance of good nutrition.

The case managers break out different parts of the program for follow-up telephone calls because they know that the members can't absorb everything they need to know at once.

"All of them have different needs. Some know a little. Others are very knowledgeable; they just aren't doing what they should. We do a lot of encouraging and a lot of empowering the member," Dulak says.

The case managers initially call the members who are at high risk every two weeks.

"They're good at receiving the first couple of telephone calls and responding. After that, it's more difficult to get in touch with them," Levesque says.

The case managers review the blood sugar level with the members and follow them until they get into the normal range.

"I can usually get a feel for whether or not they will continue monitoring their blood sugar level. It takes four to five telephone calls before we can come to any conclusion," Dulak says.

Because diabetes can lead to depression, the diabetes assessment includes a depression-screening program. If it appears a patient is depressed, the DiabetiCare case managers refer them to the mental health case managers.

"You can't change your lifestyle if you're depressed. We have to get the depression taken care of first," Levesque says.

The case management program serves both the members with diabetes and the practitioners who treat them, Salvio points out.

ConnectiCare provides practitioners with updated American Diabetes Guidelines for the management of diabetes and sends them a report every six months listing all their patients who have not had an A_{1C} examination or a cholesterol test and those whose levels are so high they should be addressed by the physician.

"We have been successful in empowering the patients to speak with their physicians about their treatment plans. We give them the knowledge they need to ask the right kinds of questions of their doctor," Levesque says. ■

Noncompliance is biggest problem in diabetes CM

Patients find it hard to change their lifestyles

The most frustrating part of **Ginette Levesque's** job as a diabetes case manager is convincing her clients to make the changes necessary to get their disease under control.

"Most of the members with diabetes are overweight. That's where the hard part of the job comes in. Nobody wants to change their lifestyle and diet. I tell them that I'll be their cheerleader," says a case manager for ConnectiCare's DiabetiCare program in Farmington, CT.

The case managers try to get the members stabilized so they can turn their attention to members at higher risk.

"One of the real challenges is to contact and interact with as many members as you can," says **Jay Salvio**, BSN, MBA, director of ConnectiCare's Health Management department. "There are so many members who need assistance, and there are always new people coming along. In a perfect world, it would be nice to have the resources to keep every member in the program as long as they need it. But we have to try to graduate them and get them on their way."

Here's a typical scenario. The case manager asks a patient to check his blood sugar level twice a day. She calls him back and finds out he's checked it once in a week.

"These are the kinds of patients who have already frustrated their doctor. He's telling them

what to do, and they're not doing it," says **Gina Dulak**, RN, DiabetiCare case manager.

After a few telephone calls, the case managers usually can tell who is going to be a compliant patient and who is not.

"I try to give them as much education and consultation as possible. The best I can do is to tell them the consequences of noncompliance and document it. We get to a point when we know nothing is going to change with this patient," Levesque says.

But even the compliant patients are likely to be back in the program a year a so after they graduate.

"The case managers do a good job of educating members and getting them stabilized, but once they graduate from the program, there is a good likelihood that without the calls, the patients will stray from the path," Salvio says.

The HMO is able to identify graduates of the program who become at high risk again by the laboratory data, Delaronde points out.

"If a graduate from the program has lab results that are out of range, they get another call. The program is not static," he adds. ■

Initiatives aimed at improving diabetes care

Postcards remind members to get checked

Starting this fall, Farmington, CT-based ConnectiCare members with diabetes will receive postcard reminders of the need for their A_{1C} test.

It's part of the regional HMO's DiabetiCare program to help diabetic members manage their disease.

ConnectiCare's computer system can identify members who have not had the screening examinations. Those who have not had a claim for an A_{1C} exam in the past 12 months will receive a postcard describing the importance of the test and the A_{1C} levels recommended by the American Diabetes Association.

Beginning last year, members with diabetes began receiving a postcard once a year, reminding them that they're due for another one and stressing the importance of eye examinations.

Those who are overdue for an examination receive a reminder card urging them to make an appointment with their eye doctor.

Before the eye card program started, 58% of members had retinal eye exams in a one-year period. The next year, the percentage had gone up to 70%.

"This is due at least in part to interventions like the eye examination," says **Steve Delaronde**, MPH, MSW an epidemiologist/research analyst with ConnectiCare's health management department. ■

Collaboration changes HMO's insulin pumps policy

CMs worked for more efficient authorization

ConnectiCare's case managers in its DiabetiCare program joined forces with the HMO's medical directors and local endocrinologists to improve the efficiency of the insulin pump authorization process.

"Gina [Dulak] and I live and breathe this disease, and we have learned a lot from case managing these patients. We were able to compile enough information so that the senior management team realized it was time to change the policy," says **Ginette Levesque**, RN, case manager for the DiabetiCare program in Farmington, CT.

She worked with her fellow case manager, **Gina Dulak**, RN, to get the policy changed so that the diabetic case managers are called on to help determine whether a patient is eligible for an insulin pump.

"We saw an opportunity here. We had a policy in place, and it was a reasonable policy, but by getting Gina and Ginnette involved, the decision-making process is more efficient. If you are evaluating whether or not someone is a good candidate for an insulin pump, it's invaluable to have someone involved who knows the patient," says **Jay Salvio**, BSN, MBA, director of ConnectiCare's Health Management department.

When the clinical review nurses get a request for an insulin pump, they get the case managers involved.

In some cases, the endocrinologist's office calls Levesque or Dulak, and they are able to start compiling their information before the formal request for a pump is made.

Patients who need insulin pumps are getting two to five shots of insulin a day and still are not able to get their blood sugar under control. The blood sugar levels of most patients have been out

of control for a long time and are facing serious complications. The HMO assumes that putting these patients on an insulin pump will be cost-effective by reducing complications, but it's hard to quantify, Salvio adds.

"ConnectiCare has an interest in helping our members obtain tighter control over their blood sugar. The purchase of the pump is not so much in the interest of a short-term gain but a long-term gain because tighter insulation controls are shown to reduce complications of diabetes. We're concerned about the members' quality of life as well as the medical expenses," he says. ■

CM helps Hmong navigate the health care system

Language, cultural differences are barriers to care

The American health care system is bewildering to many immigrants from Southeast Asia who once lived in villages and often had to walk a full day to get to a clinic for health care and who have a limited understanding of English.

That's why UCare Minnesota, a Minneapolis-based HMO, employs people who understand the culture and needs of the Hmong population, says **Chue Xiong**, RN, care coordinator for UCare's Minnesota Senior Health Options, (MSHO) a state-supported program for members age 65 and older who are eligible for Medicaid, with or without Medicare.

Xiong joined UCare as a case manager in January.

In addition to case management, UCare has Hmong employees in customer service and transportation and provides interpreters at no cost to members.

The outreach to the Hmong population was one of eight UCare Minnesota programs spotlighted by The American Association of Health Plans (AAHP) in its national report "Innovations in Medicaid Managed Care: Health Plan Programs to Improve the Health and Well-Being of Medicaid Beneficiaries."

The Hmong originally were from China and migrated throughout Southeast Asia, including Laos, Thailand, and Vietnam. Many ended up in refuges camps in the late 1970s and early 1980s and were relocated all over the world, including Australia, Canada, France, and the United States. California has the highest population of Hmong in the country, but Minnesota is second, Xiong says.

Xiong, herself a Hmong, relocated to Duluth, MN, in 1980 as part of the United Nations Refugee Resettlement Program.

Many of the Hmong refugees are older and have not been able to learn English.

"Even if they have been here for 20 years, English is just too difficult for them. They have enough stress in their lives without trying to learn another language," Xiong says.

The language barrier is complicated by the fact that younger Hmong generations often do not speak Hmong anymore and are unable to translate for their older family members.

"I try to bridge that gap," Xiong says.

Most of UCare's MSHO members in the Hmong community go to two family practice physicians who are Asian and understand the Hmong culture.

When Xiong is notified of a new enrollee, she visits them within 10 days, goes over the coverage, and explains what it's about.

She assesses whether the members need other community services, such as meals on wheels and adult day care, and if they need durable medical equipment.

After the assessment, she puts the patients in four risk categories. Those who are at lowest risk may get an occasional phone call and a visit every six months.

If the member has complex medical or social needs, Xiong follows up with repeated home visits, arranges for home health care, physical therapy, occupational therapy, or whatever else the member needs.

She typically gets more involved when the members are hospitalized or need to see a specialist.

When Hmong UCare members are referred to specialists, Xiong often accompanies them.

"If they have medical problems and need to see a specialist, I handle the referral, arrange for transportation, and schedule interpreters if I cannot go. When they go to the specialty clinic, they often don't know how to tell the doctors why they were referred. I talk to the clinic and explain the situation," she says.

Xiong is notified when a patient is admitted to the hospital. She makes an appointment to visit the patient to find out what is happening and to help with communication between the patient and the physician.

"If the case gets complicated, I schedule frequent care conferences to prevent misunderstandings and

miscommunication. This usually includes the doctors, nurses, social worker, patient, family members, and myself," she adds.

If members have to go to a skilled nursing facility for rehabilitation, Xiong works with the nursing home to make sure they get the appropriate level of care and to get them discharged as soon as possible. ■

Patience is key when working with other cultures

Learn something about their values and customs

Don't get upset if your case management clients from other cultures have trouble understanding Western medicine, **Chue Xiong**, RN, advises.

Among the case management clients Xiong works with in her role as care coordinator for Minneapolis-based UCare Minnesota Senior Health Options are people from the Hmong culture.

Throughout her health care career, Xiong has worked with Somali, Russian, Cambodian, Bosnian, and Hispanic patients. Her advice to case managers working with clients from diverse backgrounds apply to more than the Hmong population.

First and foremost, Xiong advises, be patient with your clients. Many don't understand Western medicine, and it may take some education to get them to agree to treatment.

"These clients may not be familiar with technology or with western practices of treatment. When I deal with the Hmong members, I have to take that into consideration and explain it over and over to the family," she adds.

Xiong spends a lot of her time explaining the Hmong culture and traditions to clinicians. For instance, the patient may not be the person in the family who can make health care decisions. It may be an older or a younger member who needs to be called in.

"As a case manager, you have to know the family structure. We have to make sure that the person in the family who is responsible is called in when there is a need to communicate," she says.

Sometimes, a physician may not understand the Hmong traditions and how they affect health care decisions.

For instance, if a patient has cancer and the physician wants to do a biopsy, the patient may decide to wait and involve the family in making a decision about whether an invasive procedure is right for them.

"That is where I walk in. I tell the physician that we need to have a care conference and find out who is the decision maker in the family. The process of making a decision for treatment can take a long time, and sometimes there is an emergency and the doctor needs to know right away. My role is to help improve the communication between the health care provider and the Hmong family," Xiong says.

Xiong acts as a liaison between the physician, who often feels that immediate medical action is necessary, and the family, who may want to think about it and consult among themselves.

"The physician may not understand that the patient needs to go through such a process. I tell them that they have to wait for the patient and family members to make the decision to prevent future problems," Xiong says.

Occasionally, if the patient has a terminal illness, the physician will ask if the family wants to bring in the Hmong shaman, or spiritual leader, for a traditional ritual.

"I tell them that the ritual is very complicated and must be done in the home because it's very noisy and very intrusive for other patients in the hospital," Xiong says.

Here is some other advice from Xiong for dealing with patients of other cultures:

- If you don't know much about the client or the population, be honest with them and ask questions.
- Learn something about the cultures of the people with whom you work. They won't expect you to know the language, but you should know about their culture, Xiong says.
- Make sure you have an interpreter who is familiar with the language and the culture as well. For example, Hmong are very polite and if you ask a question they don't understand, they may say "yes" so they won't offend you.
- Remember that people in some cultures need a lot of time to evaluate information before they make a decision. Be patient with them. Advocate for your clients and be there for them.
- Remember that building trust is a slow process. It may take a while for them to open up to you, but if you're patient, you'll find that they trust you more with each encounter.
- Respect their culture and particularly the family culture. ■

Transplant CMs coordinate care and communication

Members need help with all the details

Managing the care of an organ transplant patient requires a lot of coordination and communication among the transplant facility, the family, and the insurer.

That's where **Vickie Wrigley**, RN, and **Olivia Farrell**, RN, come in.

They are medical management coordinators for Regence Blue Cross and Blue Shield of Oregon (BCBSO) who case manage all the transplant patients covered by the plan.

Most of the time, the case managers get involved when a member has been evaluated as a successful transplant candidate by a transplant facility. **(For details on the steps the case managers take, see related article on p. 131.)**

But about 20% of the time, the case managers hear from the patient or a family member before the transplant facility is involved. They call in as soon as they get the news from their physician, wondering what they should do next.

"In those cases, we spend a lot of time calming people down. They've just gotten a diagnosis of a dying heart or acute leukemia and in addition to dealing with that, they're worried about financing," Wrigley says.

The case managers talk mainly to family members, but some patients are very aggressive in trying to find out every detail about their illness and the transplant procedure.

Many of the questions involve benefits and what BCBSO will cover. "We are interpreters. We can turn their benefits legalese into plan English for them," Farrell says.

"The questions vary so much between people. It's always constantly changing. We never know what the next question will be," Farrell says.

Farrell and Wrigley refer patients who need transplants to a transplant center, depending on their benefits.

"If the benefits require that they go within our national transplant network, I try to get them to the closest one or in a place where they have family," Farrell says.

For instance, she placed one member from southern Oregon at a transplant facility in Cleveland because that's where he had family and friends.

The case managers follow the patients through the course of treatment and the recovery period, making sure the care is coordinated. When the patient is hospitalized, the transplant case managers communicate mainly with the transplant teams.

"I feel like, if they're in the transplant center, that is where their care should be coordinated. The transplant facility case manager is in their room every day, and we don't want to confuse them by having two people manage their care," Farrell says.

"We follow through with utilization review and concurrent review over the phone with the hospital case management for transplant. We make sure everything is going well and identify their discharge needs," Farrell says.

If the case managers feel that the care is not what it should be, they step in.

For instance, the mother of a baby who had a liver transplant called Regence because she was concerned about the care her baby was getting.

Farrell contacted the transplant team and discussed the issue. She then notified Regence's credentialing facility. The credentialing facility set up an on-site review of the program to determine if Regence should continue its contract with that facility.

"We do make recommendations to change clinical practices at the transplant facility, but that very rarely happens," Farrell adds.

The case managers follow the transplant patients clinically to identify their discharge needs and to identify an inpatient rehabilitation facility or skilled nursing facility before the patient is discharged.

If patients goes home with home health services, the case managers monitor the patients' progress and make sure they're getting the services they need.

The case managers provide invaluable assistance

COMING IN FUTURE MONTHS

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- How case managers are proving their worth to the company
- Why member satisfaction surveys are important
- Using family-centered case managers with pediatric patients

to the home health and hospice team in the event that the transplant isn't successful and the patient is terminal.

Case managers stay involved as long as the members need them — sometimes just six months and sometimes for two years. ■

Transplant case begins with eligibility verification

CMs help find resources for family

The first step in a typical transplant case for Regence Blue Cross and Blue Shield of Oregon's transplant case managers is to verify that the member is eligible for the transplant.

Some of the plans have a 24-month waiting period before the transplant benefit takes effect. However, Regence gives members credit for any insurance coverage, and in 3½ years, there have been only two people who were not eligible, Wrigley says.

"Once we have established their eligibility, we determine whether a transplant is medically appropriate and meets our policy for medical necessity," Ferrell says.

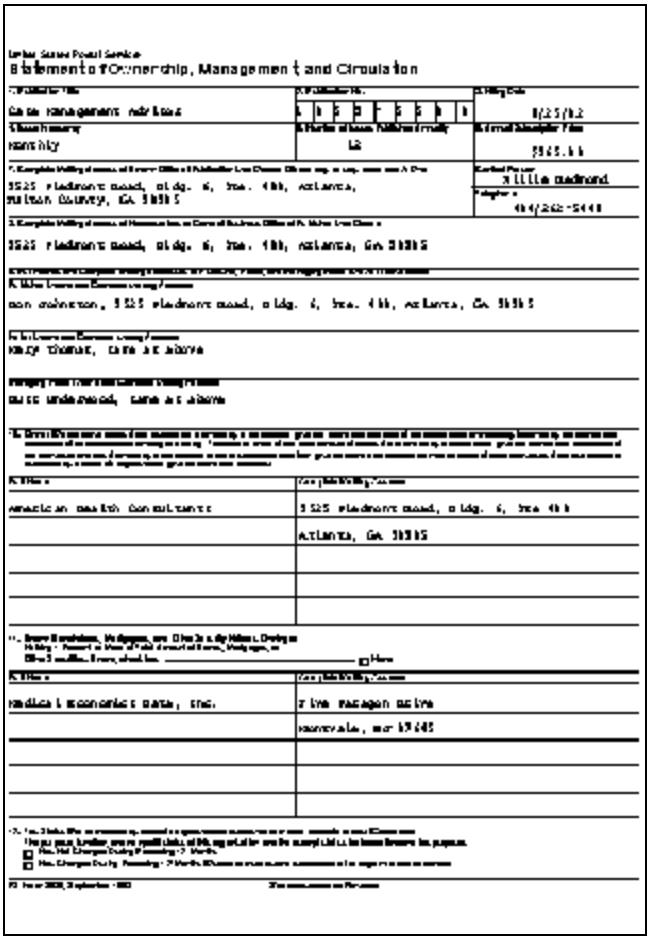
There often are complicating factors in transplant patients. For instance, people who need a kidney transplant typically have so many comorbid conditions that they may need to lose weight before the transplant.

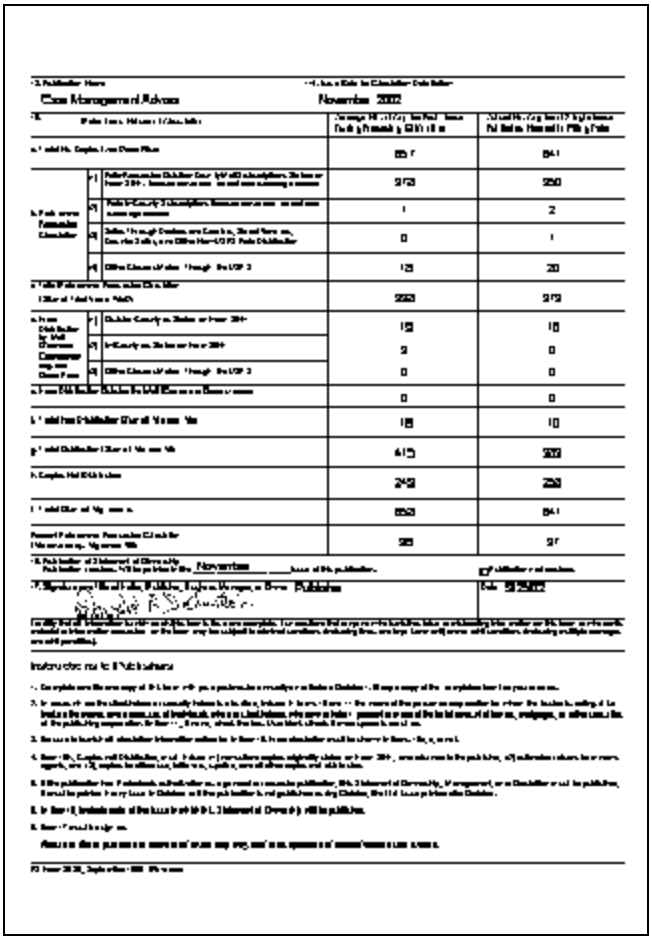
If a liver transplant patient still is using drugs and alcohol, the case managers work with the transplant facility to impose restrictions, such as waiting six months to a year with random testing.

The case managers rarely get involved in compliance issues because transplant centers won't approve the procedure if the patients aren't compliant. "They [transplant centers] are coordinating all the care, the tests, the scheduling, and dealing with any compliance issues," Farrell says.

Sometimes the patients may need transplants that involve such cutting-edge technology that they are considered investigational, she says. "Occasionally, we have to deny a transplant, but it isn't very often. When it doesn't meet our regular medical policy, we look to see if there are clinical trials that we can support."

Farrell says the most frustrating part of her job happens when a patient needs a bone marrow transplant from an unrelated donor. The search


Statement of Ownership, Management and Circulation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for a compatible donor often is not covered by the health care benefit she says.

The case managers often have to tell the patients that they will cover the procurement and the bone marrow infusion but not the search. They then refer them to the social worker at the transplant facility who may be able to help them find funding for the search.

"We help them get hooked into resources as fast as possible and they usually cope with it. The cost of the search is a small piece compared to what we are paying for the transplant. That doesn't make us feel any better when we tell people no, but it is the way I can sleep at night," Farrell says. ■

CE questions

17. The Care Support Program at First Health Group Corp. in Downers Grove, IL, is overseen by how many medical directors?
A. 10
B. 21
C. 25
D. 28

18. By the end of 2001, how many of Humana's 6.6 million members were enrolled in its Personal Nurse program?
A. 17,000
B. 30,000
C. 40,000
D. 200,000

19. Before Farmington, CT-based ConnectiCare began its "eye card" program, what percentage of its diabetic members had retinal eye exams in a one-year period?
A. 58%
B. 62%
C. 70%
D. 77%

20. Which U.S. state has the largest population of Hmong?
A. Minnesota
B. Oregon
C. New York
D. California

Answers: 17. C; 18. B; 19. A; 20. D.

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. ■

Osteoporosis screenings urged

Women 65 and older should routinely be screened for osteoporosis to reduce the risk of fracture and spinal abnormalities associated with the disease, the U.S. Preventive Services Task Force has recommended.

The task force, an independent panel of experts sponsored by the Agency for Healthcare Research and Quality also called for routine screening to begin at age 60 for women who are identified as high risk because of their weight or estrogen use. It marks the first time that the panel has called for routine osteoporosis screening.

The task force found that dual-energy X-ray absorptiometry (DEXA), a noninvasive test, is the most accurate method for measuring bone density.

"Screening women at risk for osteoporosis can lead to early detection and treatment to prevent fractures. We recommend that clinicians discuss the potential benefits and risks of each treatment with their patients before deciding on a specific option," says **Janet Allan**, PhD, RN, vice chair of the task force.

The findings are reported in the Sept. 17 *Annals of Internal Medicine* (Screening for osteoporosis in postmenopausal woman: Recommendations and rationale. *Ann Intern Med* 2002; 137:526-528). ▼

Americans' health improving, according to HHS report

Americans are living longer, fewer babies are dying in infancy, and the gap in life expectancy between white and black Americans has narrowed in the past decade, according to a U.S. Department of Health and Human Services (HHS) report on American health over the past 50 years.

"As we take better care of ourselves and medical treatments continue to improve, the illnesses and behaviors that once cost us the lives of our grandparents will become even less threatening to the lives of our grandchildren," says HHS Secretary **Tommy Thompson.**

By the year 2000, infant mortality had dropped to a record low and life expectancy hit a record high, according to *Health, United States 2002*, a statistical report on the nation's health prepared by the Centers for Disease Control and Prevention.

The report noted that Americans spent $1.3 trillion on health care in 2000, a figure equal to 13.2% of the gross domestic product. A third was spent on hospital care, one-fifth on physicians, and almost 10% on prescription drugs.

Federal and state programs, principally Medicare and Medicaid, paid 43% of all medical bills. Private insurance covered 25%, and other private sources paid 5%. Consumers paid 17% of their health care costs.

Among other key findings of the report:

- Death rates among children and adults were cut in half during the past 50 years. Deaths among those 65 and older dropped by a third.
- In 2000, Americans' life expectancy was almost 77 years — 74 for men and almost 80 for women. A century earlier, life expectancy was 48 for men and 51 for women.
- Men and women who reach age 65 live on average to age 81 and 84, respectively.
- More than 40% of adults were smokers in

1965, compared to 23% in 2000. Those without a high-school education were three times as likely to smoke as college graduates.

• Infectious disease rates have declined. For instance, the syphilis rate in 2000 was the lowest since national reporting began in 1941.

• Three in five adults ages 20-74 are overweight, with one in four considered to be obese. Almost 40% of Americans engage in no physical activity during leisure time.

• Hospital stays averaged 4.9 days in 2000. Twenty years ago, patients spent an average of more than seven days in the hospital.

The report is available on the CDC web site: www.cdc.gov/nchs. ▼

Multivitamin use in pregnancy cuts childhood tumor risk

Pregnant women who take multiple vitamins can cut their children's risk of neuroblastoma by 30%-40%, a study has shown.

The study, conducted chiefly at the University of North Carolina (UNC) at Chapel Hill, is the largest epidemiologic study ever conducted of neuroblastoma, a childhood nervous system cancer.

"Neuroblastoma is the most common tumor diagnosed in infants and is usually diagnosed in children under three. Typically, fewer than 50% of affected patients live five years following diagnosis," says **Andrew F. Olshan**, MD, professor of epidemiology at the UNC School of Public Health.

Researchers interviewed mothers of 538 children with neuroblastoma and 504 control subject children without the illness. They asked the mothers about their vitamin use before, during, and after pregnancy and other possible health- and illness-related factors.

"Our findings, combined with previous work on reducing several birth defects with vitamin supplementation . . . supports the recommendation that mothers' vitamin use before and during pregnancy may benefit their babies' health. We believe physicians and other health care providers should continue to educate women about these benefits and recommend appropriate dietary habits and daily dietary supplements," Olshan says. ▼

Delayed evaluations increase risk for kidney patients

Kidney patients are at a greatly increased risk of death when they have delays getting to a specialist, researchers at Johns Hopkins University in Baltimore have concluded.[1]

The study shows that a nephrologist evaluated a third of chronic kidney disease patients only four months before having to start dialysis treatment. Those evaluated late were more likely to die within two years.

Delayed in getting specialty care probably can be attributed to poor access to primary care, delayed or absent referral to a specialists from a primary care physician, and patients' lack of information about the importance of early intervention, says **Neil R. Powe**, MD, MPH, MBA, senior author of the study.

Powe and his colleagues examined data from Choices for Healthy Outcomes in Caring for End-stage renal disease, a study at Hopkins that followed more than 1,000 dialysis patients.

Among the patients who were evaluated late, 13% died one year after starting dialysis, and 27% died two years after starting dialysis. By contrast, patients who were evaluated early had death rates of 4% after the first year and 15% after the second year.

Reference

1. Kinchen KS, Sadler J, Fink N. The timing of specialist intervention in chronic kidney disease and mortality. *Ann Intern Med* 2002; 137(6):479-86. ■

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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CMA must receive news about conferences and seminars at least 12 weeks prior to the event to meet our publication deadlines. ■